

**Review of the performance of  
South Australian health systems,  
the health of South Australians  
and changes in health outcomes  
over the reporting period  
2015-2018**

18-HPC-1947

Health Performance Council



Government  
of South Australia

Health Performance Council

## Acknowledgment

The Health Performance Council acknowledges all the Aboriginal peoples of South Australia, the complexity and diversity of their communities and that each has its own beliefs and practices. The Council recognises their cultural authority and respect their enduring spiritual relationship with their countries. The Council knows that there are people of Torres Strait Islander heritage living in South Australia; however, in recognition that Aboriginal people are the original inhabitants of this state, in this document the Council respectfully use the term 'Aboriginal' in this document to refer to all people who identify as Aboriginal, Torres Strait Islander, or both.

The region that is now South Australia is estimated to have had 50 different language groups at the time of European colonisation and 36 continuing language groups (Reconciliation SA 2012). Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite the ongoing effects of colonisation and dispossession.

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**Review of the performance of South Australian health systems, the health of South Australians and changes in health outcomes over the reporting period 2015-2018**

Dear Minister

In line with requirements of the *Health Care Act (2008)*, I am pleased to submit the Health Performance Council's four-yearly report, which summarises the Council's work in examining the achievements of the public and private health systems, population health outcomes and consumer and community engagement in health systems in South Australia from 2015 to 2018.

There are bright spots where the Council can see health-system managers and clinicians working with each other and with consumers to improve health care and health outcomes. However, while the policy narrative is about delivering 'consumer-centred care', it is impossible to claim this achievement when the public health system chooses so infrequently and selectively to ask consumers what they expect and experience from and in the system. We have observed other Australian states developing their health systems' quality and safety, health outcomes, patient-reported outcomes and data reporting systems in public and private health sectors and found that, in some instances, South Australia has been left behind.

Access to quality health care in the public and private systems is a priority for South Australians. Our analyses tell us that what is important to South Australians is the ability to be confident that our health systems are there for us when needed, whoever and wherever we are. But we have not found cause for such confidence. The Council's reviews, and its assessment of those reviews, provide state-wide, all-of-South Australian population perspectives on outcomes and equity over time. We have carefully examined instances where average statistics hide disparities for specific population groups. We have found that if you are an Aboriginal person in South Australia, you are less likely than a non-Aboriginal to receive the help you need, and should expect to receive, to become healthy. If you are a member of a culturally and linguistically diverse group within the population, if you are old, if you live in a rural or remote area, or if you are in a lower socio-economic group, you are probably better able than members of Aboriginal communities to achieve healthy outcomes, but still less likely than the 'average South Australian'. The Council strongly urges that this disparity must be eliminated. There are circumstances in which equality in the provision of services must occur, if one population has greater need than others, to achieve equity in health outcomes for all.

For the most part, this report has observed the results of health policies in place before the announcement of your proposed reforms towards regionalised governance, increased clinical and community engagement, and pillar agencies to be established for wellbeing and excellence and innovation. We understand that addressing underperforming elements of any system can take time, especially if they have not been effectively tackled over years. So, our four-yearly report focuses on key advice drawn from what we found in reviewing the health systems, which we are confident can be implemented to quickly influence Department of Health and Wellbeing leadership and management, ways of working in the department and local health network governing boards, and the engagement of staff and community.

Priority should be given to:

- the availability and use of data, and robust analysis and transparent reporting on health outcomes, including patient-reported outcomes that arise from services in public and private sectors, to inform clinical improvement and policy-making
- listening to all staff and consumer voices for insight into what works and what could be better at the frontline of service provision
- workforce planning aligned with every new strategy
- tackling discrimination and racism in the health system, as reported by consumers and staff
- clearly describing how the new governing boards must work to ensure their governance reflects all dimensions of quality and safety, and access and equity, within their local health networks and collectively across the health system for all consumers and communities.

As with the reports of other monitoring bodies, the Council's findings and advice do not always provide comfortable reading, but our form of democracy relies on its institutions being accountable, transparent and trustworthy. For the South Australian health system to achieve its objectives, the provision and public availability of this expert, independent analysis and advice to the Minister should be preserved.

It is my sincere hope that the advice offered within this report can be included within your restructure plans, to strengthen the public and private health systems in South Australia in delivering high-quality, safe and continuously improving care for all South Australians.

Yours

A handwritten signature in black ink, appearing to read 'Steve Tully', with a stylized flourish at the end.

Steve Tully  
Chair  
Health Performance Council  
December 2018

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# 1. Introduction

This is the Health Performance Council's third four-yearly report. During the years under review – 2015 to 2018 – there have been many changes to the system and its services, including some with impacts on the delivery of care to South Australians across the state: the end of 'Transforming Health', introduction of a new model of health system governance, and the rollout of new Commonwealth programs such as the National Disability Insurance Scheme. And there is more change on the horizon, with the introduction of some national aged care reforms and the Australian Government's Royal Commission into Aged Care Quality and Safety set to begin in 2019.

The true measure of the South Australian health system's performance is its capacity to deliver care to all people when, how and where they need it. Such a system balances the provision of primary and preventative care and hospital-based care. It should promise the same access to all consumers, no matter where they live or what their cultural backgrounds. It should support its users at the very times of their lives when they most need it.

The Council has found much that is outstanding about the South Australian health system, public and private, and the achievements of the thousands of people who work within it. However, there is room for improvement. It is recognised that a balanced and consumer-centred health system fosters better health outcomes and is most efficient when it integrates preventive and primary care with hospital services. In terms of the Australian system, the involvement of federal and state governments in policy setting and funding makes it complicated for patients using services in overlapping and potentially conflicting areas.

The Council offers this report in the hope that the South Australian Government and, where relevant, public, private and not-for-profit care providers in the wider health industry will consider its advice as an important step in providing access to high-quality and safe care for all South Australians.

## Requirements under the *Health Care Act 2008*

### Part 3—Health Performance Council

#### 13—4-yearly report

- 1) Health Performance Council must, on a 4-yearly basis, furnish to the Minister a report that assesses the health of South Australians and changes in health outcomes over the reporting period.
- 2) The report must—
  - a) identify significant trends in the health status of South Australians and consider future priorities for the health system having regard to trends in health outcomes, including trends that relate to particular illnesses or population groups; and
  - b) review the performance of the various health systems established within the State in achieving the objects of this Act; and
  - c) identify any other significant issues considered relevant by Health Performance Council; and
  - d) conform with any requirements of the Minister as to the form of the report and other matters to be addressed by the report.

Refer to Appendix One.

## Meeting the requirements of the Act

The Council provides the Minister with this four-yearly report to indicate significant trends in the health status of South Australians and what actions could be taken to improve health outcomes, including the findings and advice generated from this work:

- key system performance inputs from ‘watching briefs’ on -
  - progress against ‘SA Health-agreed’ indicators in the HPC’s 2014 4-Yearly Review (Appendices Four and Five)
  - population health indicators through the Council’s *State of Our Health* (Appendix Three)
- review topics -
  - monitoring SA Health’s implementation of ‘Transforming Health’
  - an Aboriginal health case study, working with the Aboriginal Leaders’ Forum
  - a culturally and linguistically diverse communities’ health outcomes audit
  - a ‘revisit review’ of the Country Health Advisory Councils Governance Arrangements 2011
  - post-implementation review of the Country Health SA Local Health Network Aboriginal Community and Consumer Engagement Strategy
  - revisiting the review of South Australia’s *Palliative Care Services Plan 2009-16*
  - scoping an approach to monitor health outcomes for people with mental health and addiction issues in South Australia
  - an ‘Areas to Act’ analysis, examining health system data for indicators of potentially preventable hospitalisations using the Grattan Institute’s *Perils of Place* (2016) method, in collaboration with SA Health and Adelaide and Country SA Primary Health Networks (PHNs).

Refer to Appendix Seven for the full Health Performance Council publications list from 2015- 2018.



## 2. State of Our Health

Over the past four years, the Health Performance Council has monitored select components of South Australia's public and private health systems, assessed the quality and performance of the overall system in providing quality care for South Australians, and examined and reported on population health outcomes.

### 2.1 Review Findings

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As the Council conducted its priority reviews – of care for Aboriginal peoples and for those at the end of their lives, of care for people of culturally and linguistically diverse backgrounds and those living in remote and rural areas, and of the impact of the 'Transforming Health' hospital reform program on care for South Australians – it became clear that there were issues common to many or all of the reviews. These are issues the Council considers are having major impacts on planning, developing, introducing and evaluating projects and initiatives, and allocating the funds to those projects and initiatives. The Council knows the South Australian public and private health systems are striving to provide safe and high-quality care, yet there are still many inequities in how the system delivers this care. Section 3 provides the key advice provided to the Minister in each of the Council priority reviews in 2015-2018, followed by summaries of individual reviews that have informed the advice in this four-yearly report.

The Council is aware that SA Health and public health services are being extensively restructured. The directions that have been announced in the media and other forums include the development of a new health and wellbeing strategy, new and regionalised public health network governance, more clinician and community engagement, and more focus on quality and safety. These are logical reforms with the potential for major improvements. However, the South Australian health system has had plans like this before. The Council highlights issues in this section that it considers are having a significant impact on service delivery and outcomes across the areas it has examined over the past decade.

#### Consumer and staff voices are missing

The Council observed that consumer and staff voices were selectively sought and not heard nearly often enough at the higher levels of SA Health decision-making, nor heard with a willingness to introduce change according to what was heard.

SA Health has previously promised a 'patient centred' health system. But the system cannot claim to be 'patient centred' if it is not as informed as it could be about patients' health experiences and outcomes. This can only occur through the collection and use of data from patients, and other consumers such as family and carers, who have navigated the system, about their experiences and outcomes.

In many reviews, the Council could not find evidence of the level of consumer engagement that is expected in today's user-focused health systems. Aboriginal people have specific engagement and care needs that are frequently ignored or not understood. Members of culturally and linguistically diverse communities report that their cultures, literacy levels, faith-based needs and other characteristics are frequently not considered, either in their care or in communicating aspects of that care.

People do not always have access to interpreters to help them explain and understand their conditions and treatment options. A South Australian Consumer Experience Surveillance System (SACESS) survey of people's experience with public health services systematically excludes the voices of people without the English language skills to complete it.

Health systems around the world now have a myriad of engagement tools to capture their users' needs and wishes. For example, the Council found the International Association for Public Participation's *IAP2* framework mentioned in some SA Health engagement policies, and observed that it had been useful when

used to evaluate consumer engagement in health care in South Australia. The Council considers more must be done to explore the types of engagement suited to South Australian health environments and communities, and to implement the best tools and techniques available.

In the same way, the Council found that the people working in the system are rarely heard, or given opportunities to offer their invaluable knowledge of what works, fails and could be better 'on the ground'.

In the public health system, staff account for most of the budget, are crucial to providing any service, and determine the quality of the care. Recruiting, training and retaining staff should be core to managing the health service, and evolving health strategy and health care to the changing needs of the population. The Council considers that strategies will not work if they do not have well-developed workforce plans that demonstrate how staff will be involved and developed to maximise their potential and their effectiveness.

Recent experience with 'Transforming Health' is not encouraging. Even the relatively recent *SA Health Strategic Plan 2017-20* only stretched as far as having an early action to 'develop a work plan for the development of a workforce plan for SA Health' (*SA Health Strategic Plan 2017-20 – Early Actions Section 3*). SA Health must do better than this, and cannot afford to forget workforce planning again.

Asking staff for feedback shows them that leaders value their knowledge and expertise, and maximises the benefits of that knowledge and expertise in improving the system. However, in the series of reports that monitored the implementation of 'Transforming Health' (2015-2017), the Council pointed to a lack of trend data that may have indicated that staff opinions about working for the Department of Health and Wellbeing and its local health networks were being sought and heeded. The Council encourages SA Health to at least maintain a commitment to undertake annual, organisation-wide staff surveys to build a consistent and comparative picture of staff perceptions of workplace practices and outcomes over time.

## **Aboriginal health outcomes are not improving fast enough**

The Council's 2014 four-yearly review report and the evaluative work of others have shown that Aboriginal people experience a range of disparities in health outcomes and do not benefit equitably from health services. Across Australia, Aboriginal Australians die 10 years younger than non-Aboriginal Australians; there is no South Australian-specific data for this measure, but there is also nothing to suggest the findings would be different. The Council's work with Aboriginal leaders gathered for the jointly hosted Health Performance Council and Wardliparingga Aboriginal Leaders' Forum – which has met 10 times since 2013 – confirms that the health of Aboriginal people in South Australia remains poor, despite targeted initiatives by governments and positive movement in some areas.

For example, as noted in the *2017 Aboriginal Health Case Study*, the SA Health Aboriginal Cultural Respect Framework from 2007 launched the mandatory *SA Health Aboriginal Health Impact Checklist* to ensure programs that have an Aboriginal impact are effective and engage Aboriginal stakeholders in culturally respectful ways. Culturally respectful engagement will contribute to proposals that address Aboriginal health disparities. But more than a decade after the checklist's release, the Council has had difficulty identifying routinely collected information about if, where and when it has been applied, even in designing major projects such as the new Royal Adelaide Hospital, the Enterprise Patient Administration System (EPAS) and 'Transforming Health'.

The current government is not adhering to the *SA State Strategic Plan*, which established 100 or so aspirational targets for the government between its release in 2004 and June 2018. SA Health has never met the Strategic Plan's target of two per cent Aboriginal workforce participation; there continues to be a significant shortfall in Aboriginal people in health-related professions and other roles across all levels.

Aboriginal leaders have told the Health Performance Council that if better health outcomes are to be realised, there must be an integrated, cross-discipline, cross-portfolio and Aboriginal-led approach to reforming health programs and practices that is based on what Aboriginal people say. This holistic approach must take account of social, cultural, spiritual, economic and environmental determinants such

as education, employment, safe housing, and culturally appropriate health practices and health promotion. It is time to practise zero tolerance for institutional discrimination and racism within the health system, and for ensuring Aboriginal health consumers know their rights.

Innovative options that fall outside 'western' health and medical models are needed. The Council has found that there is excellent knowledge of what will work. For instance, the Council has been pleased to be represented on the SA Aboriginal Chronic Disease Consortium Monitoring and Evaluation Action Group. The consortium has a list of immediate actions to tackle specific chronic diseases that should be prioritised and resourced by SA Health for local level application. These actions will maximise outcomes for Aboriginal people with these health problems, no matter where they live in the state.

## Statistical averages hide disparities

There is a role in statistical analysis for the measurement and reporting of averages and medians. The comparison of such measures over time provides a picture of change over that period, for example. But averages and medians cannot capture the individual experiences and outcomes that together contribute to those statistical measures of a system's performance.

The Council has found that in focusing on averages and medians, the health system has been able to congratulate itself on improvements that would not be so satisfying if individual stories or even those of population sub-groups were provided to illustrate the measures of central tendencies. For example, the Council understands from its work with specific population groups that there are particular challenges that require tailored responses for:

- South Australians from culturally and linguistically diverse backgrounds
- South Australians living with disability
- South Australians who are carers
- South Australians who are veterans
- South Australians who are lesbian, gay, bisexual, transgender, intersex or queer people
- South Australians in prison.

The *Areas to Act* report delivered to the Minister shows that in some postcode areas the rates of preventable hospitalisation are at least 50 per cent above the state-wide averages for conditions such as asthma, diabetes and high blood pressure, and have been for a decade or more. This signals that the existing health policies are insufficient. But if SA Health, the Adelaide and Country Primary Health Networks and the Council were to work together to provide the baseline data, attention could be given to working differently and monitoring what works to address these inequalities.

Similarly, the Council's bite-sized statistical report on the health of South Australian prison populations highlighted how poor the data is for this specific and quite vulnerable population group. The health system does not have the information about prison populations it needs to understand the base from which it is starting, what to improve, or how realistic it is to expect to meet the objectives of any program or reform.

Limited understanding of the impacts of physical, social and cultural aspects on people's health can constrain health services' ability to plan, deliver and evaluate services that best serve their consumers. Gaps are evident in the collection of relevant data for specific population groups making it virtually impossible to develop a complete picture of the variations in health outcomes and making identification of progress difficult. An absence of epidemiological data also limits comparisons with other population groups in South Australia and with similar populations interstate. Without quantitative data, these population groups may be invisible to health services.

## Data is non-existent, inaccessible and underused

South Australia's health systems hold vast amounts of routinely collected data that could and should be inform clinicians on improving clinical practice and guide policy-making. The data could and should support the Council and other entities in enabling the scrutiny and accountability of system performance, including comparing the quality and efficiency of care in different parts of the state, for different therapeutics and between public, private and other care sectors. Too often, however, the Council has not been able to find or access the data to support these objectives, all of which would support better health outcomes. In 2014, the Council found limited evidence that the health system linked and analysed data or disseminated results to inform decision making across the service for continuous improvement. Unfortunately, little has changed.

In addition, the Council has found several cases of public health policies and directives – including the *Palliative Care Services Plan 2009-16* – launched without explaining the baseline or specific targets and indicators for implementation, monitoring and evaluation. In some cases, such as the *Aboriginal Community and Consumer Engagement Strategy* (2015), the Council decided to commission its own data collections from consumers and communities to review the effectiveness of SA Health community and consumer engagement strategies, because no baseline or routine data source was available.

There is also very little available information on how well health services perform in the private sector. The Council's 2014 advice, agreed by the then Minister, was to make data about private hospital use available to SA-NT DataLink in a form that would allow monitoring of all-of-South Australia population health outcomes (Appendix Six). Four years later, no progress has been made, leaving South Australia unable to develop an all-of-population dataset from which to assess population health outcomes. As the Productivity Commission's *Data Availability and Use* report stated in 2017, the availability of this linked data is fundamental to the analysis that will trigger innovation and service improvements. In South Australia, however, the Council could not (for example) track the number of public hospital admissions prompted by complications acquired in the private system (and vice versa); nor could it analyse the treatment outcomes of the thousands of South Australians who receive a mix of private and public care.

The Council has benefited from direct access to some of SA Health's major corporate data collections, and indeed could not have functioned effectively over the past 10 years without this. But direct access to a few activity datasets has not been sufficient to complete all reviews. Over this four-year review period, the Council has observed a slowing responsiveness to data requests at SA Health and considerations by the SA Department for Health and Wellbeing Human Research Ethics Committee, compared with the review period to 2014. While the Council has not established a cause for this, it may signal increased aversion to risk.

The Council queries whether SA Health decision-makers value high-quality information and data analytics in designing and implementing successful policy and strategy. The Council advises that South Australian Government strategies, plans and policies should only be launched if they identify clear and measurable health and wellbeing outcomes for consumers, families and carers, and how they will be achieved. This needs to bring together use of current routinely collected data; new routine collections of patient-reported outcome and patient-reported experience measures; availability of data to clinicians and clinical units for quality improvement; and data use in policies and performance monitoring.

The impending South Australian Government health governance reforms also offer an opportunity to change legislation and remove impediments to data linking.

## Policies and plans do not lead to action

There are many people aiming to 'do good' in South Australia's health system. Politicians, their staff and health agency officers engage with stakeholders and design policies to address their issues and concerns. But despite these efforts, there is too often a chasm between publicised plans and what South Australians see in improved services.

Some plans are not implemented; others are not reviewed or evaluated. New plans are sometimes introduced part-way through the lifespan of their predecessors.

Consumers and staff express frustration as they watch resources spent on much-needed reform agendas, only to find that the results they wanted were not achieved because the policies or initiatives were not introduced, did not include measures and deadlines that would demonstrate failure or success, or did not identify who was or should be responsible. The Council has often found such attention to implementation to be lacking.

For example, the South Australian Government's *Palliative Care Services Plan 2009-16* included some measures that could track whether or not results were achieved, but too many others were not assigned tracking tools to enable measurement of progress or outcomes. Similarly, the Council found that Country Health's *Aboriginal Community and Consumer Engagement Strategy* (2015) included a list of actions for implementation, but failed to identify either desired outcomes or ways of measuring progress. The flagship Aboriginal Health Experts by Experience (EbE) Register section of that strategy won a SA Health Awards 2015 prize, but without monitoring and reporting on progress, outcomes were compromised.

Successful strategies should recognise the problems they are attempting to solve. They should be designed with the input of the right people, state their desired outcomes, and outline the approaches, methods and mechanisms that can be expected to achieve these outcomes – a well-developed theory of change – and how they will be monitored. Too often, South Australian health strategies appear not to be developed this way; in turn, lack of attention to implementation and monitoring mean that they do not achieve the better outcomes and organisational learning that might be expected.

## 2.2 Advice to the Minister for Health and Wellbeing

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The Health Performance Council applauds any and all measures designed to improve services and outcomes for all South Australians. It recognises the financial constraints facing governments and health sector institutions as they attempt to manage and improve a system that must meet the needs of a culturally diverse, ageing and widely dispersed population. In conducting its analysis and reviews, it has worked with stakeholders in and related to the health system.

In this context, the Council urges the Minister to consider the following advice for the health systems of South Australia, public and private, and especially as the public health services restructure progresses with a vision to improve health outcomes for all South Australians. The advice is based on the individual reviews conducted during the four-yearly report period and the broader learning from 10 years of advising health ministers about the South Australian public and private health systems and population health outcomes. The advice is consistent with national standards and principles, and is considered by the Council to be achievable within existing budget parameters.

### Aiming for excellence

The Council advises that the Minister for Health and Wellbeing introduce the following changes across the state's public and private health system to improve services and outcomes for all South Australians.

#### **1. Establish clear, actionable initiatives, expected outcomes and related performance indicators in all policies.**

The Minister should direct the Department for Health and Wellbeing (department) and local health network boards to:

- 1.1. monitor and report on a completed Aboriginal Health Impact Statement or Checklist of Best Practice Program Development for Aboriginal Health for all new strategies, plans, policies and initiatives including proposals for funding discontinuation or service closure
- 1.2. provide local health networks boards and their respective committee memberships with health literacy and health governance skills and knowledge to ask better questions and understand and use data in reports on regional health outcomes, finances, quality and safety including clinical governance, and consumer and staff surveys, and other topics
- 1.3. ensure all new strategies, plans, policies and initiatives include a workforce plan that demonstrates how staff will be involved and developed to maximise their potential and their effectiveness.

#### **2. Ensure governance recognises, reflects and addresses the needs and expectations of communities who are served.**

- 2.1 The Minister should make a clear public statement on his diversity and inclusion strategy for health, including expectations for the public and private health systems, the department, local health networks, boards and workforce as a cornerstone of an effective health system for South Australians. This should cover, and not exhaustively, policies on recruitment, training, language access and communication, and seeking input and feedback from staff, consumers and communities.

The Minister should direct the department to:

- 2.2 monitor and report on board skill mixes, ensuring clinical governance and consumer representation on every local health network board.

The Minister should direct the department and local health network boards to:

- 2.3 include representatives of local Aboriginal communities' diversity and interests in decision-making bodies (including boards, consumer advisory and clinical governance committees and groups) that advise and oversee health services used by Aboriginal people, in line with guidelines such as the *National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres and Strait Islander Health*
- 2.4 require boards to report to the community annually on how they have engaged with their consumers and communities over the past 12 months<sup>2.5</sup>
- 2.5 publish a data dashboard detailing progress on equality, diversity and inclusion, updated twice a year, including participation in cultural competence training.

### 3 Ensure the health workforce reflects the communities who are served.

The Minister should direct the department and local health network boards to:

- 3.1 set targets to increase and monitor the number of Aboriginal people trained for and recruited to the health workforce, particularly setting targets for senior and health professional roles based on local demographics and aggregated up to state-wide monitoring
- 3.2 increase diversity data recording in human resources systems and prioritise prompting staff to review their record of Aboriginal identification across the department, local health networks boards and public health human resources systems.
- 3.3 undertake annual staff surveys to build a consistent and comparative picture of differences and changes in staff perception of workplace practices and outcomes including about institutional racism, harassment and discrimination.

### 4 Practise zero tolerance for discrimination and racism.

The Minister should direct the department and local health network boards to:

- 4.1 ensure all health consumers know their rights about receiving public and private health and community services in South Australia
- 4.2 monitor and report consumer feedback and about institutional racism, harassment and discrimination and equity of access challenges in the system
- 4.3 undertake workplace audits to understand institutional discrimination and racism towards Aboriginal people, people from culturally and linguistically diverse communities, and other specific population groups who may be vulnerable within the health system
- 4.4 comply with National Safety and Quality Health Service Standards with particular attention to (i) the National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander health and (ii) developing comprehensive care, which is the integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas (<https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition/>)
- 4.5 increase recording of Aboriginal identification in the health system for consumers by using the Australian Institute of Health and Welfare best-practice guidelines for the collection of Indigenous status in health data sets, including how best to ensure that systems provide consistent and continuous transfer of Aboriginal identification data across SA Health, and by providing training to help staff reliably and appropriately collect information.

### 5 Involve and engage consumers in system development and evaluation, and ensure their voices are heard at executive and board levels.

The Minister should direct the department and local health network boards to:

- 5.1 conduct a consumer experience survey for all health consumers, including but not limited to maternity, psychiatric, substance abuse, chemotherapy and renal dialysis consumers; people from culturally and linguistically diverse backgrounds; and Aboriginal consumers



- 5.2 collect patient-reported outcome and patient-reported experience measures, make these measures available to clinicians and clinical units for quality improvement, and use the results in performance monitoring.

## **6 Collect, make accessible and publish data about health outcomes and health systems performance.**

The Minister should:

- 6.1 pursue changes to legislation and tackle other system impediments to require public and private health systems' data to be available in a linked all-of-population dataset for clinical improvement, audit, evaluation and research
- 6.2 maintain a function reporting directly to the Minister that provides expert, independent analysis and advice on population health outcomes and public and private health systems' performance, as a component of successful, sustainable restructured health systems in South Australia.

The Minister should direct the department to:

- 6.3 improve data collection about specific population groups to improve policy making and service planning and delivery by undertaking purposeful sampling of specific population groups and routinely reporting on these groups on a cyclic basis, to improve South Australian population health data collection and analysis
- 6.4 make private hospital data available to SA-NT DataLink, as agreed in response to the Council's 2014 four-yearly report (Appendix Six)
- 6.5 collaborate with key stakeholders to regularly repeat the 'Areas to Act' research and analysis and publish the results at least every two years.



## 2.3 At a Glance: Health Outcomes and Health Determinants

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Understanding how chronic disease and health risks vary depending on where we live, and how these factors change over time, is critical to responding to emerging health trends and our diverse health needs. South Australians in general have access to some of the best healthcare in the world. However, differences in income, employment, education, housing and social environment are leading to inequalities in health outcomes.

One method of assessing the performance of South Australia's health system is to look at changes and differences in population health outcomes. The Health Performance Council's 'State of Our Health' resource – published online at [hpcs.com.au/state\\_of\\_our\\_health](http://hpcs.com.au/state_of_our_health) – provides a picture of population health over time in each of the South Australian local health networks, by age and sex, by socio-economic status, and against national and Aboriginal population comparators.

The report contains a mix of good and bad news for South Australians. For this four-yearly report, the Council perused the 166 statistical measures it currently reports for indicators of improvement or challenge. The full 'State of Our Health' (SoOH) indicator report is at Appendix Three. The criteria used in short-listing are subjective but include persistent increasing or decreasing trends over a decade, a prevalence of more than 10 per cent, and/or measures where South Australia was ranked first, second, penultimate or last compared to other states and territories. The Council prioritised measures where data was most current.

This process short-listed 20 measures of health outcomes and determinants noted as strengths, which indicated improvements, or that the Council decided presented current or emerging challenges to the health system. The Council has denoted these 20 strengths and challenges below with ticks ✓ and crosses ✗, along with brief context explaining why the selected measure should be brought to the attention of the Minister for Health and Wellbeing. More information is available at [http://www.hpcs.com.au/state\\_of\\_our\\_health](http://www.hpcs.com.au/state_of_our_health)

### Staying healthy

While the gap between Aboriginal and non-Aboriginal life expectancy is about 10 years, life expectancy across the population in South Australia is rising. The vast majority of South Australians self-report that their general health status is good, very good or excellent – despite around a quarter having disabilities that restrict everyday activities and around one in 20 needing assistance with core activities due to profound or severe disability. Most South Australians do not eat the recommended amounts of fruit and vegetables, or undertake the recommended amount of moderate or vigorous physical activity, including walking.

Approximately two-thirds of South Australians are overweight or obese, around a quarter have high blood pressure, and about one in six has high cholesterol. Approximately one in eight South Australians has recently experienced high or very high levels of psychological distress. One in 10 has been told by a doctor that he or she has or has had cancer.

Around a quarter of South Australians drink at levels on a single occasion that puts them at risk of an alcohol-related injury, and about one in six consumes alcohol at levels that puts them at lifetime risk of alcohol-related harm. One in six is a current smoker. Just under one in six South Australians aged 14 years and older reported using drugs illicitly, including the use of pharmaceuticals for non-medical purposes, in the 12 months before survey.

## Living with chronic conditions

Changing lifestyle choices, improved healthcare responses and increased life expectancy mean more South Australians are living with chronic conditions. However, not all South Australians with chronic conditions are older; such conditions may exist at birth or be acquired in childhood or early adulthood.

Looking at chronic conditions in this state from highest prevalence to lowest, approximately one in four South Australians has arthritis, about one in five lives with a doctor-diagnosed mental health condition, around one in seven has asthma, and one in 10 has diabetes. About one in 12 South Australians lives with cardiovascular disease, one in 17 with osteoporosis (with the rate for females four times than that of males), and one in 40 with chronic obstructive pulmonary disease such as bronchitis or emphysema.

## Starting well and the early years

- ✓ **Fewer teenaged women are giving birth.** The percentage of births to women aged 19 years or less is decreasing in South Australia, from 4.6 per cent in 2006 to 2.4 per cent in 2016. The percentage of births to Aboriginal women aged 19 years or less is also down, from 20.3 per cent to 15.2 per cent in the same time period. These trends are in line with falls in the corresponding Australian rates over the same period. [SoOH §2-2]
- ✓ **More women are starting antenatal visits early in their pregnancy.** The percentage of women who had their first antenatal visit within the first 14 weeks of pregnancy increased from 70.8 per cent in 2007 to 78.2 per cent in 2015. However, there is a large gap between the rate for non-Aboriginal women (79.0 per cent) and Aboriginal women (56.5 per cent). [SoOH §2-4]
- ✓ **Fewer women are smoking while pregnant.** The smoking rate during pregnancy (recorded at first antenatal visit) decreased from 23.4 per cent in 2005 to 12.5 per cent in 2015. However, there remains a large gap between the rates for non-Aboriginal women (11.2 per cent) and Aboriginal women (48.4 per cent). South Australia is ranked equal third-highest (with Queensland) among the states and territories for smoking rate at first antenatal visit. [SoOH §2-4]
- ✓ **More children are immunised.** The percentage of children in South Australia fully immunised by age five years has increased from 80.5 per cent in 2007 to 93.5 per cent in 2017. This is in line with increases in the overall Australian rate over the same time period. The percentage of Aboriginal children in South Australia fully immunised by age five years also increased, from 70.4 per cent in 2007 to 93.0 per cent in 2017. [SoOH §2-10]
- ✓ **Perinatal deaths are down.** The rate of perinatal deaths – that is, foetal deaths (at least 20 weeks' gestation or at least 400 grams birth weight) plus all neonatal deaths – in South Australia dropped from 6.3 perinatal deaths per 1,000 births in 2006 to 5.5 in 2016; South Australia now has the lowest rate of the states and territories. The Aboriginal perinatal death rate is even lower at 4.5 per 1,000 relevant births in 2012-2016. [SoOH §5-3]
- ✗ **Diabetes during pregnancy has more than doubled.** The prevalence of gestational diabetes among women who gave birth in South Australia has more than doubled over 10 years, from 4.5 per cent in 2005 to 10.4 per cent in 2015. [SoOH §2-4]
- ✗ **Overweight or obesity rates during pregnancy are high.** South Australia ranks highest among the states and territories for the rate of women overweight at their first antenatal consultation (28.0 per cent) and second-highest for obesity in pregnancy (24.4 per cent). National rates have fallen while South Australian rates are relatively steady. [SoOH §2-4]

- ✗ **Rate of caesarean births is high.** South Australia, at an overall rate of 35.1 per cent (35.2 per cent for non-Aboriginal women and 32.7 per cent for Aboriginal women), ranks second-highest among the states and territories for births by caesarean section. The overall South Australian rate has been above the national average for 10 years. [SoOH §2-7]

## Staying healthy and ageing well

- ✓ **Fewer people are consuming alcohol at risky levels.** The percentage of the South Australian population consuming alcohol at risky levels is dropping. The proportion of people at risk of alcohol-related single-occasion injury is down from 26.4 per cent in 2011 to 24.6 per cent in 2017; the percentage at lifetime risk of harm from alcohol-related disease or injury dropped from 19.1 per cent in 2011 to 15.6 per cent in 2017. Fewer than one in 10 (9.6 per cent) Aboriginal people in South Australia exceeds lifetime risk guidelines for alcohol consumption, well below the national average for Aboriginal people of 14.7 per cent. Nationally, South Australia is ranked third-lowest of the states and territories for long-term risk of harm from alcohol. [SoOH §3-8]
- ✓ **Fewer people are smoking.** The percentage of the South Australian population that smokes daily, weekly, or less often than weekly, dropped from 20.1 per cent in 2007 to 16.5 per cent in 2017. South Australia is ranked second-lowest of the states and territories in the proportion of current daily smokers. However, more than a third (35.4 per cent) of Aboriginal people in South Australia reported being current daily smokers in 2014-15; this was below the national average for Aboriginal people of 38.9 per cent. [SoOH §3-12]
- ✗ **Fewer people are exercising at healthy levels.** The proportion of South Australians undertaking 150 minutes or more per week of walking or other moderate or vigorous physical activity is decreasing, from 53.0 per cent in 2007 to 45.0 per cent in 2017. No directly comparable national figure is available. In 2012, about half (51.6 per cent) of Aboriginal people in South Australia reported undertaking sufficient physical activity. [SoOH §3-5]
- ✗ **The rate of disability is high.** The prevalence of disability (22.9 per cent) in the South Australian community and the proportion of those who need assistance with core activities due to profound or severe disability (6.0 per cent) are both second-highest of the states and territories. In South Australia, 7.7 per cent of Aboriginal people require assistance with core activities due to profound or severe disability, which is above the national average of 6.7 per cent. [SoOH §3-6]
- ✗ **More people are living with multiple health risk factors.** The percentage of South Australians living with two or more risk factors – current high blood pressure; current high cholesterol; fewer than 150 minutes per week of walking, moderate or vigorous physical activity; overweight or obese; current smoker; long-term alcohol risk; and/or insufficient consumption of fruit and vegetables – is increasing, from 28.5 per cent in 2007 to 32.7 per cent in 2017. No directly comparable national figure is available. [SoOH §3-7]
- ✗ **More people are overweight or obese.** The percentage of South Australian adults overweight or obese is increasing, from 56.9 per cent in 2007 to 63.7 per cent in 2017. The South Australian rate is above the national average. In 2012-13, 62.9 per cent of Aboriginal people in South Australia were classified as overweight or obese. [SoOH §3-9]
- ✗ **More people have high blood pressure.** The percentage of South Australians living with doctor-diagnosed high blood pressure or on medication for high blood pressure increased from 19.2 per cent in 2007 to 22.3 per cent in 2017. South Australia is ranked second-highest of the states and territories for prevalence of high blood pressure. In 2012, 20.0 per cent of Aboriginal people in South Australia self-reported that they were living with doctor-diagnosed high blood pressure and/or were on medication for high blood pressure. [SoOH §3-10]

- ✗ **More people have high cholesterol.** The percentage of South Australians living with doctor-diagnosed high cholesterol or on medication for high cholesterol increased from 15.1 per cent in 2007 to 17.5 per cent in 2017. South Australia is ranked third-highest of the states and territories, and above the national average, for rates of high cholesterol [SoOH §3-11]

## Living with chronic conditions

- ✗ **More people are living with multiple chronic and long-term health conditions.** The percentage of South Australians living with two or more chronic conditions – diabetes, asthma, cardiovascular disease, arthritis, osteoporosis and/or a mental health condition – is increasing, from 17.8 per cent in 2007 to 21.9 per cent in 2017. (No directly comparable national figure is available.) In 2012-13, 35.7 per cent of Aboriginal people in South Australia reported living with three or more long-term health conditions. [SoOH §4-1]
- ✗ **More people have a mental health condition.** The percentage of South Australians living with a doctor-diagnosed mental health condition is increasing, from 16.7 per cent in 2007 to 20.9 per cent in 2017. South Australia is ranked third-highest of the states and territories for population living with a mental or behavioural problem. In 2012, 10.3 per cent of Aboriginal people in South Australia reported living with a doctor-diagnosed mental health problem. [SoOH §4-3]
- ✗ **More people have diabetes.** The percentage of South Australians ever told by a doctor that they have diabetes increased from 7.5 per cent in 2007 to 10.1 per cent in 2017. South Australia is slightly under the national average for the rate of the population living with diabetes mellitus. The prevalence of diabetes/high sugar levels in the South Australian Aboriginal population was 8.9 per cent in 2012-13. [SoOH §4-5]
- ✗ **Prevalence of chronic back pain is high.** The proportion of South Australians living with a back problem which has lasted, or is expected to last, six months or longer is very high (17.0 per cent) and is ranked highest of the states and territories. [SoOH §4-9]

## 2.4 Ten trends in 10 years: South Australia's health system performance over the last decade

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Fifteen years ago, the then South Australian Minister for Health launched the Generational Health Review, chaired by John Menadue AO. Its subsequent report called for system reform to tackle increasing budget and demand pressures that were considered unsustainable for hospitals and the workforce, and sought a change in focus towards implementing health promotion, illness prevention and early intervention measures.

The *Health Care Act 2008* emerged from this review, as did the Health Performance Council – the latter created to report to the Minister for Health on population health outcomes, health system performance and quality of care.

In the 10 years since, both the quality of care and patient outcomes have generally improved. By world standards, South Australia's health system delivers effective services to the community and responds well to health-care needs that range in complexity across lifespans and affect families, friends and colleagues in different ways. However, there remain many opportunities for improvement in the next 10 years, particularly in quality and safety areas, in productivity areas, in the workforce, and for specific population groups within which health outcomes lag to an inexcusable degree behind those of the population average. The decade ahead is one of opportunity for South Australian health services, with the current Minister for Health and Wellbeing establishing new structural arrangements and reform plans that include focuses on clinical governance and patient safety, and on clinician and consumer leadership.

After a decade of analysing data, reports and other aspects of South Australia's health system, the Council has decided to include in this report this '10 x 10' overview of its findings, based on its analysis of 10 important indicators over 10 years.

### Quality of care has improved

The South Australian media's reports of crises and mismanagement in SA Health tell only part of the story of health services in the state. Despite increasing demands on the public health system, including more patients being treated in emergency departments and admitted to hospital beds, the quality of care is improving in areas ranging from cancer and stroke care to maternity care and orthopaedic surgery.

Five-year survivals for all cancers increased from 60 per cent for 2000-2004 diagnoses to 66 per cent for 2010-14, as Table 1 shows. The corresponding increases, by primary site of cancer, were from 87 per cent to 95 per cent for prostate cancer, 86 per cent to 90 per cent for female breast cancer, 61 per cent to 68 per cent for colorectal cancer, and 11 per cent to 15 per cent for lung cancer. A decrease in five-year survival for primary site of skin cancer (melanoma) from 93 per cent to 89 per cent ran counter to the general trend.

Five-year survival figures for all cancers in South Australia during the period 2010-2014 (66 per cent) were very similar to national averages reported by the Australian Institute for Health and Welfare (68 per cent for the period 2009-2013). However, Table 1 highlights differences between specific population groups; of note are five-year survival rates by Aboriginal status and according to socio-economic status (SES) of geographic area of residence.

**Table 1: Five-year period survival rates, South Australia by specific population groups and cancer type (by percentage)**

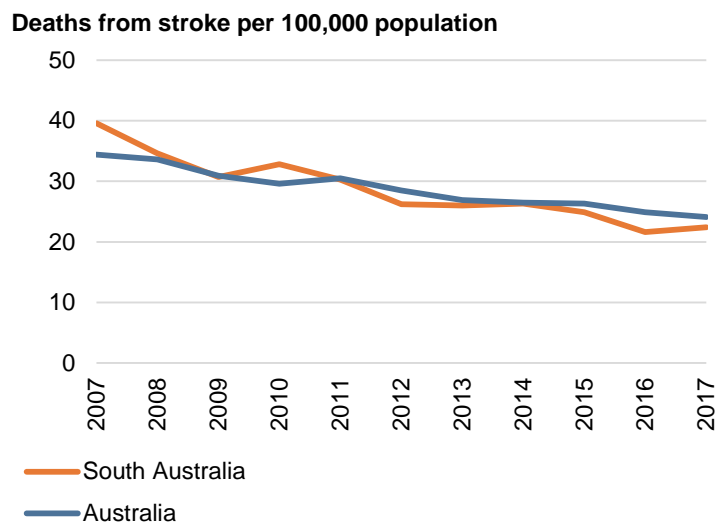
	All cancers	Prostate cancer	Female breast cancer	Colorectal cancer	Lung cancer	Skin cancer (melanoma)
<b>Diagnostic period</b>						
2010–2014	66	95	90	68	15	89
2005–2009	64	91	89	65	12	90
2000–2004	60	87	86	61	11	93
<b>Sex</b>						
Male	66	95	–	67	13	85
Female	67	–	90	68	17	93
<b>Aboriginal status</b>						
Non-Aboriginal	66	95	90	68	14	89
Aboriginal	39	79	73	58	21	–
<b>SES status of area</b>						
1 (lowest)	60	92	88	63	14	86
2	64	93	89	67	14	89
3	66	95	89	69	13	88
4	70	97	92	68	16	91
5 (highest)	72	99	92	72	17	89
<b>Remoteness of area</b>						
Major city	66	96	90	68	14	88
Inner regional	68	94	89	69	18	90
Outer regional	65	94	90	65	17	88
More remote	66	94	93	65	12	92

Source: South Australian Academic Health Science and Translation Centre (Health Translation SA) 2018, 'Table 4: Five-year period survival (95 per cent CL), SA, 2010–2014', *Health System & Service Reform in South Australia, Phase 1 – Insights from an Evaluative Case Study of Transforming Health*.

In October 2014, SA Health published *Stroke Management: Procedures & Protocols*, which was developed by the Statewide Stroke Clinical Network and based on national best-practice guidelines known to provide good patient outcomes, including within designated stroke units in key hospitals across South Australia. The implementation was part of Stroke Clinical Improvement Project of 'Transforming Health'. Audits over the past 10 years show 67 per cent of South Australians diagnosed with stroke received 90 per cent of acute hospital care in the state's stroke units, on par with average across-Australia performance (2017 national adherence to the 'Acute Stroke Clinical Care Standard Indicators').

Death from stroke in South Australia, as a proportion of the population, is decreasing, roughly halving from 39.6 deaths per 100,000 population (standardised) in 2007 to 22.4 in 2017. However, the overall Australian rate has reduced in a similar fashion, as Figure 1 shows.

**Figure 1: Number of deaths from stroke per 100,000 population, South Australia and Australia by calendar year**



Source: Australian Bureau of Statistics, cat. no. 3303.0

Age-standardised rate

Deaths from stroke defined as cause of death ICD-10 codes I61–I64 & G45

However, the Council’s reporting has revealed there is still too much variation in the quality of care: the difference between access to care for the general population and specific population groups, such as Aboriginal South Australians or people living in rural and regional regions of the state, remains great. High-quality care for all is not a reality. The principles that underpinned SA Health’s ‘Transforming Health’ – that care should be ‘Patient-centred’, ‘Safe’, ‘Effective’, ‘Accessible’, ‘Efficient’ and ‘Equitable’ – are not always evident in the standards of care.

There are also services about which the Council does not know enough. Despite commitments from the previous government’s ministers in response to the Council’s 2014 four-yearly report, *What’s Working, What’s Not* (Appendix Six), the Council has not received or been able to access the private-hospital data that would enable it to build a system-wide picture of the South Australian health system and its care outcomes. For example, the Council cannot examine the number of unplanned hospital readmissions between private and public hospitals. Unplanned readmissions are a measure of issues that may exist with the quality, continuity and integration of care provided to patients during or after their original hospital admission, whether in a private or public facility. Without private-sector data, the Council cannot examine the extent of these issues and their costs to the health system.

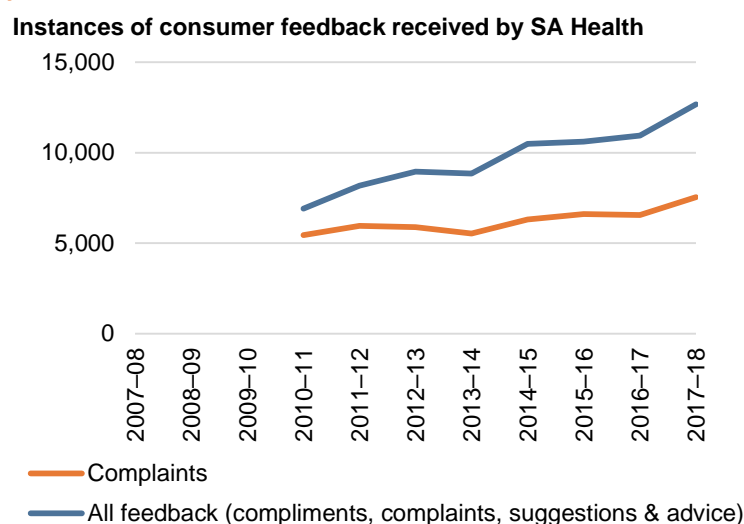
### **Focusing on patient safety will pay off**

In the wake of publicly-reported breaches in patient safety such as the sub-standard care of the Oakden Older Persons Mental Health Service and chemotherapy under-dosing caused by clinical governance failures, the South Australian Government has prioritised safety and clinical governance. It has committed to establishing a clinician- and consumer-led Commission on Excellence and Innovation in Health, and to increasing the use of data analysis for quality improvement, both of which are intended to improve service quality and safety.

Analysis by the Grattan Institute indicates that South Australia has the best incident reporting system among the states. Introduced in 2010, SA Health’s Safety Learning System (SLS) Incident Management module supports SA Health staff to record, manage, investigate and analyse patient and worker incidents

in their workplaces. The SLS also records details of feedback received from members of the public, either as consumers or on behalf of family and friends who have received health care. The SLS categorises feedback as a complaint, compliment, suggestion or advice. Year-on-year, more SA Health consumers and their carers, families and friends are providing this feedback and, over time, proportionally less of this SA-Health-recorded feedback is categorised as complaints.

**Figure 2: Number of instances of consumer feedback recorded as received by SA Health by financial year**



Source: SA Health, customised SLS extract

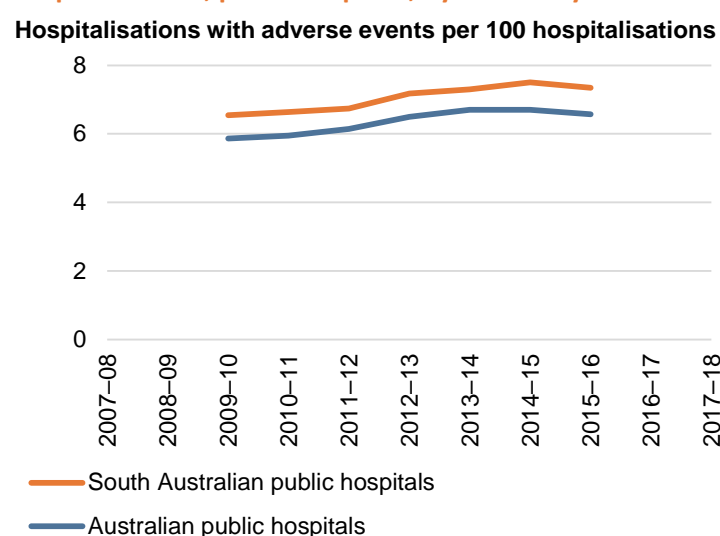
All feedback includes compliments, complaints, suggestions and advice

Excludes feedback 'rejected' by SA Health (SLS classification)

Data prior to 2010-11 not available

There was a statistically significant increase in the rate of hospital-acquired complications in South Australian public hospitals between 2009-10 and 2015-16. The number of hospital-acquired infections remained steady.

**Figure 3: Number of hospitalisations (inpatient separations) with an adverse event per 100 hospitalisations, public hospitals, by financial year**



Source: Productivity Commission, *Report on Government Services*, public hospitals attachment tables

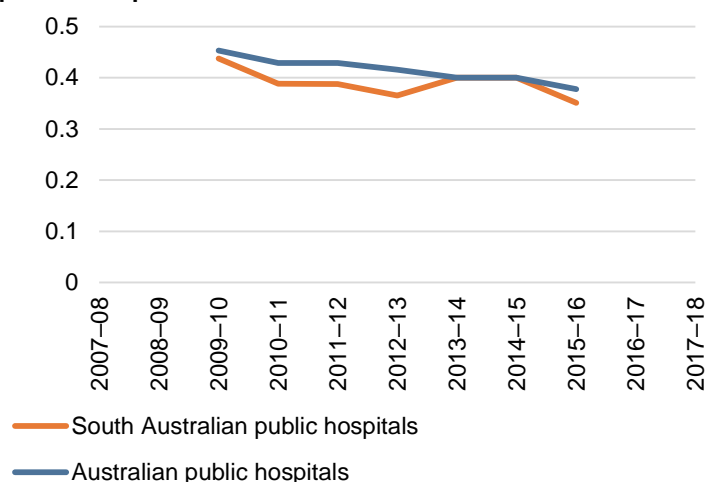
Age-standardised rate

Data prior to 2009-10 and after 2015-16 not published



**Figure 4: Number of hospitalisations (inpatient separations) with an infection following a procedure per 100 hospitalisations, public hospitals, by financial year**

**Hospitalisations with infections following procedures per 100 hospitalisations**



Source: Productivity Commission, *Report on Government Services*, public hospitals attachment tables

Age-standardised rate

Data prior to 2009-10 and after 2015-16 not published

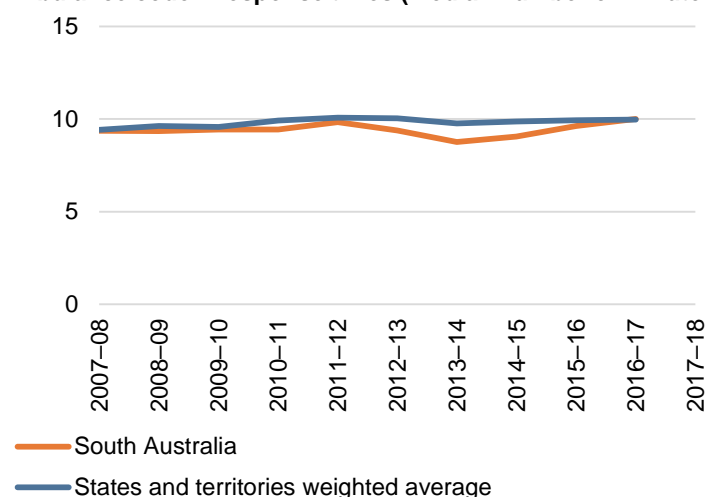
## Accessing some services is more difficult

Access to services remains a major problem for some South Australians, and is more difficult for members of some population groups than others.

Ambulance 'Code 1' median response times – relating to immediate responses requiring lights and sirens – remained at about 10 minutes from 2007-08 to 2016-17, and are similar to the weighted average for all states and territories in the period.

**Figure 5: Ambulance emergency response times, South Australia and Australia**

**Ambulance code 1 response times (median number of minutes)**



Source: Productivity Commission 2018, 'Table 11A.3 Ambulance code 1 response times (minutes)', *Report on Government Services 2018*, Ambulance services attachment tables

Response times commence from the following time points: NSW, Queensland and WA from transfer to dispatch. Victoria, SA, Tasmania, NT and the ACT from first key stroke. Statewide 50th percentile

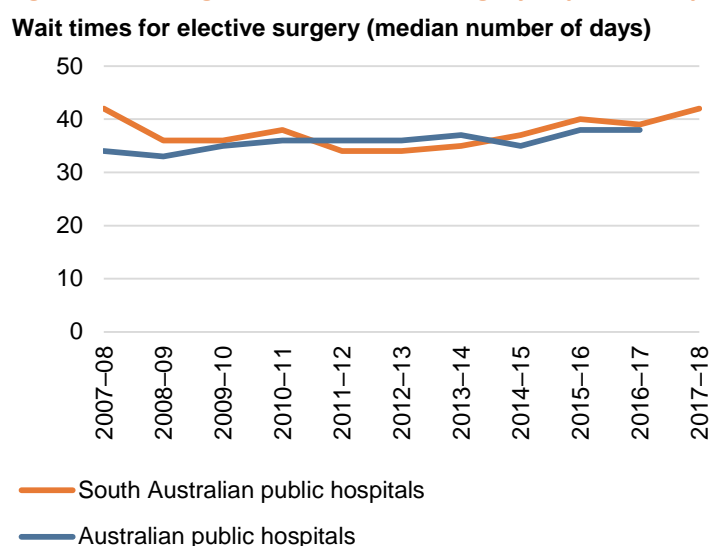
'States and territories weighted average' calculated by HPC Secretariat

The proportion of patients seen on time at public hospital emergency departments in South Australia peaked at 76 per cent in 2011-12 (81 per cent for Aboriginal people) and declined to 60 per cent in 2017-18 (69 per cent for Aboriginal people).

Waiting times for public dental services have increased dramatically. The median waiting time for an offer of public general dental care for people living in South Australia increased from 105 days in 2013-14 to 405 days in 2016-17. The median waiting time for an offer of public general dental care was similar for non-Aboriginal people (405 days) and Aboriginal people (406 days). However, median waiting times were inversely correlated with socio-economic status (SES) of area: 420 days for people living in the bottom SES quintile compared to 395 days for people living in the top SES quintile (Appendix Five: SA Health annual report on progress against advice in the Council's four-yearly report 2014).

Waiting times for elective surgery in South Australian public hospitals increased over the same period. The median waiting time for elective surgery across all South Australian public hospitals was 34 days in 2011-12 and reached 42 days in 2017-18.

**Figure 6: Waiting times for elective surgery in public hospitals by financial year**



Source: Productivity Commission, Report on Government Services, public hospitals attachment tables and SA Health customised BLIS extract (2017-18)

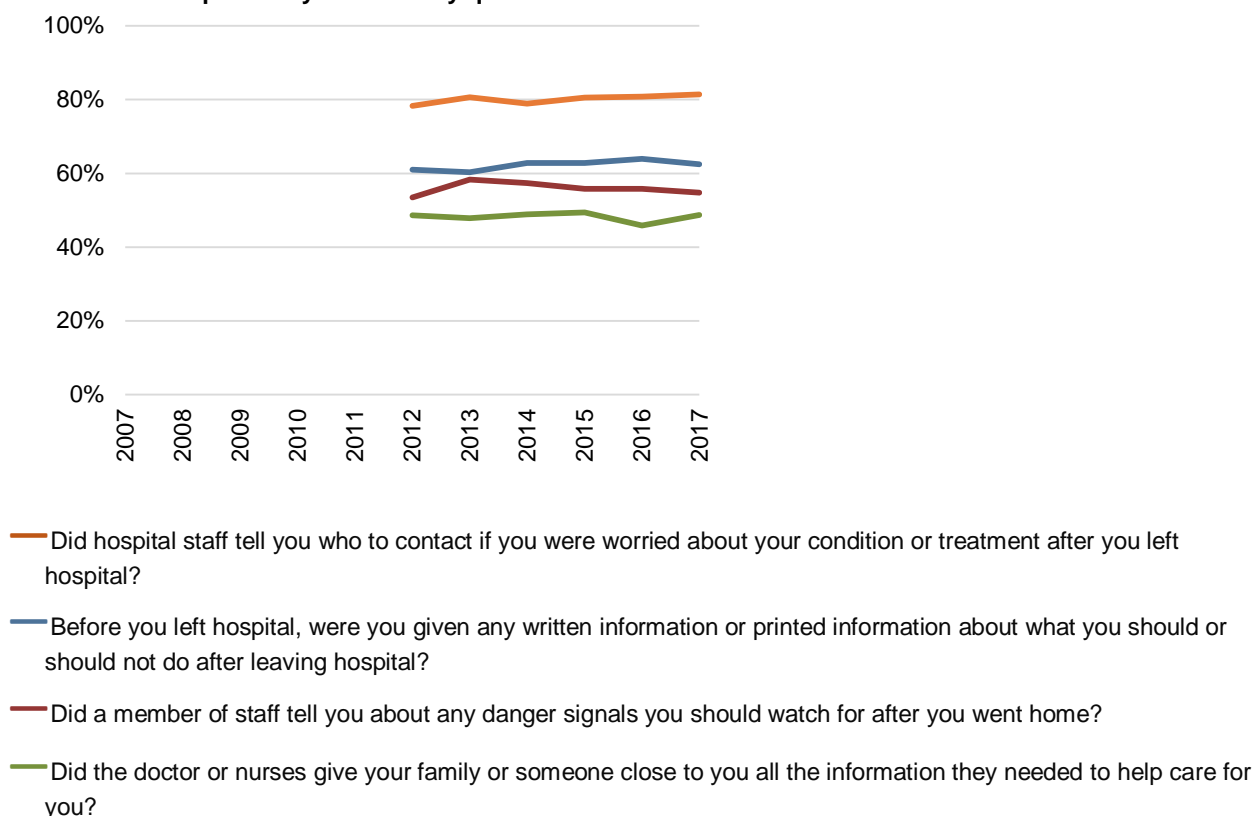
## Consumer confidence is steady, but better consumer communication is needed

Consumer confidence in the South Australian public health system has held up well over the past decade, as demonstrated by responses to surveys intended to gauge consumer confidence in doctors and nurses. But responses remain at below expected levels for consumer involvement in discharge information, perhaps a significant measure of how well the health system is succeeding in caring for consumers transferring between hospital and community or primary care. There is evidence that there is not enough being done to actively seek, encourage and evaluate feedback from consumers and other users of the system.

Patient-centred care is defined by the Picker Institute as health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers, and Picker definitions are applied by SA Health. Picker includes four elements in its core domain of care regarding discharge information provided to consumers as part of their health care. These are shown in Figure 7. All four elements have remained relatively steady for South Australian public hospitals from 2012 to 2017.

**Figure 7: Consumer involvement in discharge information, South Australian public hospitals, by calendar year**

Patients who responded 'yes' to survey question



Source: SA Health, customised SACESS extract

Excludes respondents who answered 'don't know' or refused to answer

SACESS measures experiences of care reported by South Australians who spent at least one night in a public hospital within South Australia, and who were aged 16 years and over; not of Aboriginal or Torres Strait Islander descent; not admitted for maternity, psychiatric, substance abuse, chemotherapy or renal dialysis episodes of care; and proficient in spoken English.

SACESS does not include the Women's and Children's Hospital

Data prior to 2012 not available

SA Health promises a system that is consumer-centred, and for good reason: understanding consumers' experience of care is central to understanding how well the health system is working and the extent to which it is delivering a person-centred service. But there is not enough activity in gathering, recording and listening to the voices that would provide evidence of that experience. While SA Health publishes an annual report, *Measuring Consumer Experience*, which collates the output of the South Australian Consumer Experience Surveillance System (SACESS) telephone survey of selected public hospital inpatients, the survey itself excludes many groups of consumers with important experiences to share, including potentially vulnerable population groups such as Aboriginal health consumers and people who do not speak English well enough to complete a telephone survey.

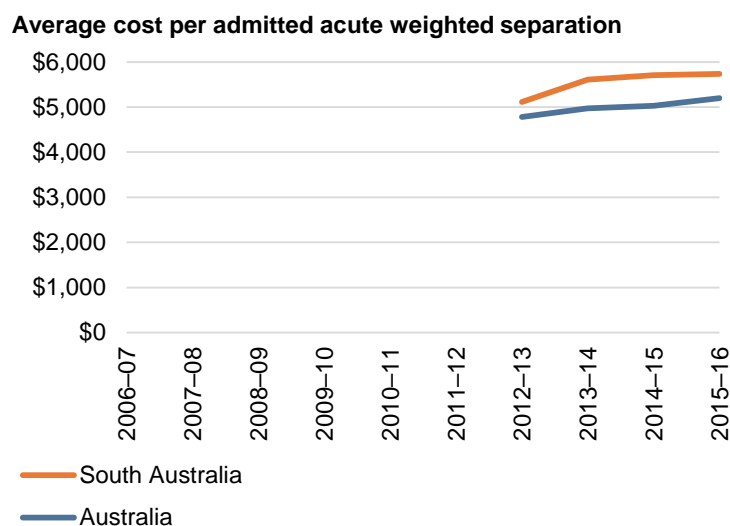
## Costs are increasing

In 2003, the Generational Health Review concluded that on a per capita basis, South Australia spends more money, and has higher utilisation rates, more health professionals and more beds than other states and territories.

Little has changed in the 15 years since. South Australia's average cost per admitted acute weighted separation (hospitalisation) is above the national average, which can reflect a less efficient service even

when adjusted for casemix. Casemix adjustment takes account of variation in the relative complexity of the patient's clinical condition and of the hospital services provided, but cannot capture all other influences on length of stay. South Australia has growing demand for public health services and an ageing population.

**Figure 8: Average cost per admitted acute weighted separation, excluding depreciation**



Source: Productivity Commission, *Report on Government Services*, public hospitals attachment tables  
Data prior to 2012-13 not published.

The cost of admitted hospitalisations is placing increasing pressure on the SA State Budget and on health's share. As a result, the public health service is currently being asked to examine the factors that influence costs and how they may be managed differently while maintaining quality and effectiveness. Reforming how the service works is on the SA Health strategic agenda, with prevention, integration between health services, and strengthening home-care alternatives among the options.

## The workforce needs more attention

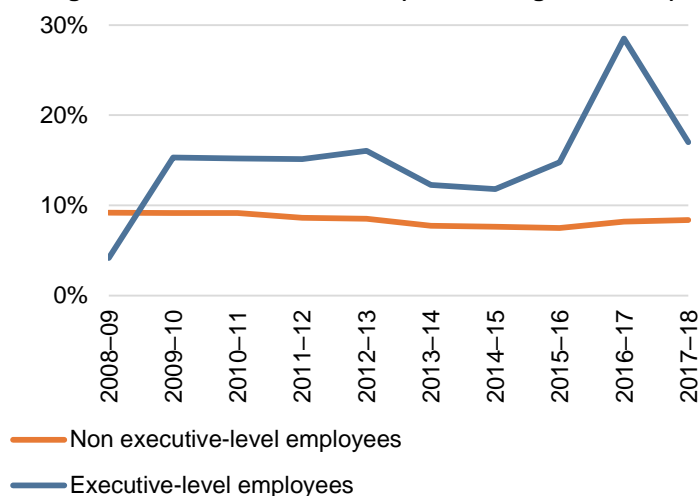
Most of South Australia's health budget is spent on the staff critical to providing quality care and services – the people who are facing more complicated and complex demands from more patients. Yet it seems that policy makers may at times pay too little attention to the needs, ideas or experiences of SA Health staff.

Large-scale change programs such as *'Transforming Health'* (2015-2017) raised expectations among health staff about how and where they would work. However, Health Translation SA's *'Evaluative Case Study of Transforming Health'* (2018) found some staff felt unsupported and unclear about governance and authority after the changes. As the Council noted in the sixth edition of *Monitoring Implementation of Transforming Health*, SA Health staff were asked to assess the statements 'this organisation is good at learning from its mistakes and successes' and 'my work area encourages me to be innovative'. Of those who responded, 46 per cent agreed or strongly agreed.

The Council also noted in that report that *'Transforming Health'* implementation could have been adversely affected by the acceleration in executive turnover. Below-executive-grade staff turnover remained steady.

**Figure 9: SA Health staff turnover rate by financial year**

**Average annual staff turnover rate (% who left government)**



Source: SA Health, customised CHRIS extract

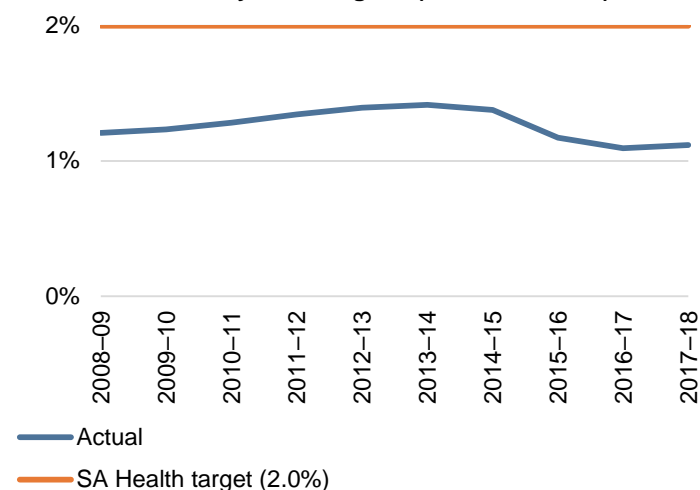
In calculating staff turnover rate, the Health Performance Council applies the SA Health Workforce definition: number of SA Health staff who separated from SA Government entirely as a percentage of average monthly headcount.

Executive-level employees: SAES levels 1 & 2 and EXEC levels A–F.

Action to increase diversity in the workforce has stalled. In 2002, the *South Australian Strategic Plan* aimed to increase the participation of Aboriginal people in the South Australian public sector, spread across all classifications, to 2 per cent, aligned to population make-up. The current proportion in SA Health is 1 per cent. This may be a missed opportunity with direct implications both for Aboriginal employment and on the consumers and staff who would benefit from receiving and working with culturally sensitive personnel.

**Figure 10: SA Health Aboriginal workforce participation by financial year**

**Staff who self-identify as Aboriginal (% of headcount)**



Source: SA Health, customised CHRIS extract

South Australia's Strategic Plan target calls for 2.0% of the public sector workforce to be Aboriginal persons.

## **Working differently will make a difference**

The pressures on the health services of the past decade show no signs of diminishing. Costs are increasing in a sector being asked to perform more services for an increasingly ageing population. Every year, the health workforce is asked to do more with less. But there are ways to manage the pressures, if and when the system chooses to explore and implement those best suited to this state and its circumstances. Internationally, a proactive attitude towards capitalising on new and emerging research and technologies, a commitment to evidence-based decision-making, and maximising the value of the workforce have been shown to have real and measurable impacts on improving quality, safety and outcomes. The Council suggests that listening to people – consumers, carers, family members, communities and health staff in all population groups in towns and centres and hospitals across the state – will be a great place to start.

### 3. Summary of Council Reviews, 2015 to 2018

This section outlines the Council's role and functions, summarises key advice provided to the Minister in each of the Council priority reviews presented between 2015 and 2018, and provides summaries of individual reviews that have informed the advice in this four-yearly report.

#### The Council's role and functions

The Health Performance Council is appointed to provide an independent, objective and expert analysis of the state of South Australia's health system (Appendix Two). It aims to describe what works well, the challenges facing South Australian public and private health systems, and opportunities for system improvement. It is important to select measures that reflect the performance of the system overall, and check and report on unwarranted variation of outcomes across the South Australian population – particularly for specific groups including, but not limited to, Aboriginal communities, people from rural areas and older South Australians.

Early on, the Council established a working framework for reviewing public and private health systems' performance and health outcomes (based on the National Health Performance Framework), which informs on the context; analyses inequities; checks indicators of equity and access, and quality and safety; and looks for effective community and consumer engagement.

Within this framework the Council provides analysis with the support of its secretariat of four full-time equivalent staff, and with external support from the health-based community organisations, university researchers and State Government officers who have generously shared their research and insights.

Over the past 10 years, the Council has provided successive Ministers for Health with analysis and advice that forms an expert, authoritative resource for evidence-informed policy about population health and public and private health systems' performance. Some of this material is quantitative and qualitative data and analysis that has not otherwise been publicly available, including primary data we seek for review that is not routinely collected by government agencies. Most often, the Council uses existing health data, having limited access to anonymised linked records and very limited resourcing for primary data collection. Where appropriate for review projects, it benefits from oversight from the SA Department for Health and Wellbeing Human Research Ethics Committee and advice from the Aboriginal Health Research Ethics Committee. It uses the *SA Health Aboriginal Impact Checklist* and is committed to the *SA Aboriginal Health Research Accord*. The Council hosts meetings of leaders' forums: Aboriginal Leaders, Culturally & Linguistically Diverse Communities' Leaders, and Regional Leaders.

It also works with like-minded collaborative networks such as Health Translation SA to argue that access to health data is critical to clinical improvement, monitoring and audit.

The Council selects its review priorities by scanning the policy landscape and raising and debating issues with stakeholders such as statutory agencies, community leaders, bodies prescribed in the 2008 Health Performance Council regulations, and Country Health Advisory Councils. Stakeholders including departmental senior officials have been offered Council findings to inform policy development and program design. Expert monitoring and commentary demonstrates how local health outcomes change over time, highlighting areas where improvement is possible and improving data access for measures of all-of-South Australia quality and outcomes. The Council provides these measures and commentary to highlight both strong and weak aspects of the system, and to contribute to continuous quality improvement in the public and private health systems.

The Council's reviews culminate in papers that are published for public attention on [the Health Performance Council website](http://www.hpcsa.com.au/state_of_our_health). They include the *State of Our Health* population health statistics [www.hpcsa.com.au/state\\_of\\_our\\_health](http://www.hpcsa.com.au/state_of_our_health). All reports from 2015 to 2018 are listed at Appendix Seven.

The following advice has emerged from the individuals reports, and is numbered according to the summaries of those reports on the following pages. This advice and the reports' findings have together led the Council to offer the advice presented in Section 2.2, *'Advice to the Minister for Health and Wellbeing'*.

### **3.1 Indicator reports monitoring SA Health's implementation of 'Transforming Health'**

1. Publish performance measures, including patient-reported outcome measures and patient-reported experience measures.
2. Introduce a means through which all consumers – including maternity, psychiatric, substance abuse, chemotherapy and renal dialysis patients; people from culturally and linguistically diverse backgrounds; and Aboriginal consumers – can share their experiences with the state's health system.
3. Undertake annual staff surveys to build a consistent and comparative picture of differences and changes in staff perception of workplace practices and outcomes.
4. Increase the level of Aboriginal identification in SA Health's human resources system.

### **3.2 Aboriginal Health Case Study working with the Aboriginal Leaders' Forum**

1. Increase the number of Aboriginal people trained for and placed in the health workforce, particularly in senior and health professional roles.
2. Expand culturally appropriate treatment so it is a requirement of, and provided in, the entire health system.
3. Remove barriers to the reporting and recording of Aboriginal identification in the health system, both as staff and consumers.
4. Reduce and remove perceived and real institutional racism towards Aboriginal people within the health system through workplace audits, consumer feedback, safety and quality standards, and personalised healthcare plans, and by ensuring Aboriginal health consumers know their rights.

### **3.3 Culturally and linguistically diverse communities (CALD) health outcomes audit: tackling equity**

1. Include equity and access outcomes as key performance indicators in leaders' and managers' performance assessments and policy development, including in the ways in which the chief executive and, in future, local health network governing boards model behaviour and commission and track metrics to monitor their effectiveness.
2. Use survey and technology tools to gather information and feedback about equity of access challenges in the system, including those related to institutional racism, harassment and discrimination, and to assess status and changes.
3. Use research and evidence to help explain the reason for any proposed equity and access policy, to encourage evidence-informed policy and describe how measurable interventions will lead to desired outcomes.
4. Reinforce existing South Australian Government policy by explaining how improving diversity in the workforce – from policy makers to service providers – improves access and outcomes in the health system.



### **3.4 Revisit Review of Country Health Advisory Councils (HACs)'s Governance Arrangements 2011**

1. Improve health governance in regional areas by describing clearly the roles and responsibilities of health advisory councils.
2. Implement Country Health SA Partnership Framework actions, particularly relating to support for staff and advisory councils to build health literacy and health governance literacy, and delivering performance data relevant to local areas.
3. Invest in information technology that will improve performance data and help health advisory council members develop the skills and knowledge to understand and use it in reports on regional health outcomes, finances, quality and safety, consumer and staff surveys, and other topics.
4. Ensure delivery of culturally competent health services, with an emphasis on Aboriginal Australians.
5. Build diversity into each health advisory council, governing group (board) and executive.

### **3.5 Post-implementation review Country Health SA Local Health Network Aboriginal Community and Consumer Engagement Strategy**

1. Increase Aboriginal participation in the workforce.
2. Introduce measure to help Aboriginal communities and consumers engage with health services.
3. Strengthen the strategic relationship between Country Health and Aboriginal Experts by Experience.
4. Strengthen governance structures to support full implementation of the *Aboriginal Community & Consumer Engagement Strategy*.
5. Build cultural competence and safety across the health service.

### **3.6 Revisit End of Life Care Case Study**

1. Develop a strategic and state-wide model of end-of-life care.
2. Embed person-centred care into the model of end-of-life care.
3. Ensure equal access to end-of-life care for all South Australians.
4. Improve health and wellbeing outcomes.
5. Expand end-of-life care in the community
6. Support paediatric palliative care.
7. Ensure high-quality and consistent care.
8. Develop a workforce that is expert, responsive and culturally mature.
9. Establish effective governance and accountability mechanisms.
10. Develop and implement policy that is evidence-based.

### **3.7 Scope an approach to monitor health outcomes for people with mental health and addiction issues in South Australia**

In 2018 the Council scoped a review to be conducted in 2019 that will examine:

- health outcomes for South Australians with mental health and addiction issues
- how general health outcomes for South Australians with mental health and addiction issues compare to those of the whole population
- whether and to what extent there are effective service models and strategies in the state
- whether and to what extent the state's mental health workforce, facilities and resources are adequate to provide quality care for South Australians with mental health and addiction issues, and for their families and carers.

### **3.8 *Areas to Act* analysis - in collaboration with SA Health and Adelaide and Country SA PHNs, examining health system data for indicators of potentially preventable hospitalisations using Grattan Institute's *Perils of Place* (2016) method**

1. Commission primary care and preventive approaches to improving and reducing preventable hospitalisations. This might be general practitioner-led work and it might be primary care workforce in hospitals such as Aboriginal health workers.
2. Collaborate with SA Health and governing boards, primary health networks and local clinicians and communities to trial tailored local programs in 'hotspot' places to build the evidence of what works.
3. Practice rigorous evaluation so lessons can be spread quickly to increase SA population leading healthier, more productive lives.
4. Regularly repeat the 'Areas to Act' analysis on a regular basis.

## 3.1 Indicator reports monitoring SA Health's implementation of Transforming Health

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### The review

'Transforming Health' was a South Australian Government initiative that ran between 2015 and 2017. It aimed to improve the metropolitan Adelaide public acute hospital system and align it with more effective models of care to improve the health and health outcomes of South Australians.

The Health Performance Council identified monitoring the progress of 'Transforming Health' as a critical factor in its assessment of health performance in the state.

### What was Transforming Health?

In November 2014, the South Australian Government announced an initiative designed to improve the metropolitan Adelaide public acute hospital system.

'Transforming Health' aimed to introduce new models of health care along with new and upgraded hospital facilities, to deliver the best quality services and outcomes for South Australians and their communities. It promised a system that would provide 'Best Care. First Time. Every Time.'

After extensive engagement and consultation, SA Health's *Delivering Transforming Health – Our Next Steps* was released in March 2015. It outlined initial decisions and timelines for their implementation and noted that all 'Transforming Health' decisions would align with the six quality principles of a quality health system: that the system is patient-centred, safe, effective, accessible, efficient and equitable.

This document established that 'Transforming Health' would aim to change important weaknesses in the existing health system:

- too many deaths in the state's hospitals
- senior clinicians unavailable overnight
- too few opportunities for staff to maintain their skills
- too many cancelled elected surgeries
- low day surgery rates
- too many procedures being performed
- long waiting times for discharge or placement
- too many transfers between hospitals
- the health system failing to meet some national standards
- risks to the financial sustainability of South Australian health care.

Although initially promoted as a four-year project to continue until 2019, the South Australian Government announced in June 2017 that 'Transforming Health' would end after the new Royal Adelaide Hospital opened (September 2017) and the Repatriation Hospital closed (November 2017).

The Council produced six reports between March 2017 and May 2018 that monitored the results of implementing 'Transforming Health'.

The Council developed its monitoring based on the following questions:

- Was the 'Transforming Health' aim of providing 'Best Care. First Time. Every Time.' realised consistently across the system for specific population and patient groups?
- How did patient experience change during 'Transforming Health' implementation?

- How did staff engagement change during 'Transforming Health' implementation, with a focus on the importance of human behaviour as a critical factor in any change process?

The Council selected measures for monitoring 'Transforming Health' based on the availability of data and evidence corresponding to the above questions. The first five reports monitored changes in measures identified in *Delivering Transforming Health - Our Next Steps* as indicators of how 'Transforming Health' affected access and equity outcomes for South Australians: hospitalisations (inpatient separations), average length of overnight stay, in-hospital deaths and hospital transfers.

### **1. Too many deaths in the state's hospitals**

- More deaths occur in South Australia's hospitals compared with other hospitals across Australia.
- Mortality rates vary in hospitals, overnight and on the weekend.
- Contributing factors include lack of senior clinical support available 24/7 and services spread too thinly across too many hospitals.

### **2. Long waiting times for discharge or placement**

- Some patients stay in hospital many days longer than other patients with the same condition.
- The hospital attended and the day of the week they are admitted can affect a patient's length of stay.
- Insufficient allied health staff and the lack of senior clinicians working on the weekend can influence discharge timing.

### **3. Too many transfers between hospitals**

- Several thousand patient transfers occur between hospitals in South Australia each year.
- Patients may not initially be admitted to the most appropriate hospital for optimal treatment.
- Transfers cause treatment delays that can lead to longer recovery times.

### **4. Senior clinicians are unavailable at night.**

- While senior clinicians are available on call overnight in cases of emergencies, in most cases there are no senior clinicians rostered overnight in South Australia's major hospitals.

Within the above areas, the Council prioritised monitoring new models of care for two clinical groups:

- Medical – cardiovascular disease (incorporating stroke, chest pain, and heart failure and shock)
- Surgical – hip and knee replacement. One of the aims of 'Transforming Health' was to safely reduce the time hip and knee replacement (H&K) patients stay in hospital, particularly at the Royal Adelaide Hospital, so the Council monitored this indicator.

In monitoring these aspects, the Council looked to use data and other evidence to demonstrate the impact of 'Transforming Health' models and services on the outcomes of, access to and use of South Australia's health system. In particular, it sought to understand the effects on members of vulnerable groups: Aboriginal people, culturally and linguistically diverse communities, lower socio-economic communities, aged people, and people in rural or remote areas. Results were presented according to local health network.

The sixth and final report was released in May 2018. It updates the previous five reports, and also includes patient/consumer experience and staff engagement measures; inpatient involvement in care and treatment; consumer complaints; waiting times for elective surgery; staff opinions about working for SA Health; and staff turnover.

## Summary of findings

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The Council's key findings in relation to its monitoring of the effects of implementing 'Transforming Health' were captured in its May 2018 report.

As noted in that report, the Council found that the volume of inpatient hospital activity at metropolitan Adelaide public acute hospitals continues to increase above the rate of population growth, while the average length of an overnight stay is declining. The percentage of in-hospital deaths in metropolitan Adelaide public acute hospitals is falling. The percentage of inpatients transferred between hospitals increased rapidly during the period of 'Transforming Health' and has since declined.

The Council notes that, year-on-year, SA Health is receiving more feedback on experiences of health services from consumers, carers, their families and friends. Over time, proportionally less of this feedback is complaints.

## What can be improved?

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The Council recommends SA Health improve its monitoring of perceptions of health consumer involvement in care and treatment. The Council recommends SA Health give all consumers, including maternity, psychiatric, substance abuse, chemotherapy and renal dialysis patients, people from culturally and linguistically diverse backgrounds, and Aboriginal consumers a better chance to share their experiences with the state's health system.

The Council found that there was no statistically significant change in underlying trend in wait times for elective surgery at metropolitan Adelaide public hospitals during the period of 'Transforming Health'.

The Council notes a lack of trend data available for monitoring staff opinion of working for SA Health, including local health networks. It recommends that SA Health undertake annual staff surveys across the organisation to build up a consistent and comparative picture of differences and changes in staff perception of workplace practices and outcomes.

With the exception of executive-level staff, the SA Health staff turnover rate decreased over the time series presented in the Council's sixth report. The turnover rate for Aboriginal employees was higher than for non-Aboriginal employees, although lower than a peak in 2008-09. Turnover of executive-level staff increased during the period of 'Transforming Health'.

The Health Performance Council recommends that SA Health improve its means of identifying Aboriginal employees in its human resources system.

## Links to the full reports

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Monitoring 'Transforming Health' indicator reports are at [www.hpcsa.com.au/reports](http://www.hpcsa.com.au/reports)

## 3.2 Aboriginal Health Case Study working with the Aboriginal Leaders' Forum

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### The review

In the Health Performance Council's 2008-2010 review of the health system, it found Aboriginal health outcomes were unacceptable and that access was limited to culturally appropriate services. The Council's consultation with communities and clinicians in 2011-12 highlighted that there had been very little progress and continuing challenges. The Council decided to again review the health system's response to Aboriginal health during 2011-2014 and in 2015-2018.

When the Council examined the status of Aboriginal health in South Australia in its October 2014 case study, it found significant gaps in health outcomes between Aboriginal people in South Australia and other people in the state. It advised the health system to do more to provide respectful, safe, relevant health services for Aboriginal South Australians, and to increase the number of Aboriginal people employed in the state's health workforce.

In 2017, the Council updated the 2014 work to examine:

- the health and wellbeing status of Aboriginal people in South Australia
- the workforce participation of Aboriginal people in South Australia in the health sector
- the effectiveness of the health system in providing services to Aboriginal people in South Australia.

It launched its report, *Aboriginal health in South Australia – 2017 case study*, initially as consultation draft, at the seventh Aboriginal Leaders' Forum in May 2017. The Council co-hosts these forums bi-annually with the South Australian Health and Medical Research Institute's (SAHMRI) Wardliparingga Aboriginal Research Unit.

As well as Aboriginal leaders and Wardliparingga, the Council finalised the draft report in consultation with the Aboriginal Health Directorate (Country Health SA LHN), the Aboriginal Health Strategy Branch (SA Health), Adelaide and Country Primary Health Networks (PHNs), health researchers and other stakeholders.

### Summary of findings

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What these consultations told the Council is that this case study is critically important and demonstrates the significant health gap that remains for Aboriginal people in South Australia.

The overall outlook for the health of Aboriginal people in South Australia remains poor. Piecemeal responses to issues of Aboriginal health have not worked. Aboriginal leaders told the Council that Aboriginal people and communities are not receiving the cohesive, comprehensive approach they require: one founded on careful and respectful listening to what they say they want and need.

Aboriginal leaders seek an Aboriginal-led approach that considers social, cultural, spiritual, economic and environmental factors; among them, education, employment, safe housing, and culturally sensitive health practices and promotional tools. They have indicated that the best options may lie outside 'western' models.

The data does demonstrate some progress since 2014. Strong cultural and community ties continue to support Aboriginal people in South Australia, including through cultural and sporting events. In times of crisis, most Aboriginal people could access assistance from outside the household. Childhood immunisation for Aboriginal South Australian children aged five years is above the state average. Fewer Aboriginal people are being re-admitted to hospital within 28 days of discharge. An increase in early-

childhood health checks for Aboriginal South Australian children has brought the rate in line with the overall state figures.

These and other improvements are noteworthy and have real impacts on health outcomes. But they are not enough: on many more measures, the health-related status of Aboriginal South Australians is much lower than that of non-Aboriginal South Australians. Fewer Aboriginal people report being in very good or excellent health. More than one in three Aboriginal South Australians is a daily smoker. Two-thirds are classified as overweight or obese. One in five has been diagnosed with high blood pressure. Rates of anxiety and depression among Aboriginal South Australians are more than double those for non-Aboriginal people in the state.

Across Australia, life expectancy is lower and the rates of death of Aboriginal Australians due to heart disease, diabetes, respiratory disease, cancer and self-harm are many times those in the non-Aboriginal population (South Australia-specific data is not available for these measures).

These factors exist within a socio-economic context in which many elements may be linked to physical and mental health outcomes. Many Aboriginal South Australians are living with the significant and lifetime impacts of removal from their birth families. The experience of violence and the threat of violence for Aboriginal people in South Australia is high compared with that of the general population. Aboriginal unemployment is three times the state rate. Aboriginal people in South Australia experience high levels of homelessness and overcrowding; many have experienced periods in which they do not have the funds to pay for basic expenses.

Aboriginal leaders say policies and programs must take an integrated approach across disciplines and portfolios. Health to Aboriginal people 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 and medicines or the absence of disease and incapacity.

The health of Aboriginal people in South Australia is the responsibility of the whole South Australian Government and the community. Health-sector initiatives must be integrated with change across public sector portfolios and with the private and community sectors.

## What can be improved?

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Reform in four areas will provide quick and longer-term improvements in health outcomes among Aboriginal South Australians.

### **1. Increase the number of Aboriginal people trained for and employed in the health workforce, particularly in senior and professional roles and occupations.**

The South Australian Aboriginal Health Research Accord (SAHMRI 2014) notes that the best health outcomes for Aboriginal people can be achieved only with Aboriginal people engaged at every point, from identifying issues to researching and designing responses to on-the-ground health treatment and care.

Aboriginal employment in SA Health has decreased since 2011. Aboriginal persons make up one per cent of SA Health employees, compared with a state target of two per cent. Aboriginal people are also under-represented in applications for SA Health positions.

In June 2016, most Aboriginal SA Health employees were in administrative or non-client contact roles. There were 4.0 FTE doctors in SA Health who identified as Aboriginal employees, 0.1 per cent of the number employed.

Aboriginal representation in health professions generally remains below the proportion of Aboriginal people in the population. In the 2011 Census, of South Australia's total health professional workforce, 190 identified as Aboriginal, 0.5 per cent of the total number and less than a quarter of the proportion of Aboriginal people in the state (2.4 per cent).

The number of Aboriginal students starting health profession training at university in South Australia has increased, but as a proportion of all student commencements it has remained unacceptably low at 1.3 per cent.

## **2. Provide culturally respectful care**

The health system must improve its capacity to deliver culturally respectful healthcare to Aboriginal people, with a focus on:

- the cultural competence of the whole health workforce
- identifying and removing barriers to reporting and recording Aboriginal identification of both staff and consumers
- identifying and eradicating institutional racism and its effect on delivering safe healthcare to Aboriginal people
- identifying and addressing the health effects and impacts of removal from family and of institutional care.

The *National Cultural Respect Framework 2016-2026* was developed by the National Aboriginal and Torres Strait Islander Health Standing Committee to guide strategies to improve culturally respectful health services. It outlines six key factors in delivering culturally respectful health services: whole-of-organisation approach and commitment; communication; workforce development and training; consumer participation and engagement; stakeholder partnerships and collaboration; and data, planning, research and evaluation.

## **3. Improve the identification of Aboriginal staff and consumers in the health system.**

When there is data missing from administrative data sets, it can and does affect both analysis and reporting and the potential benefits that come from measuring and analysing data and other evidence.

Like other agencies, the Council has been able to examine and report only what is available. Much is missing. For example, not all Aboriginal people are correctly identified in the data and not all Aboriginal people choose to identify themselves or their loved ones in administrative datasets, national censuses or other collections. Many Aboriginal health consumers do not identify as Aboriginal for fear of discrimination. Health service providers may not ask about the Aboriginal status of health consumers, even where collection of this status field is mandatory. Aboriginal leaders told the Council that it is not enough to self-identify as Aboriginal, and that Aboriginal identity 'goes well beyond what you look like'. Identity incorporates connection to community, connection to country, culture and language. Culturally competent health services must encompass all of these things.

Further, due to the relatively small population size and small numbers of Aboriginal people within the state, reliable data and estimates cannot always be obtained.

The Council has submitted a recommendation to the Australian Bureau of Statistics that the 2021 Census expand its questions about Aboriginal heritage. It suggests that in addition to the question, 'Is the person of Aboriginal or Torres Strait Islander origin?' that the Census ask:

Has the person always known that they are of Aboriginal or Torres Strait Islander origin?

- a. Yes – they have always known.



- b.No – they have not always known.
- c.Unsure.

In this way, data would not require as much subjective interpretation as the single question, and so support respondents' (and Census) accuracy.

#### **4. Eradicate racism in the health system through workplace audits, feedback tools, safety and quality standards and personal healthcare plans; and by ensuring Aboriginal health consumers know their rights.**

Many Aboriginal health consumers do not identify as Aboriginal for fear of discrimination. Aboriginal leaders expressed concern about misinformation in their communities regarding the perils of identifying Aboriginal status to health services. Aboriginal people need health service providers to explain why information is sought; that is, to promote better health outcomes.

Health service providers are not consistently asking for Aboriginal status when consumers present for care. Aboriginal leaders told the Council that the Aboriginal status field needs to be mandatory, even if the answer is 'prefer not to say'.

Aboriginal consumers will not be confident in the health system until action is taken against racism and bias. Aboriginal leaders suggested that racism be addressed through workplace audits, consumer feedback, safety and quality standards, personalised healthcare plans and making Aboriginal health consumers aware of their rights, which can be recorded and measured more systematically than responses to complaints. Aboriginal leaders sought a way for people to 'scorecard' healthcare providers.

Prevention is always better than interventions and treatment. Some elements of health promotion, brief interventions and screening programs make a difference in areas such as childhood disease prevention (such as through immunisation), smoking quit rates and cancer survivability. These approaches must be resourced and culturally relevant and take into account both the broad distribution of Aboriginal people across metropolitan, country and remote South Australia and the different needs within the Aboriginal population.

The Aboriginal community has prioritised prevention of heart and stroke, cancer and diabetes. SA Health received completed chronic disease plans for identified community priority areas on 30 June 2016:

- *SA Aboriginal Heart and Stroke Plan 2017-21*
- *SA Aboriginal Diabetes Strategy 2017-21*
- *SA Aboriginal Cancer Control Plan 2016-21.*

These should be prioritised and the SA Aboriginal Chronic Disease Consortium supported to implement their programs.

#### **Links to the full reports**

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Aboriginal Leaders' Forum meeting output reports are at [http://hpcsa.com.au/get\\_involved](http://hpcsa.com.au/get_involved)

The *Aboriginal Health Case Study 2017* is at [www.hpcsa.com.au/reports](http://www.hpcsa.com.au/reports)

### 3.3 Culturally and linguistically diverse communities (CALD) health outcomes audit: tackling equity

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#### The review

In 2014, the Health Performance Council identified that people from culturally and linguistically diverse backgrounds are among the population groups missing out on accessing suitable services or gaining equitable health care outcomes. As a result, it commissioned a study to discover whether culturally and linguistically diverse individuals and groups, and particularly older people in these communities, are receiving adequate and appropriate health care in South Australia.

*Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds* was released in September 2015. It captured the knowledge and experience of culturally and linguistically diverse population representatives, advocates and service providers. It found that a system that is already failing many South Australians with little or no English-speaking skills is likely to become more flawed as the number of these people increases, they become older, and new and emerging – and often small and fragmented – communities arrive in South Australia, some with complex physical and psychological needs.

However, in the years since that report was released, the Council has observed that the problems it noted in examining the health services and outcomes for the state's culturally and linguistically diverse communities are found in many population groups. Its work has discerned common characteristics in issues relating to equity of access in and among groups such as Aboriginal communities and people in remote regions of South Australia.

In August 2018, the Council provided comments on SA Health's 'Equity and Access in Health Care Policy Directive' (version 1). In its comments, the Council noted that the policy focused on identifying select actions and resources to support equity of access, rather than respond to evidence that would generate methods of tackling wider determinants of health and disease prevention. It asked SA Health to produce 'the definitive policy directive' on equity of access to public health services – to work with partners to develop an 'all-of-South-Australia' direction on the broader aspects of equity and access.

In doing so, it sought to address issues such as institutional racism, which is also a barrier to care for many Aboriginal South Australians.

The Council's comments reflected its February 2017 recommendations to the Australian Productivity Commission, in response to the Commission's December 2016 *Reforms to Human Services* issues paper. Then, the Council urged the Commission to ensure effective communication was at the core of health services. 'It is imperative neither language, religion nor cultural differences should be a barrier to health care and good health outcomes,' the Council wrote.

Now, as the Council reflects on its work throughout this review period, it suggests this advice can be broadened to include barriers of distance, of geographical location, and of economic disadvantage. The advice remains the same: in a society such as South Australia's, each and every person must be able to expect the same access to the same level of care.

The commentary below emanates from the Council's review of health services for South Australia's culturally and linguistically diverse communities. The Council suggests that the issues it examined and the weaknesses of the system in addressing those issues remain common to members of those communities, and to other specific population groups in South Australia – and that they have implications for care, service costs and health outcomes for everyone in the state.

## Summary of findings

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In the Health Performance Council's 2015 scoping study *'Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds'*, culturally and linguistically diverse community leaders reported that South Australia's health system is better than it used to be in helping and caring for their members. The study indicated that cultural awareness had expanded, there were more culturally and linguistically diverse employees in the health system, and there was a greater presence and participation of people from culturally and linguistically diverse backgrounds in the community. However, the system remains inadequate. It does not and cannot respond as it should to the needs of people from culturally and linguistically diverse backgrounds.

The 2011 Census indicated that about two per cent of South Australia's population was born overseas. About 230,000 adults speak a language other than English at home, and about 40,000 speak little or no English. Health and aged-care reforms to providers, services and procedures are reducing rather than increasing access to care for people from culturally and linguistically diverse backgrounds, particularly from community support organisations. Reforms that rely on digital and English-language literacy limit access to information that helps people navigate the health system and its services.

In March 2015, the Federation of Ethnic Communities' Councils of Australia (FECCA) released the *Review of Australian Research on Older People from Culturally and linguistically diverse Backgrounds*. This analysed evidence about older culturally and linguistically diverse Australians and identified gaps in data about:

- older people from culturally and linguistically diverse backgrounds in general
- older people from culturally and linguistically diverse backgrounds with dementia
- ageing and mental health issues for people from culturally and linguistically diverse backgrounds
- culturally and linguistically diverse carers and carers of older people from culturally and linguistically diverse backgrounds.

Issues that compromise the effectiveness of care ultimately affect health and wellbeing outcomes of individuals in South Australia's culturally and linguistically diverse communities. Health literacy is generally poor; this includes an understanding of messages about healthy living and ageing well, and of what services are available and how to use them.

Lower levels of service use do not equate to need but reflect difficulties in seeking and finding culturally safe and appropriate care. There may be stigma attached to certain illnesses and conditions; this, along with fear and mistrust, can add to communication issues and further discourage members of culturally and linguistically diverse communities from seeking help.

New migrants and isolated members of culturally and linguistically diverse communities may 'fall through the cracks' while facing challenging physical, psychological, social and economic circumstances. Innovative community-based approaches that capitalise on culturally and linguistically diverse knowledge, experience and networks and are known to have worked elsewhere should be tried for individual and community benefit.

### **A. Helping older people in culturally and linguistically diverse communities**

South Australia's population is older than that of other states, and the culturally and linguistically diverse community has a higher age profile than the state's average, largely because of post-World War II migration and the number of older new arrivals from non-English speaking countries in recent years. In 2011, 18.5 per cent of people aged over 65 were born in non-English-speaking countries.

Older people from culturally and linguistically diverse backgrounds have difficulty accessing health, aged care and community services. Language barriers increase if older people lose acquired English skills due to isolation or memory-related conditions.

The shift from the Commonwealth Home and Community Care Program (HACC) to the 'consumer directed' Commonwealth Home Support Program (CHSP) and My Aged Care introduced new challenges. HACC is a largely online system, which older residents, and particularly those with little or no English skills, may not be able to use with confidence. Simple changes to programs and processes can be confusing.

## **B. New and emerging communities**

In the mid and later 20<sup>th</sup> century, most of South Australia's migrants came from Europe. Increasingly, however, South Australia's population includes people from many countries beyond these 'traditional' immigration sources: more from China, India and South East Asia, and from nations in Africa and the Middle East. New and emerging culturally and linguistically diverse communities include skilled migrants, international students, people on working visas, refugees and asylum seekers.

Some of these culturally and linguistically diverse community members arrive in South Australia after traumatic experiences in their homelands. Some have complex physical and mental health needs; helping them can be complicated by the lack of, or a reluctance to accept, overseas medical reports, and by their own issues with privacy and trust.

Culturally and linguistically diverse families, young people and those in rural areas are particularly vulnerable to having their needs overlooked if their numbers are small and they have limited contact with others.

## **C. Mental health**

Mental illness is a growing concern in the community generally. There is reason for particular concern for impacts among older members of culturally and linguistically diverse communities and those within the new and emerging culturally and linguistically diverse groups in the state: older people from culturally and linguistically diverse backgrounds have a higher risk of mental health issues than other older members of the population, and refugees and others who have experienced trauma are more likely to have mental health issues than their peers in the Australian population.

Older people within culturally and linguistically diverse groups tend to seek medical help later than other older Australians, especially for symptoms of conditions such as dementia, which they may not understand or which may have a cultural stigma.

## **D. Priority issues**

Cultural sensitivity is increasingly reflected in health policies and practices, and in the services provided to help people from culturally and linguistically diverse backgrounds. However, there is much still to be done to improve health services to, and health outcomes for, people from culturally and linguistically diverse backgrounds, so that access and outcomes are similar to those for other members of the population.

Priority issues have been categorised as relating to 'inclusion and empowerment', 'access and equity', and 'quality and capacity building'.

## **E. Inclusion and empowerment**

South Australia does not have a specific policy framework, action plan and reporting mechanism for health-care services to people from culturally and linguistically diverse backgrounds. SA Health is not

required to report on access and equity to the South Australian Multicultural and Ethnic Affairs Commission. While some SA Health policies, plans and standards recognise cultural diversity and aim to address culturally and linguistically diverse needs, any gap in accountability may influence practices, procedures and competency across the health system. Any absence of data to measure and monitor performance affects the system's capacity to identify and respond to issues appropriately.

Culturally sensitive advocacy is critical for people who may not have the language skills to explain or even ask for the health services they need. The needs of culturally and linguistically diverse populations are not considered during the planning, design and development of health policies, programs and services. Culturally and linguistically diverse community needs may be considered less important or even 'impossible' to address due to the smaller size or complex needs of some groups or their members.

Suggestions from culturally and linguistically diverse communities about how to improve communication with members of their communities have been largely ignored or set aside because they are perceived as too hard, or due to time and resources issues.

## **F. Access and equity**

### *Language and culture*

- Inconsistent and inadequate training of health care employees leads to cultural insensitivity, poor communication, no training in supporting survivors of torture and trauma, and even incidents of racism.
- Without adequate translation services, people cannot explain their needs or receive and understand information and advice, including complex medical information. Too few interpreters are available to help people at all stages of hospital contact, from pre-admission to discharge and outpatient care. The interpreter booking process varies between hospitals, and interpreters are not 'matched' to patients, either for continuity of care or to provide better reporting and evaluation data.
- Likewise, transport arrangements differ between hospitals and clinics. Some hospitals require patients to complete forms (which adds another layer of complexity for people with limited or no written English skills) and then present them at various places, with each contact potentially adding to the patient's anxiety; some forms also are valid only for a limited time and require the patient to repeat the booking process for later appointments.
- The risk of re-admission increases when discharge planning and services do not reflect the specific needs of culturally and linguistically diverse patients; some support organisations report receiving many requests for urgent assistance from patients or their families because they were not told, or did not understand, how to care for themselves at home.
- Communication issues reduce the effectiveness of what are often time-limited GP consultations. Many GPs do not use translators. The quality of primary care has implications for the individual and for the capacity of the acute-care system.
- Printed documents in languages other than English are helpful but should not be the only form of translated communication. Some people are not literate in their own language and prefer verbal explanations. Online information is not suitable for older members of culturally and linguistically diverse communities. When looking to obtain feedback or ideas, face-to-face groups are more effective than phone or online tools.

### *Using services*

- There is no culturally inclusive baseline data to assess disparities in quality of care, health outcomes or patient satisfaction among members of culturally and linguistically diverse groups.
- Data is collected about 'country of birth' but this is not always known.

- People from culturally and linguistically diverse backgrounds are less likely than other members of the community to access mental health services. Refugee children and adolescents are at particular risk of developing mental health problems and not accessing necessary care.

## G. Quality and capacity building

- Health workers and associated staff need cultural sensitivity training. Diversity within the workforce is critical. Clinicians from culturally and linguistically diverse backgrounds need more support and should be encouraged to share concerns about their workplaces and ideas for improvement.
- Engagement should focus on the channels known to work: face-to-face, radio and television, and through community members and groups.
- Members of culturally and linguistically diverse communities are not included in population-wide consumer experience surveys – most of which are conducted over the phone – in proportionate numbers.

## What can be improved

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The Council's response to SA Health's draft policy directive, issued in August 2018, summarises its advice to the South Australian Government and the wider sector in helping all South Australians access the health services they need – including members of culturally and linguistically diverse communities.

At the same time, it highlights issues that the Council has found to be common to most, if not all, of the areas it has analysed during this reporting period.

- There must be more accountability for policy implementation and outcomes, making it clear who will be responsible for what, and how it will be measured.
- Policy and the evaluation of its success must be based on reliable evidence – data, consumer feedback and staff surveys – from the initial reason for its existence through to measuring its success.
- Consumer engagement must play a part in the design, development, delivery and evaluation of any policy and related initiatives.
- Health system employees need more cultural sensitivity training to support members of culturally and linguistically diverse communities and Aboriginal communities. Diversity within the workforce is also important.

The Council presented the response after working in 2016 with the SA Health Integrated South Australian Activity Collection (ISAAC) Working Group, where it successfully applied to have three additional state-wide data items collected on culturally and linguistically diverse (CALD) identification, and provided a guide to collecting the three additional data-items to support the pilot year from July 2017.

## Links to the reports

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Culturally and Linguistically Diverse Communities (CALD) Leaders' Forum meeting output reports are at [http://hpcsa.com.au/get\\_involved](http://hpcsa.com.au/get_involved)

A guide to assist SA Health agencies and staff to collect data relating to the cultural and linguistic diversity of health consumers is at <http://www.hpcsa.com.au/statistics>

The 2015 Scoping Study and 2018 Council response to the SA Health Equity and Access in Health Care Policy Directive is at [www.hpcsa.com.au/reports](http://www.hpcsa.com.au/reports)

## 3.4 Revisit Review of Country Health Advisory Councils' Governance Arrangements 2011

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### The review

Under the *Health Care Act 2008*, the South Australian Government abolished all hospital boards and established 41 Country Health Advisory Councils (HACs) to provide local community advice on the diverse health service needs of the 408,498 people living in country South Australia (2006 ABS Census). Boards in metropolitan hospitals were also replaced with local advisory councils.

The Act (Part 11, section 101) required the Health Performance Council to review the Country HACs in 2011 and report to the Minister for Health on:

- their effectiveness in promoting the interests of local communities
- the level of satisfaction with the governance arrangements between HACs and relevant hospital/s from the perspective of the members of the HACs, the local communities and the hospitals
- any other significant issues considered relevant.

On 7 December 2011, the *Review of Country Health Advisory Councils' Governance Arrangements* report was submitted to the Minister for Health and Ageing with a focus on the description in the Act; that is, about HACs and:

- their effectiveness in promoting the interests of local communities
- the level of satisfaction among HAC members, the local community and relevant hospitals with governance arrangements between the HACs and those hospitals
- other significant issues.

It found that:

- while country HACs promote the general interests of local communities, there was limited promotion of the interests of specific population groups
- country HACs had a low profile in their communities and their efforts were not well supported or promoted by the health system
- there was a low level of satisfaction with the governance arrangements between country HACs and the local health staff
- communication and collaboration between different HACs and the health system varied.

The review found in a significant number of cases that the HACs did not effectively engage with or work for their hospitals and communities. In addition, there was little evidence that HACs adequately promoted the interests of some population groups – such as Aboriginals, members of CALD groups or people with disabilities – within their communities.

The 2015-18 review of country Health Advisory Councils (HACs) follows the Council's similar review during the four years leading to the four-yearly report released in December 2014. The revisit review, published in September 2017, examined changes over the intervening period and how HACs could support the improvement of regional residents' health outcomes.

The Council commends HAC members – who are unpaid, part-time volunteers – for their efforts. However, the increased focus across Australia on health governance demonstrates how important health services are in maximising patient safety, engaging with communities and consumers, improving health outcomes for country people, and continuing to provide appropriate, high-quality health care. The Council's review and findings are provided in this context. For the 2017 review, HPC collected and analysed information from documents, interviews, surveys and focus groups between May 2016 and June 2017.



The preparation of the 2017 review coincided with the release of the [Social Development Committee of South Australian Parliament's inquiry into regional health services' governance arrangements](#) in August 2017.

## Summary of findings

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The Council's report concluded with the following suggestions for strengthening country HACs as a critical and significant community engagement mechanism of the health system with local country communities.

### **1. CHSALHN staff and country HACs have a shared vision for future collaborative action and engagement across the whole community.**

The Council found a strong commitment to improving services, despite differences in perceptions about how well functions are currently delivered. The Council considers that implementation of the June 2017 CHSALHN Partnership Framework will help address some issues raised, but it does not offer complete coverage of country HAC functions.

### **2. Country HACs have a low profile in the community and their direction is not well described by CHSALHN to ensure efforts support governing council functions and the organisation's strategic directions for patient safety and quality health outcomes.**

Country Health SA Local Health Network (CHSALHN) staff and HAC members were found to have a shared vision for how they should work together to support their communities. However, there were differences between how CHSALHN, community members and the HACs themselves perceive HACs' effectiveness.

More HACs agreed or strongly agreed (49 per cent) with their ability to provide good advice about health issues, goals, priorities and plans compared with CHSALHN staff (26 per cent) and community members (32 per cent). Thirty percent of community members strongly disagreed.

Similarly, only 20 per cent of CHSALHN representatives and 28 per cent of community members believed HAC members had the 'competency' to provide advice to support the delivery of local health services.

Yet there was significant evidence of HACs' significant achievements in their communities, particularly in working with local government, community groups and service providers to raise funds for necessary equipment and services. These fundraising projects include:

- the Naracoorte Area HAC, the local council and the Kincaid Medical Clinic working with local service clubs to raise more than \$850,000 for CT services at the Naracoorte Hospital
- the Loxton & Districts HAC leading fundraising activity that raised \$300,000 to renovate and refurbish wards and bathrooms, and another \$67,000 to install a new call bell system, at the local hospital
- the Port Pirie HAC, local government, CHSALHN and the local community working together to raise funds for a helipad at the Port Pirie Hospital, a palliative care unit and a dialysis unit, and to upgrade an aged-care facility
- the Renmark Paranga Districts HAC reporting that its activities included upgrading an outdoor area, developing donations processes, and supporting a music and dementia program; its focus also includes expanding mental health and addiction services and attracting and retaining visiting specialist services at the Renmark Paranga District Hospital.

These accomplishments indicate substantial interaction with local communities and partners, so it may be that 'a sustained low profile of HAC work', rather than the amount of cooperation and efforts, limits CHSALHN staff and community members' awareness of HAC roles.



### **3. There is room for improving CHSALHN performance data provision to HACs and development of health literacy and linkage between staff and HACs so the HACs can provide leadership in an advisory capacity and monitoring of regional health services performance.**

Country HACs do not receive sufficient data and information to achieve identified patient safety and services objectives. There is inconsistency in the types of corporate and clinical governance reports provided to different HACs and how the information is reported.

CHSALHN may not recognise what HACs can achieve in terms of providing sound and strategic advice with this limited evidence and information. Similarly, HACs may not feel equipped to support CHSALHN's strategic directions to expected levels with these resources, or with the minimal training in governance and health-related matters they receive. For example, when HACs members were asked what would help them:

- 24 per cent reported more information on the community and its needs and more specific statistics and relevant to their area
- 20 per cent reported more understanding of the role and value of HACs within the health system
- 20 per cent reported more training on governance, engagement processes and skills
- 12 per cent sought greater understanding of plans and their implementation.

In June 2017, CHSALHN released a 'Partnership Framework' to guide collaboration and engagement between CHSALHN, the HACs and their communities. One of the aims of the framework was to improve both the 'health literacy' and the 'health governance literacy' of country HAC members; this, along with other work to clarify how HACs connect with CHSALHN's strategic directions, should improve both the HACs' effectiveness and collaboration between all parties.

#### **Country HACs promote the general interests of local communities to the health system, although promotion of the interests of specific population groups remains limited.**

Many CHSALHN respondents reported that they had no engagement with HACs, while 23 per cent reported engaging with HACs at the 'inform' level. Among the HACs, 46 per cent said their engagement with CHSALHN was of the 'inform' nature, 15 per cent was characterised as 'consult', and a total of 18 per cent was shared between the more desirable 'involve', 'collaborate' and 'empower' categories.

Surveys with community members demonstrated limited engagement with some population groups. For example, there was a wide disparity between what engagement 'is' and 'should be' with Aboriginal residents, members of CALD communities, health consumers, people with a disability, low-income and isolated families, and young people.

The 2015 *Country Health SA Aboriginal Community & Consumer Engagement Strategy* has changed the engagement and involvement of Aboriginal people in the health system, and recommended that CHSALHN consider focusing on and introducing similar engagement strategies for CALD and youth populations that include HAC membership.

#### **What can be improved**

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It is a challenge for CHSALHN and HACs in strengthening governance and partnership to establish methods by which HACs can access the information they need and want, when and how it is relevant to them. It is at the same time imperative that they do so.

Many HACs are unaware of what their peers in other South Australian regions do. They operate under very different governance arrangements. A clear understanding of what their functions are, particularly in relation to clinical governance, could support system and service improvements.

More information about governance and health services would support HAC members' capabilities in serving their communities. More data, and training in interpreting the data, is also important in equipping members to perform their functions as the government, CHSALHN and their communities expect.

Some country HACs still have low profiles within their communities; others may be visible but still have limited engagement with specific populations. HACs should seek and aim for 'collaboration' with their communities and the groups within them, and look for opportunities to include representatives of those groups within HACs.

[Links to the full report](#) 

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The Council's review into Country HAC operations can be found at <https://www.hpcsa.com.au/reports>

### 3.5 Post-implementation review of Country Health SA Local Health Network's *Aboriginal Community and Consumer Engagement Strategy*

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#### The review

Following the 2016-2017 revisit review of South Australia's country Health Advisory Councils (HACs), the Council noted and endorsed Country Health SA Local Health Network's (CHSALHN) *Aboriginal Community and Consumer Engagement Strategy*, launched in May 2015. A linked project was undertaken to review the strategy, and the Council's *CHSALHN Aboriginal Community and Consumer Engagement Strategy Post Implementation Review* was completed in November 2018.

South Australia's Aboriginal population equates to about two per cent of the state's total population; about half live in regional areas.<sup>1</sup> The CHSALHN strategy points out that Aboriginal South Australians experience a higher prevalence of a range of chronic diseases, biomedical and behavioural risk factors, and psychological distress than the non-Aboriginal population.

The CHSALHN released its *Aboriginal Community and Consumer Engagement Strategy* in May 2015 to provide direction for its engagement with Aboriginal communities in regional South Australia. It aimed to maximise Aboriginal people's engagement in health-care planning and service delivery in South Australia's regions, recognising that engagement is a vital tool in designing and developing services that Aboriginal people want, need and will use, and ultimately leading to improvements in the health and wellbeing outcomes of the state's Aboriginal people.

Information and feedback from Aboriginal health providers, health professionals and community members were instrumental in ensuring the strategy and its objectives were culturally meaningful and respectful, and would foster and encourage Aboriginal participation in health service delivery, design and decision-making.

The CHSALHN strategy outlined goals, strategies and actions focusing on:

- individuals – capitalising on experts' expertise in developing and implementing health-related engagement activity
- directorates, programs and services – building CHSALHN staff's capacity and cultural awareness and respect
- network – ensuring necessary governance, implementation, evaluation and reporting structures and processes are in place
- systems – increasing the number of Aboriginal people working in a health system that reflects the latest research and evidence about Aboriginal health and wellbeing.

In January 2018, HPC commissioned PwC Indigenous Consulting to undertake the post-implementation review, which examined:

- the strategy's success in influencing change in the short term
- gaps in consumer and community engagement activity that could support strategy objectives in the short term
- emerging areas for future focus that would help achieve medium and long-term outcomes.

To conduct the review, PwC gathered information from HPC and the CHSALHN that formed the basis of stakeholder surveys and focus groups. CHSALHN staff members involved with or responsibility for the

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<sup>1</sup> Australian Bureau of Statistics Census, 2016

strategy, and Aboriginal consumers and community members for whom the strategy was designed, participated in the surveys and focus groups.

The Council's Country Health SA Local Health Network *Aboriginal Community and Consumer Engagement Strategy* Post Implementation Review was completed in November 2018.

## Summary of findings

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The Council's review found that in the three years since the implementation of the *Aboriginal Community and Consumer Engagement Strategy* there had been an increase in how confident Aboriginal people felt in engaging with their health providers and services. There is as yet no measurable evidence that the boost in confidence is directly attributable to the strategy. However, the Council notes that, to its knowledge, there is no similar strategy nor similar gains in levels of confidence elsewhere in Australia. The Council therefore suggests that the change is a result of the strategy and that the strategy's design, development and implementation could be copied, and its outcomes measured, elsewhere in the nation.

However, the Council also found that at the time of its review, services 'on the ground' continue to be largely designed and delivered in a 'top-down' manner. There remains too little consideration of whether services are appropriate for Aboriginal people or for the individuals within different Aboriginal communities, in different regions, across the state. Staff have limited knowledge of the value of culturally specific engagement, and so their use of and commitment to such engagement is minimal.

Specifically, the Council's review outlined six short-term objectives of the CHSALHN engagement strategy and measured progress in those areas.

### **A. Individuals have increased awareness of how to engage with health services.**

The review found there is more awareness among Aboriginal people about engaging with health services now than was the case in 2015, but that more communication about the strategy and its activities to CHSALHN staff and external stakeholders would further expand awareness.

### **B. Individuals – community and consumers feel supported to engage.**

The review found that the strategy had little impact on the levels and types of support Aboriginal consumers and communities believe to be in place, and that they do not feel that the health system and its services are adequate for and respect the needs and ways of engaging for the diverse Aboriginal communities in country South Australia.

### **C. Community and consumers participate in the 'Experts by Experience' register.**

The 'Experts by Experience' register lists the names and expertise of Aboriginal people who have indicated they wish to offer this expertise to boost Aboriginal health and wellbeing in South Australia. The review noted that while there has been some progress in developing a register that will best support strategy objectives, a more detailed register would increase its value.

### **D. Staff participate in professional development about Aboriginal community and consumer engagement.**

The review noted some progress but recommended that CHSALHN receive more training in engagement and advocacy.

## **E. Staff are aware of the benefits of community and consumer engagement.**

The review found little evidence of success in this area. It suggests major effort is needed to meet desired outcomes, including training staff to understand and appreciate the value and potential outcomes of engagement and introducing an effective governance structure to ensure engagement activities are implemented, monitored and reported consistently across all regions.

## **F. Health services form partnership/s with communities that make change and innovate.**

The review found evidence of little progress in this area. It suggested major adjustments to fulfil strategy objectives, including boosting the roles of and opportunities for Aboriginal consumers to participate in their health services and engagement programs.

In summary, the review found that the strategy's activities have made progress towards the achievement of its short-term objectives, but that a concerted effort is required to fulfil its aims and improve service delivery.

### **What can be improved**

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The Council found that while the strategy has made significant progress in removing barriers between Aboriginal communities and CHSALHN staff, more effort is required to maximise the value and potential benefits of the strategy.

In particular, it found that CHSALHN staff require more training in cultural awareness, so they understand how best to engage with Aboriginal individuals and communities, and in the engagement techniques that will enable them to engage effectively. In addition, CHSALHN staff must understand the value of interactive engagement as an essential element in their service 'toolkit'; without effective engagement, their well-intended efforts to deliver services and care may have limited impact and outcomes.

The Council suggests that increasing Aboriginal involvement in developing and delivering health programs – both through meetings to initiate programs and through higher levels of Aboriginal representation in the health workforce – would contribute to this awareness and understanding, while building confidence among Aboriginal communities of the value of those programs. The Council also suggests that more engagement with representatives of specific groups within Aboriginal communities, such as youth and elders, will help the CHSALHN understand and respond to specific health and wellbeing needs of individuals within those groups.

Within the context of these findings, the Council offers the following recommendations for the Department for Health and Wellbeing, LHNs, workforce trainers and other people and organisations involved in providing and improving care with and for South Australia's Aboriginal people.

### **1. Increase Aboriginal people's representation at all levels of the health workforce.**

The Council strongly recommends that LHNs recruit more Aboriginal staff at all levels of their local workforces. Audits of workforce personnel and culture should provide mechanisms through which appropriate staff positions can and should be introduced.

### **2. Establish binding agreements on Aboriginal community and consumer engagement.**

The Council recommends that engagement with Aboriginal communities, including appropriate representation of Aboriginal people, be prescribed in binding agreements between the Department for Health and Wellbeing, SA Health, LHNs and Aboriginal people, and that the establishment of the new country LHNs is an ideal opportunity for this.

### **3. Improve the effectiveness of the 'Experts by Experience' register.**

With improved governance and engagement conduits, the 'Experts by Experience' register will be better able to fulfil its purpose and clearly valuable objectives. The Council suggests that the introduction of the new Local Health Networks (LHNs) in July 2019 provides an opportunity for improved engagement in designing, maintaining and promoting the register. For maximum value, the register should include experts' expertise, knowledge and the areas in which they can and are willing to offer support in areas such as service provision, recruitment and training, and resource development.

The Council recommends:

- clearly communicating the register's benefits as an engagement model to staff, communities and other stakeholders
- increasing the number of experts on the register
- updating the registration form to help potential members understand the register's purpose
- improving experts' induction training
- helping CHSALHN staff understand how experts can be used to help achieve health and wellbeing outcomes
- using a better data management system to manage experts' registration and other details.

### **4. Develop strategic partnerships with community and stakeholder organisations.**

The Council recommends that LHNs take more steps to build strong and sustainable working partnerships with external stakeholders, including their local Aboriginal community-controlled health organisations, to develop and implement appropriate and relevant services. Health representatives at all levels should understand the value of engagement, and be trained in this area if necessary.

More opportunities for Aboriginal voices to contribute to and provide feedback on services and program delivery will improve confidence in those services and the likelihood of health benefits.

### **5. Eradicate real and perceived racism and its implications for health services and outcomes.**

The Council recommends that existing and future LHNs take immediate action to tackle racist attitudes and behaviours in the health workforce, including those attitudes and behaviours that employees may not understand to be racist. All staff should have initial and ongoing cultural training, and executives should monitor and enforce completion.

The new LHNs should undertake regular audits of workforce culture, including indicators that measure employees' understanding of Aboriginal cultural awareness, human rights and reconciliation awareness, along with those that assess institutional racism.

### **6. Shape and embed a workforce that understands the benefits of community and consumer engagement.**

The Council recommends that the new LHNs immediately design and implement communication platforms, tools and techniques that maximise opportunities for, and demonstrate the value of, ongoing collaboration and engagement. Communication should include and promote events, policies and

presentations designed to maximise engagement and, in doing so, provide measurable indicators of the value of ongoing engagement.

Effective engagement outcomes will require:

- increasing Aboriginal representation in engagement development and feedback forums and in the health workforce
- improving service standards to meet those outlined in the second edition of the National Safety and Quality Health Service Standards, released in June 2017
- increase staff understanding of how the *Aboriginal Health Impact Statement* can be used to support strategy outcomes
- introduce an effective governance structure to ensure engagement activities are implemented, monitored and reported consistently across all regions.

## **7. Adapt the Aboriginal Community and Consumer Engagement Strategy to comply with changing national guidelines.**

The Council recommends that in implementing the strategy and services, LHNs pursue every opportunity to comply with current national guidelines and targets, including the National Safety and Quality Health Service Standards, (November 2017). Recommendations for best practice are also regularly revised.

## **8. Recognise and respect difference.**

The Council recommends that the LHNs take steps to ensure their community and consumer engagement strategies and activities recognise the differences in and among the Aboriginal communities they serve and how those differences must be reflected in service design and delivery. The Council suggests that the LHNs:

- provide more culturally sensitive information about services
- work with communities to provide services that are appropriate to different Aboriginal cultural communities, including those that will address the needs of specific groups such as older Aboriginal people and youth.

## **9. Regularly evaluate the *Aboriginal Community and Consumer Engagement Strategy's* implementation and progress.**

The Council recommends that the strategy, its successors, and any aligned policies and initiatives be regularly evaluated to ensure they are and remain effective and relevant. Such evaluation will require the inclusion of indicators that can be measured. Evaluation results should be communicated to highlight those activities that are working, and so could be replicated elsewhere, as well as those that are not succeeding as planned, and so could be further analysed or changed.

The Council suggests that the introduction of the new LHN structure in July 2019 provides an opportunity to address these recommendations. It looks forward to the development of systems and services that require Aboriginal representation in decision-making and in the engagement processes that drive and disseminate those decisions.

Links to the project 

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<http://www.hpcs.com.au/reports/2018-post-implementation-review-of-country-health-sas-aboriginal-community-and-consumer-engagement-strategy>



## 3.6 Revisit End of Life Care Case Study

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### The review

There is growing demand for, and increased public attention on, the quality and availability of end-of-life care in South Australia. The Health Performance Council considers the provision of quality end-of-life care to be an important measure of a humane 21<sup>st</sup> century society and an essential element of that society's health-care system. In the Council's view, end-of-life care includes more than medical treatment in the very last days of life; 'dying well' does not mean merely the absence of pain and suffering but requires consumer choice, connectedness and community. It is a psychosocial event as much as a physical one. The Council considers end-of-life care optimises the quality of life as well as the quality of death.

To examine the status of and improvements in end-of-life care the South Australian Government provides for South Australians, the Council revisited its 2013 report *Improving end of life care for South Australians*. This report was a midpoint examination of the implementation of *SA Health's Palliative care services plan 2009-16*, which outlined the Government's commitment to expand and reshape end-of-life services in the state. The Council's 2018 report updates the 2013 analysis to determine what initiatives have been implemented since then and if they have worked. The Council released its report *Revisit review of South Australia's Palliative Care Services Plan 2009-16* in November 2018.

### Demand for palliative care

South Australia faces growing demand for end-of-life services because of its ageing population and a growth in chronic and life-limiting diseases. Population projections indicate 25.2 per cent of the state's population will be aged 65 and older by 2060. Meeting the increasing demand for end-of-life care will require both capacity and capability building in SA Health. Evidence indicates that most demand is currently, and will continue to be, met in the public health system.

There is the expectation among citizens that consumers' choices, and respect for those choices, will be at the heart of their end-of-life care.

Consumers expect that the care provided to them will not add to their confusion and stress, or that of their families and carers. They seek care that will be seamless, coordinated, and available when they need it and where they want it, and will support their physical, psychosocial and spiritual needs.

### Palliative Care Services Plan 2009-16 – SA Health, May 2009

South Australia's *Palliative Care Services Plan 2009-16* outlined how the South Australian Government intended to expand and reshape end-of-life services in the state, particularly considering South Australia's ageing population and the increasing prevalence of chronic diseases.

The plan acknowledged a shift in thinking from clinically-focused treatments and care to a broader concept of end-of-life care with pathways tailored to individual needs. It recognised that different people seek different options during the end-of-life period, and that respect for those choices influences their quality of life during that time.

While the plan's objectives were not explicit or prioritised, the Council considered that the plan aimed to achieve:

- improved health and wellbeing outcomes – better health and wellbeing outcomes for consumers, their families and carers
- person-centred care – respectful end-of-life care services that put people and their wishes at the centre



- more care in the community – increased end-of-life care and death and home and in the community
- best practice service delivery – quality, consistency and streamlining of care for all people across all settings.

To achieve these objectives, the Council identified eight goals in the plan:

- Goal 1: Establish a statewide, integrated service model
- Goal 2: Improve care in the community and at home
- Goal 3: Improve care in the hospital setting
- Goal 4: Build the capacity of the specialist and generalist workforce
- Goal 5: Ensure access and equity in service delivery
- Goal 6: Increase consumer knowledge and respect consumer choice
- Goal 7: Deliver high-level and consistent quality and efficiency
- Goal 8: Enhance the state's research, policy and planning endeavours.

Across the eight goals, the Council found 32 supporting initiatives. These initiatives were not prioritised, nor were performance indicators or targets attached. Details of how the projects would be developed, introduced, managed and funded, or who would be responsible, were not outlined in the plan.

### Revisit review of the *Palliative care services plan 2009-16* – Health Performance Council, November 2018

The Council's 2018 report evaluated the progress in achieving elements of the 2009-16 plan as an indication of the quality and levels of, and access to, appropriate palliative care services in South Australia. It adopted the Palliative Care Australia (PCA) definition of palliative care:

*Palliative care is person-centred and family-centred care provided for a person with an active, progressive advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary treatment goal is to optimise the quality of life.*<sup>2</sup>

This definition reflects recent changes in what end-of-life care is now considered to be, and how and where consumers expect it to be provided.

In evaluating progress in implementing South Australia's 2009-16 plan, the Council consulted with stakeholder groups and examined available evidence to determine whether objectives outlined in the 2009-16 plan had led to improved care and outcomes for consumers, their families and carers. However, in attempting to analyse 2009-16 plan outcomes, it found that the plan failed to detail clear baseline measures, measurable performance indicators and explicit targets. No accountability framework was provided. Without reliable statewide and local network reporting on progress, analysis was tentative in some areas and impossible in others. The following findings should be considered in this context.

### Summary of findings

The Health Performance Council found that achievement of South Australia's *Palliative care services plan 2009-16* is uneven across the state. In fact, despite the early impetus to establish a sustainable, consumer-centred and centrally coordinated model of end-of-life care, progress in achieving the 2009-16 plan has stalled. The four objectives identified in the plan – improved health and wellbeing outcomes, person-centred care, more care in the community, and consistent service delivery – were achieved only in part.

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<sup>2</sup> PCA 2018b 6

Status of the plan's 32 initiatives									
Achieved	3	Partially achieved	10	Discontinued	2	Not achieved	6	Data not sourced	11

Initiatives achieved in full or in part under the plan include:

- formation of three integrated regional services
- reforms in workforce structures and roles
- initiatives to increase and recognise consumer knowledge and choice
- expansion of community-based care.

Less successful initiatives include:

- proposals to establish strategic and statewide systems of quality and efficiency
- data collection, research and evaluation
- policy and planning.

Two initiatives were started but subsequently disbanded (establishment of a Palliative Care Clinical Network and a research collaborative).

Of major concern to the Council is the difficulty in sourcing data to draw reliable conclusions on more than one-third of identified initiatives, as well as five additional identified proposals.

The lack of progress is due to factors such as contested resources, service variability between local health networks, and the absence of central coordination and governance. Confusion about the plan's strategic intent, priorities and desired outcomes and explicit priorities also contribute. The Council can only conclude that, in many cases, the state-level data that would justify additional funding and other resources, and establish benchmarks for future assessment, does not exist. The degree to which data and evidence do inform current end-of-life policy and planning in the state should also be questioned.

For consumers, families and carers, the lack of action has had real and significant impacts: less community-based care than was promised, continued high levels of hospitalisation and acute care treatments, more pressure on carers, more disruption for consumers as they move between systems, delays in receiving care, and inconsistent quality of care. For SA Health, it has meant ongoing pressure on financial, staff and other resources in many parts of the system.

In short, consumers of palliative care cannot be sure they are more likely now than they were before the plan was introduced to receive the care they want, where they want it. They are no more certain now than previously that their choices about how and where they are cared for and die will be respected and met. They still cannot be assured of living and dying well at the end-of-life stage.

This is not to say there are no palliative services in South Australia, or that what exists is substandard or unprofessional. Despite shortfalls in implementing the 2009-16 plan, excellence in end-of-life care can be found in South Australia's public health system, within local health networks and work units, and among individual staff. Consumers regard highly the expertise and compassion of palliative care specialists. New advance-practice roles and regional and integrated service units, operating from the metropolitan local health networks, have centralised expertise and resources. There has also been an expansion of community care, including through the use of extended care paramedics. But almost two years after the plan's conclusion, there is much undone.

The Council will continue to seek and analyse available data and will in 2019 provide further analysis of end-of-life care in the state. In the meantime, the Council hopes its review of the 2009-16 plan will support the development, implementation and outcomes of the new South Australian Government end-

of-life strategy. The Council also notes the recent South Australian Government Budget allocations to palliative care support and a new Commission on Excellence and Innovation in Health, and the Australian Government's announcement of a Royal Commission into aged care.

The ultimate goal must be the delivery of person-centred care that guarantees people will receive quality end-of-life care that respects their choices.

## What can be improved

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The Council notes that the South Australian Government has committed to providing \$16 million over four years to increase and improve palliative care services in the state. It also notes the release in mid-2018 of a new SA Health *End of Life Care Strategy* that outlines objectives to achieve similar goals to those outlined in the 2009-16 plan. It was not possible to measure any progress in achieving these goals by the time the revisit review was developed and released in November; in many ways, the Council's advice – here and in the November review – is an expression of its hopes and ambitions for the new strategy and its outcomes.

In summary, in reviewing progress in achieving objectives of the 2009-16 plan and in assessing the status of palliative care services at November 2018, the Council recommends that the South Australian Government does the following within its *End of Life Care Strategy* initiatives and other policies and activities.

### **1. Develop a strategic and statewide model of care that:**

- is person-centred rather than system-centred
- respects consumer choice
- is available to and appropriate for everyone
- recognises the roles and needs of families and carers
- is co-designed and transparent
- is coordinated, flexible and collaborative
- is based on consistent service delivery
- is underpinned by sufficient and sustainable levels of resourcing.

### **2. Embed person-centred care into the model of care, so that:**

- consumers are integral to designing, delivering, evaluating and improving all end-of-life care services
- consumers and their supporters have information to help them make choices about care.

### **3. Ensure equal access to care, so that all South Australians have the same access to and level of care, no matter where they live, their cultural or linguistic background, their health literacy or their socioeconomic status.**

### **4. Improve health and wellbeing outcomes.**

- Identify clear and measurable health and wellbeing outcomes for consumers, families and carers, and how they will be achieved and measured, in all plans and strategies
- Develop a grief and loss agenda
- Expand respite options for families and carers within the 24-hour services announced in the 2018-19 Budget
- Review the comprehensiveness of and access to public information on end-of-life issues and services.

## **5. Expand care in the community.**

- To build on gains made in this area, the Health Performance Council recommends:
  - that the renewed commitment from the South Australian Government in providing round-the-clock support for palliative patients across the state include:
    - more extended care paramedic roles, including in rural areas
    - consideration again of rapid response teams
    - the use of appropriate technology options
  - a review of day hospice and ambulatory services across the state, considering:
    - the roles of GP Plus centres, regional hospitals and community health centres
    - the demand for specialist expertise
    - generalist capacity and availability
    - support for families and carers, including expanded respite options.

## **6. Support paediatric palliative care with 24-hour, statewide services that include psychosocial support, options that meet the varying needs of children and adolescents and their families, new and advanced practice roles and specialist paediatric medical expertise, and support for staff.**

## **7. Ensure high-quality and consistent care.**

- Develop and implement a statewide quality framework for SA Health-funded end-of-life care services
- Eliminate funding silos and barriers to collaboration
- Improve service coordination and continuity.

## **8. Develop a workforce that is expert, responsive and culturally mature, with:**

- adequate specialist providers, including outside the metropolitan area
- more end-of-life care knowledge and expertise in the generalist health workforce, both in primary health and in relevant caring professions
- professional pathways for existing and emerging end-of-life care roles
- more nurse practitioners
- nurse-led beds in hospital and hospice settings
- more staff in advance-practice roles in paediatric services, allied health and social work
- support services to help staff manage the emotional and physical demands of their work.

## **9. Establish effective governance and accountability mechanisms that support consistent and high-quality care, including:**

- central oversight of a statewide plan and model of care, drawing on the experience of the Palliative Care Clinical Network
- clear lines of responsibility and accountability for delivery of the plan and of services, recognising the role of local health networks in delivering services
- integration of the new health networks into the model of care
- statewide, transparent and evidence-based processes of and initiatives for service design, delivery, evaluation and performance improvement.

## **10. Develop and implement policy that is evidence-based and that generates consistent, high-quality, system-level data.**

The Council concludes that strategic and statewide models of care should identify clear and measurable health, wellbeing and psychosocial outcomes for consumers, their families and carers.

## Links to the full reports

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*Improving end-of-life care for South Australians* (2018 and 2013) are found at [www.hpcsa.com.au/reports](http://www.hpcsa.com.au/reports)

## 3.7 Scope an approach to monitor health outcomes for people with mental health and addiction issues in South Australia

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### The review

In July 2016, the Health Performance Council decided that it would add an initial examination of mental health and addiction services to the aspects of the health system it would monitor in its 2014-18 review phase.

The Council had noted anecdotal evidence of the poor state of mental health services across South Australia. The evidence included complaints received by the Council's chair in his then separate capacity as the Health and Community Services Complaints Commissioner, Coroner's reports, media coverage and reports from partner organisations about the impact of tension within the mental health and addiction sector on service delivery and effectiveness.

The Council considered that the evidence pointed to a system unable to help all the people who needed it, as they should expect to be helped. It chose to undertake the first stages of a review to be conducted in the 2019-23 reporting period, to examine the state of mental health and addiction services and the potential impact of such those services on the health and wellbeing outcomes of vulnerable South Australians.

The 2018 scoping project produced a proposed review framework that would culminate in a one-off report examining:

- health outcomes for South Australians with mental health and addiction issues
- how general health outcomes for South Australians with mental health and addiction issues compare to those of the whole population
- how South Australian outcomes compare to those of people in other Australian jurisdictions
- whether and to what extent there are effective service models and strategies in the state
- whether and to what extent the state's mental health workforce, facilities and resources are adequate to provide quality care for South Australians with mental health and addiction issues, and for their families and carers.

The project noted that extensive stakeholder engagement, including input from consumers and other members of the public with experience of mental health and addiction issues and existing services, would be critical to the review's success.

The Council's experience in reviewing many aspects of South Australia's health system leads it to suggest that the project will change during development, according to findings from the engagement, data, environment scans and other evidence that is likely to emerge during the research, analysis and reporting phases.

### Next steps

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If the Council decides to implement the full review in the 2019-23 period, the report will provide recommendations and advice for the Minister for Health and Wellbeing. However, the Council considers that its expected findings will also be valuable for public and private health providers as they plan, design, develop, implement and evaluate services for South Australians across the state.

The Council will decide in 2019 whether to release a series of 'bite-size' reports during the four-year period, or one extensive report towards the end of the period.

### 3.8 *Areas to Act* analysis in collaboration with SA Health and Adelaide and Country SA PHNs, examining health system data for indicators of potentially preventable hospitalisations using Grattan ‘Perils of Place’ (2016) method

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#### The review

In monitoring aspects of the South Australian health system, the Health Performance Council chose to explore how differences between South Australians’ access to services, and the outcomes of those services, might be aligned to where they live. It opted to explore as part of its four-yearly review the ‘place-based health inequalities’ and identify how these inequalities might be reduced or eliminated. It worked with South Australia’s primary and local health networks (PHNs and LHNs) and the Department for Health and Wellbeing (DHW) to identify areas of South Australia in which rates of potentially preventable admissions (PPAs) were high.

The *Areas to Act: A South Australian Review of Potentially Preventable Admissions* report was provided to the Minister for Health and Wellbeing in November, but had not been published when this four-yearly report was completed in December 2018. *Areas to Act* summarised the study of PPAs in South Australia from 2000 to 2015. It was a first step in building an evidence base that pinpoints areas, identified by their postcodes, where health inequalities exist and, without intervention, are likely to continue.

The Council produced, in parallel, a smaller-scale analysis, *Hotspots of potentially preventable hospitalisations in South Australia’s public hospitals*, that was released in December 2017. This study used SA Health hospitalisation data and publicly available population and state boundary data for the 10 years 2007-08 to 2016-17. The study identified that PPAs are not evenly spread through the state, and that in some areas PPA rates are problematic over many years. Noting the size of its study and that findings of the larger study would follow, the Council suggested that opportunities existed for place-targeted interventions to reduce health outcome inequality.

In developing *Areas to Act*, the Council, PHNs, LHNs and DHW chose as their model the Grattan Institute’s *Perils of Place: identifying hotspots of health inequality* (July 2016). *Perils of Place* identified ‘priority places’ in Victoria and Queensland, designated by postcodes, where consistently high numbers of avoidable hospitalisations had been reported. *Perils of Place* used the PPA-postcode measure as both an indicator of serious but reducible health inequality and a proxy measure of the effectiveness of and/or access to primary care. It designated those postcode areas with persistent issues as ‘hot’.

The South Australian study aimed to:

- identify and profile geographical areas of persistent PPAs across South Australia
- inform primary health-care and inpatient service planning by the PHNs and LHNs in which the Council and DHW have interests from operational, budgetary and/or public interest perspectives
- strengthen joint-planning relationships through experience and improved skills in analysing routinely collected government data.

The study examined PPA rates in relation to the 22 ‘ambulatory care sensitive conditions’ identified in the Council of Australian Governments’ *National Healthcare Agreement*. A PPA was defined as an admission to a public or private hospital that could have been prevented by appropriate, individualised, preventative health interventions and early disease management, usually delivered in primary care and community settings by general practitioners (GPs), medical specialists, dentists, nurses or allied health professionals.

PPAs were classified according to the following:

- vaccine-preventable conditions
- chronic and complex conditions
- acute medical conditions.<sup>3</sup>

The national classification of PPAs excludes mental health conditions, so these conditions were not investigated in the review.

The South Australian study explored the rates of the PPA conditions in both public and private hospitals in postcode areas with populations of at least 1,000 residents. PPA rates in those 189 postcodes were grouped into deciles based on the 2016 ABS socio-economic disadvantage index. Postcodes with higher disadvantage were grouped as '1' and those with least disadvantage grouped as '10'.

A postcode was flagged as 'hot' if its PPA rate was at least 1.5 times the state average in three consecutive years during the span 2011 to 2015. The study also extended the analysis to examine data available back to 2001, to determine where in the state longer-term PPA issues exist.

## Summary of findings

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### 'Hot' postcodes

Some postcode areas met the criteria as 'hot' within the 2011-15 timeframe, and others at different periods during the 15-year analysis. Some areas did not qualify as 'hot' because they did not meet the 'three consecutive years in five' criteria, but did have a PPA of at least 1.5 times the state average in many of the years between 2001 and 2015.

- Four areas had PPA rates at least 1.5 times the state average for all of the 15 years studied: Coober Pedy and the surrounds; Ceduna, Yalata and Oak Valley; Meningie and The Coorong; and Port Augusta and surrounds.
- The Maitland-Point Pearce area had a PPA rate of at least 1.5 times the state average for 13 of the 15 years.
- The Peterborough and surrounds area had a PPA rate of at least 1.5 times the state average for 10 of the 15 years.
- Elizabeth (Vale, East, Grove and South) had a PPA rate of at least 1.5 times the state average for seven of the 15 years.
- The Noarlunga Centre and surrounds area had a PPA rate of at least 1.5 times the state average for five of the 15 years.
- Christie Downs qualified in 11 of the 15 years, but not in 2013 (that is, the midpoint of the five-year period 2011-2015).
- Cockaleeche-Cummins, Whyalla and Elwomple-Tailem Bend qualified for nine of the 15 years, but all had PPAs lower than 1.5 from 2011 to 2015.

The study identified the following areas as 'hot' for particular conditions or health needs listed among the 22 ambulatory care sensitive conditions:

- Port Augusta and surrounds and Meningie-The Coorong for acute, chronic and vaccine-preventable conditions

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<sup>3</sup> Health Networks: *Lessons of Location: Potentially Preventable Hospitalisation Hotspots in Western Australia 2017*. Department of Health 2017



- Coober Pedy and surrounds, Ceduna and surrounds and Peterborough and surrounds for acute and chronic conditions
- Buckland Park-Virginia for chronic and vaccine-preventable conditions.

In general, the hot areas correlated with increased remoteness, higher-than-average proportions of Aboriginal residents, and lower socio-economic status.

Most of the 'hot' areas were in rural and remote regions, a finding that reinforced the conclusions of the Council's smaller-scale study. *Areas to Act* found that the areas of greatest need were also in these regions, and particularly in and around Port Augusta, Meningie-The Coorong, Ceduna and Coober Pedy. In the metropolitan area, Elizabeth (Vale, East, Grove and South), Noarlunga Centre and surrounds, and the Buckland Park-Virginia area were also identified as significantly 'hot'.

About 75 per cent of the 176 identified postcodes were in the deciles numbered '1' to '5' – that is, those areas with higher disadvantage, according to the 2016 ABS socio-economic disadvantage index.

Previous research<sup>4</sup> has demonstrated that Aboriginal and Torres Strait Islander Australians have a higher rate of PPAs than non-Indigenous Australians. After controlling for age, sex and remoteness, that earlier research has shown the rate to be 1.5 times the rate for non-Indigenous Australians. Indigenous status appears to have a larger effect than remoteness on whether a hospitalisation was for a potentially preventable condition. *Areas to Act* also found a strong correlation between the proportion of the population of a postcode being Indigenous and the postcode's PPA rate: the areas with higher proportions of Aboriginal residents were more likely to qualify as 'hot'.

## 'Hot' postcodes by PPA condition

Looking at the conditions themselves, the 10 most prevalent PPAs – identified as being those aligned with the most 'hot' postcodes – were asthma (chronic), angina (chronic), hypertension (chronic), chronic obstructive pulmonary disease (COPD), 'other' vaccine-preventable conditions (that is, not pneumonia or influenza) (vaccine-preventable), gangrene (acute), diabetes (chronic), anaemia (chronic), epilepsy (acute) and bronchiectasis (chronic).

- Gangrene was the most prevalent acute condition, with 11 hot areas, followed by epilepsy (10) and pelvic inflammatory disease (eight).
- Angina and asthma (18 hot areas each) and hypertension (17) were the most prevalent chronic conditions.
- Vaccine-preventable conditions were either 'other' (in 11 hot areas) or 'pneumonia and influenza vaccine-preventable' (four).

Again, most 'hot' postcodes for the top 10 PPAs were in remote and rural South Australia.

## What can be improved

*Areas to Act* provided recommendations for urgent action to reduce inequality of care and improve health outcomes, particularly for residents in 'hot' postcodes. It provided evidence to support policies

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<sup>4</sup> Brown L, Bywood P, Katterl R, Anikeeva O, Butler C, Smith B: *Potentially Avoidable Hospitalisations: Causes, Initiatives and Challenges from a Primary Health Care Perspective*: Primary Health Care Research and Information Service (PHCRIS) 2012; AIHW: *Aboriginal and Torres Strait Islander Health Performance Framework Selected Potentially Preventable Hospital Admissions 2014*

and initiatives that enable the PHNs and SA public health services to immediately introduce effective services. The Council suggests primary care and preventive approaches are likely to be key to changing this situation. This could be GP-led work, or that of primary-care hospital staff such as Aboriginal health workers.

The Health Performance Council suggests that attention initially focus on the areas found to have been classifiable as 'hot' for all of the 15 years analysed.

While for statistical reasons the study did not examine those postcode areas in which fewer than 1,000 residents live, the Council suggests that a rigorous examination of the needs of, and services provided to, residents in these low-population areas is necessary, and that the identified needs be addressed.

The Council also notes that 'hot' postcodes largely align to areas of higher disadvantage. As a major step in investigating why there are such differences between PPA rates in areas of higher and lower disadvantage, the Council suggests that the South Australian Government examine and measure what programs and services are offered in these postcode areas.

The Council notes that its advice relating to the need for more data across South Australia's health system, outlined elsewhere in this report, will support analysis, policy and planning, and system improvements in PPA rates.

Reducing the high rates of PPAs among areas with proportionately higher Aboriginal populations will require specific policy responses. The Council suggests that Aboriginal communities be involved in engagement about, and the development and implementation of, policy responses for Indigenous communities.

The Council suggests work is required at the national level to incorporate mental health conditions in PPA classifications.

### Links to the full reports

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The Council report Hotspots of potentially preventable hospitalisation in South Australia's public hospitals is at <http://www.hpcsa.com.au/statistics>

The SA Health publication *Areas to Act* prepared in collaboration with the Council and Adelaide and Country SA Primary Health Networks is in press.

## Appendices

Appendix 1. Health Performance Council – extract of the *Health Care Act 2008* legislation

Appendix 2. Health Performance Council member profiles

Appendix 3. State of Our Health full document

Appendix 4. SA Health progress report for 2016 against Health Performance Council's 2011-2014 report

Appendix 5. SA Health progress report for 2017 against Health Performance Council's 2011-2014 report

Appendix 6. SA Health response to the 2014 4-yearly report

Appendix 7. Health Performance Council publications list 2015-2018

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South Australia

## Health Care Act 2008

An Act to provide for the administration of hospitals and other health services; to establish the **Health Performance Council** and Health Advisory Councils; to establish systems to support the provision of high-quality health outcomes; to provide licensing systems for ambulance services and private hospitals; to assist with the provision of laboratory services and facilities associated with veterinary science; and for other purposes.

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**HAC** means a Health Advisory Council established under Part 4;

**health service** means—

- (a) a service associated with:
  - (i) the promotion of health and well-being; or
  - (ii) the prevention of disease, illness or injury; or
  - (iii) intervention to address or manage disease, illness or injury; or
  - (iv) the management or treatment of disease, illness or injury; or
  - (v) rehabilitation or on-going care for persons who have suffered a disease, illness or injury; or
- (b) a paramedical or ambulance service; or
- (c) a residential aged care service; or
- (ca) a research, pathology or diagnostic service associated with veterinary science; or
- (d) a service brought within the ambit of this definition by the regulations,

but does not include a service excluded from the ambit of this definition by the regulations;

**HPC** means the Health Performance Council established under Part 3;

**hospital** means, according to the context—

- (a) an entity (whether corporate or unincorporated and including a partnership or other structure) by which health services are provided, being health services that include services provided to persons on a live-in basis;
- (b) a site at which activities of an incorporated hospital are undertaken;

**hospital bed** means the bed and associated facilities provided by a hospital for the provision of health services to a patient on a live-in basis;

**incorporated hospital** means a hospital incorporated under this Act;

**liability** includes contingent liability;

**medical treatment** includes all medical or surgical advice, attendances, services, procedures and operations;

**non-emergency ambulance service** means an ambulance service other than an emergency ambulance service;

**private hospital** means a hospital other than an incorporated hospital;

**relative**—a person is a relative of another if the person is a spouse, domestic partner or parent of the other of or over 18 years of age and a brother, sister, son or daughter of the other;

**relevant interest** has the same meaning as in the *Corporations Law*;

**repealed Act** means the *South Australian Health Commission Act 1976*;

**restricted ambulance service licence** means a licence under Part 6 Division 2 authorising the provision of non-emergency ambulance services;

- (c) is revocable at will and does not prevent the delegator from acting personally in a matter.

## Part 3—Health Performance Council

### 9—Establishment of Health Performance Council

- (1) The *Health Performance Council* (*HPC*) is established.
- (2) HPC is to consist of up to 15 persons appointed by the Governor on the recommendation of the Minister who together, in the opinion of the Minister—
  - (a) have a high level of knowledge of, and expertise in, the provision of health care or the administration of health services; and
  - (b) are able to represent the diversities of South Australia's communities; and
  - (c) have such experience, skills and qualifications to enable HPC to carry out its functions effectively.
- (3) The Minister must consult with prescribed bodies, in accordance with the regulations, before making a recommendation under subsection (2).
- (4) The Minister must ensure, as far as practicable, that the persons appointed under subsection (2) consist of equal numbers of women and men.
- (5) An act or proceeding of HPC is not invalid by reason only of a vacancy in its membership or a defect or irregularity in, or in connection with, the appointment of a member.

### 10—Provisions relating to members, procedures and committees and subcommittees

Schedule 1 has effect with respect to HPC.

### 11—Functions of HPC

- (1) The functions of HPC are—
  - (a) to provide advice to the Minister about—
    - (i) the operation of the health system; and
    - (ii) health outcomes for South Australians and, as appropriate, for particular population groups; and
    - (iii) the effectiveness of methods used within the health system to engage communities and individuals in improving their health outcomes; and
  - (b) to provide reports to the Minister in accordance with the requirements of this Act; and
  - (c) to provide advice to the Minister about any matter referred to it by the Minister or any matter it sees fit to advise the Minister about in connection with its responsibilities under this Act; and
  - (d) such other functions assigned to HPC under this or any other Act, or assigned to HPC by the Minister.



- (2) HPC should, in the performance of its functions, seek to obtain, to such extent as is reasonable and relevant in the circumstances, the views of—
  - (a) Health Advisory Councils; and
  - (b) advisory committees established by the Minister to assist HPC in the performance of its functions.
- (3) HPC must, in the performance of its functions, take into account the strategic objectives that have been set or adopted within the Government's health portfolios.
- (4) Without limiting subsection (3), HPC must, in providing any advice with respect to the provision of any health services (including proposed services), take into account—
  - (a) the net benefit provided by the services, the cost effectiveness of services, and available resources; and
  - (b) the net impact that the adoption of the advice would have on other services, or on the community more generally; and
  - (c) the value placed on any relevant services by members of the public who use those services.
- (5) The Minister must establish arrangements to meet with HPC on a regular basis.
- (6) HPC cannot, in the performance of its functions, give directions to the Chief Executive, the Department, a hospital or a HAC.
- (7) HPC may request the Chief Executive to provide it with specified information in order to assist it in the performance of its functions.
- (8) The Chief Executive may impose conditions that HPC must observe in relation to the receipt, use or disclosure of information provided under subsection (7).

## 12—Annual report

- (1) HPC must, within 3 months after the end of each financial year, deliver to the Minister a report on the operations of HPC during that financial year.
- (2) The Minister must, within 12 sitting days after the receipt of a report under this section, cause a copy of the report to be laid before both Houses of Parliament.

## 13—4-yearly report

- (1) HPC must, on a 4-yearly basis, furnish to the Minister a report that assesses the health of South Australians and changes in health outcomes over the reporting period.
- (2) The report must—
  - (a) identify significant trends in the health status of South Australians and consider future priorities for the health system having regard to trends in health outcomes, including trends that relate to particular illnesses or population groups; and
  - (b) review the performance of the various health systems established within the State in achieving the objects of this Act; and
  - (c) identify any other significant issues considered relevant by HPC; and
  - (d) conform with any requirements of the Minister as to the form of the report and other matters to be addressed by the report.

- (3) The Minister must, within 12 sitting days after receipt of a report under this section, cause a copy of the report to be laid before both Houses of Parliament.
- (4) The Minister must, within 6 months after receipt of a report under this section, cause a formal response to the report to be laid before both Houses of Parliament.
- (5) The first report under this section must be completed by a day to be fixed by the regulations.

#### 14—Use of facilities

HPC may, with the approval of the responsible Minister or, if relevant, a responsible public sector instrumentality, make use of the staff, services or facilities of an administrative unit or another public sector instrumentality.

## Part 4—Health Advisory Councils

### Division 1—Establishment of Councils

#### 15—Establishment of Councils

- (1) The Minister may, by notice in the Gazette, establish a Health Advisory Council (a *HAC*) to undertake an advocacy role on behalf of the community, to provide advice, and to perform other functions, as determined under this Act, in relation to any of the following:
  - (a) the Minister;
  - (b) the Chief Executive;
  - (c) an incorporated hospital;
  - (d) SAAS;
  - (e) any other body involved in the delivery of health services in connection with this Act.
- (2) Without limiting subsection (1), the Minister may establish and maintain a HAC, constituted by persons who have experience in providing ambulance services as volunteers, with functions that include to provide advice to SAAS in the performance of its functions.
- (3) The notice published under subsection (1) may—
  - (a) designate the entity or entities in relation to which the HAC is established; and
  - (b) make provision with respect to the functions of the HAC; and
  - (c) declare whether the HAC is to be an incorporated or unincorporated body and assign a name to the HAC (which must, if the HAC is to be incorporated, end with the abbreviation "Inc"); and
  - (d) make provision with respect to the powers of the HAC; and
  - (e) make such other provision as the Minister thinks fit (including by relating the functions of the HAC to a designated area of the State).

- (3) The Minister must, within 12 sitting days after receipt of a report under this section, cause a copy of the report to be laid before both Houses of Parliament.
- (4) The Minister must, within 6 months after receipt of a report under this section, cause a formal response to the report to be laid before both Houses of Parliament.

## **Schedule 1—Health Performance Council**

### **1—Chairperson and Deputy Chairperson**

- (1) The Governor is to appoint 2 of the members of HPC (by their respective instruments of appointment or by other instruments executed by the Governor) as Chairperson and Deputy Chairperson of HPC, respectively.
- (2) The Governor may remove a member from the office of Chairperson or Deputy Chairperson of HPC at any time.
- (3) A person holding office as Chairperson or Deputy Chairperson of HPC vacates that office if the person—
  - (a) is removed from that office by the Governor; or
  - (b) resigns by written notice to the Minister; or
  - (c) ceases to be a member of HPC.

### **2—Deputies**

- (1) The Governor may, from time to time, appoint a suitable person to be the deputy of a member of HPC, and the Governor may revoke any such appointment.
- (2) In the absence of a member, the member's deputy—
  - (a) is, if available, to act in the place of the member; and
  - (b) while so acting, has all the functions of the member and is taken to be a member.
- (3) The deputy of a member who is Chairperson or Deputy Chairperson of HPC does not (because of this clause) have the member's functions as Chairperson or Deputy Chairperson.

### **3—Term of office**

- (1) Subject to this Schedule, a member of HPC holds office for such period (not exceeding 4 years) as may be specified in the member's instrument of appointment and is eligible for reappointment at the expiration of a term of office.
- (2) However, a member may not hold office for consecutive terms that exceed 8 years in total.

### **4—Allowances**

A member of HPC is entitled to fees, allowances and expenses approved by the Governor.

## 5—Vacancy in office of member

- (1) The Governor may remove a member from office—
  - (a) for breach of, or non-compliance with, a condition of appointment; or
  - (b) for neglect of duty; or
  - (c) for mental or physical incapacity to carry out duties of office satisfactorily; or
  - (d) for dishonourable conduct; or
  - (e) if serious irregularities have occurred in the conduct of HPC's affairs or HPC has failed to carry out its functions satisfactorily and the Minister considers that HPC should be reconstituted for that reason.
- (2) The office of a member of HPC becomes vacant if the member—
  - (a) dies; or
  - (b) completes a term of office and is not reappointed; or
  - (c) resigns by written notice to the Minister; or
  - (d) becomes an insolvent under administration within the meaning of the *Corporations Act 2001* of the Commonwealth; or
  - (e) is convicted in South Australia of an offence that is punishable by imprisonment for a term of 12 months or more, or is convicted elsewhere than in South Australia of an offence that, if committed in South Australia, would be an offence so punishable; or
  - (f) is removed from office under subclause (1).
- (3) If the office of a member of HPC becomes vacant, a person may, subject to this Act, be appointed to fill the vacancy.

## 6—Procedures of HPC

- (1) The procedure for the calling of meetings of HPC and for the conduct of business at those meetings is, subject to this Act and the regulations, to be as determined by HPC.
- (2) The quorum for a meeting of HPC is a majority of its members for the time being.
- (3) The Chairperson or, in the absence of the Chairperson, the Deputy Chairperson or, in the absence of both, another member elected to chair the meeting by the members present, is to preside at a meeting of HPC.
- (4) A conference by telephone or other electronic means between the members of HPC will, for the purposes of this Act, be taken to be a meeting of HPC at which the participating members are present if—
  - (a) notice of the conference is given to all members in the manner determined by the members of HPC for that purpose; and
  - (b) each participating member is capable of communicating with every other participating member during the conference.

## 7—Committees and subcommittees

- (1) HPC may establish committees or subcommittees as HPC thinks fit to advise HPC on any aspect of its functions, or to assist HPC in the performance of its functions.

- (2) A committee or subcommittee established under subclause (1) may, but need not, consist of, or include, members of HPC.
- (3) The procedures to be observed in relation to the conduct of business of a committee or a subcommittee will be—
  - (a) as prescribed by regulation; or
  - (b) insofar as the procedure is not prescribed by regulation—as determined by HPC; or
  - (c) insofar as the procedure is not prescribed by regulation or determined by HPC—as determined by the relevant committee or subcommittee.

## Schedule 2—Health Advisory Councils

### 1—Term of office

Subject to this Schedule, a member of a HAC holds office for such period (not exceeding 3 years) as may be determined by the constitution or rules of the HAC and is eligible for reappointment at the expiration of a term of office.

### 2—Vacancy in office of member

- (1) The Minister may remove a member from office—
  - (a) for breach of, or non-compliance with, a condition of appointment; or
  - (b) for neglect of duty; or
  - (c) for mental or physical incapacity to carry out duties of office satisfactorily; or
  - (d) for dishonourable conduct; or
  - (e) if serious irregularities have occurred in the conduct of the HAC's affairs or the HAC has failed to carry out its functions satisfactorily and the Minister considers that the HAC should be reconstituted for that reason; or
  - (f) on any other ground specified by the constitution or rules of the HAC.
- (2) The office of a member of a HAC becomes vacant if the member—
  - (a) dies; or
  - (b) completes a term of office and is not reappointed; or
  - (c) resigns by written notice to the Minister; or
  - (d) becomes an insolvent under administration within the meaning of the *Corporations Act 2001* of the Commonwealth; or
  - (e) is convicted in South Australia of an offence that is punishable by imprisonment for a term of 12 months or more, or is convicted elsewhere than in South Australia of an offence that, if committed in South Australia, would be an offence so punishable; or
  - (f) is removed from office under subclause (1).
- (3) If the office of a member of a HAC becomes vacant, a person may, subject to this Act, be appointed to fill the vacancy.

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### Health Performance Council

#### **Mr Steve Tully, Chair**

**(Appointment term: 29/5/16 to 30/6/19)**

Steve Tully is the immediate past South Australian Health and Community Services Complaints Commissioner.

Previous to this role and for many years, Steve was the state Electoral Commissioner in South Australia and Victoria. Steve has many years' experience in the executive service within the state public service in SA, principally within the arts, mental health and the Department for Local Government.

Steve over the past six years has aimed to improve the safety and quality of health and community services in South Australia, through the provision of a fair and independent means for the assessment, conciliation, investigation and resolution of complaints; as well as the expert evaluation, investigation and reporting on systemic issues of concern.

Steve values honesty, transparency, open disclosure and integrity. He strongly believes that every person is important and that every person has a right to be treated with the dignity and respect they deserve when seeking, using and providing health services in South Australia.



#### **Ms Mary Patetsos, Deputy Chair**

**(Appointment term: 2/8/16 to 1/8/20)**

Mary Patetsos is a non-executive Director with a blend of academic qualifications and employment experiences covering economic, infrastructure and social policy areas. She has experience and skills in auditing and financial modelling and particularly Aged Care and Housing.

Mary is Chair of the South Australian Local Government Grants Commission, Chair of Aged Care Housing Group, Chair of the Federation of Ethnic Communities Council of Australia and previous Member of the South Australian Social Inclusion Board. As Chair of the Audit Committee of the South Australian Department of Communities and Social Inclusion, Mary is required to apply rigorous scrutiny to sensitive and critical areas of government spending. Mary holds a number of non-executive positions including Power Community Limited and Council Member, University of South Australia. Her skills and experience combined with an extensive national network enable her to add significant value to organisations at many levels. In particular, her commitment to achieve positive experiences for people drives her ambition. She contends that a strong belief in the worthiness of learning and work have become her key motivators.



### **Mr Richard (Rick) Callaghan**

**(Appointment term: 2/8/12 to 1/8/20)**

Rick Callaghan is an Executive Director and Chairman of the Yaran Group of Companies and is an Aboriginal man from an extended Potaruwutj family that comes originally from the Padthaway or Tatiara region of South Australia. His experiences cover economic, corporate and trust administration, quality management, mediation and negotiation involving native title, commercial development and social policy areas. He is an executive and non-executive director on several private company boards including as an independent director on the Regional Anangu Services Aboriginal Corporation from the APY Lands for the past 8 years. He is a current member of the Health Performance Council and the South Australian Aboriginal Advisory Committee. He has experience in quality auditing and business systems.



He is passionate about the ongoing improvement in Indigenous economies, health and the social and cultural development of Australia's Indigenous peoples. The way forward is for Aboriginal people to be engaged in their ongoing and further economic development of Indigenous peoples and this is he believes best gained by improved education, health service outcomes, quality of life, quality service delivery, diversity and long-term sustainability, culturally appropriate health service delivery. He has worked in all States and Territories of Australia during his 20 plus year consulting career.

### **Dr Stephen Duckett**

**(Appointment term: 2/8/12 to 1/8/20)**

Stephen Duckett is Director of the Health Program at Grattan Institute in Melbourne, Emeritus Professor of Health Policy at La Trobe University and is one of two interstate Council members with the Health Performance Council of South Australia. He has held senior health care leadership positions in Australia and Canada, with a reputation for creativity, evidence-based innovation and reform in areas as diverse as hospital funding (introduction of activity-based funding for hospitals) and quality (new systems of measurement and accountability for safety of hospital care).



Stephen is an economist with a Masters and PhD in Health Administration from the University of New South Wales and a higher doctorate, the DSc, awarded on the basis of his scholarly contributions, from the Faculty of Medicine of the same University. He is a Fellow of the Academy of the Social Sciences in Australia, the Australian Academy of Health and Medical Sciences and the Institute of Company Directors.

### **Professor Jennene Greenhill**

**(Appointment term: 2/8/16 to 1/8/20)**

Professor Jennene Greenhill is the Associate Dean and Director of Flinders University Rural Health. She started her career as a registered nurse in Queensland, and took on a range of roles including Assistant Director of Nursing, Nurse Educator, Senior Project Officer, Research Fellow, and Senior Lecturer. As Director of the Flinders University Rural Health, Jennene oversees rural programs for medical, nursing, paramedic, speech pathology, social work and dietetics





students. Jennene has an international research profile in rural health, clinical practice and education. Flinders University Rural Health is renowned for innovative rural placements for health professional students and research that has changed health policy and makes a significant impact in communities.

### **Professor Lisa Jackson Pulver AM**

**(Appointment term: 2/8/12 to 1/8/20)**

Lisa Jackson Pulver is a proud Wiradjuri Koori woman with connections to south western and northern NSW, South Australia and beyond. She is an academic leader, a recognised expert in public health and prominent researcher, educator and advocate for Aboriginal and Torres Strait Islander Health and Education.



Lisa is the Deputy Vice-Chancellor, Indigenous Strategy and Services at the University of Sydney. She is also a Group Captain in the RAAF Specialist Reserve (Public Health Epidemiologist) and is currently posted to the Director General, Personnel Air Force as specialist advisor to the Chief of Air Force.

Lisa has committed to a career that translates her work into research capacity building for health care workers and improved health status for Aboriginal and Torres Strait Islander people. This includes partnerships with co-investigators in both adult and child health studies and life-cycle risk factors. She has served as a member of a number of strategic committees and working groups, including Australian Health Ministers Advisory Council's (AHMAC) National Advisory Group Aboriginal & Torres Strait Islander Health Information and Data (NAGATSIHID), and a ministerial appointment to the Australian Statistical Advisory Council.

### **Professor David Roder AM**

**(Appointment term: 2/8/12 to 1/8/20)**

David Roder is Chair of Cancer Epidemiology and Population Health at the University of South Australia. He has been a Senior Population Health Advisor and Consultant Epidemiologist for Cancer Australia since 2007 and Cancer Institute NSW since 2004. He is a Senior Principal Research fellow and holds the Beat Cancer Research Chair with the South Australian Health and Medical Research Institute (SAHMRI). David is also an Adjunct Professor at Flinders University and Monash University. He is affiliated with over 20 lead committees, standing as Chair on five of these, including the National Quality Safety Monitoring Committee, Cervical Screening;



Interactive Atlas Advisory Group, Australian Commission on Safety and Quality in Health Care; the Prostate Cancer Outcome Register; ANZ Steering Committee and CanTeen Youth Cancer Service Data Advisory Committee. He is on the Executive of the Asia Pacific Organization of Cancer Prevention and works with the Pacific Regional Hub of the International Agency for Research on Cancer.

### **Mr Brett Rowse**

**(Appointment term: 2/8/16 to 1/8/20)**

Brett Rowse worked for 35 years in Treasury and Finance Departments at both the national and State level covering a diverse range of public sector policy issues. He retired from the position as Under Treasurer, Department of Treasury and Finance on 30 November 2015.

Brett chaired the SAFA Board and was also a Board member of the Adelaide Festival, Motor Accident Commission and Funds SA. From July 2016 Brett is Chair of the Essential Services Commission of South Australia.



### **Ms Debra Kay, PSM**

**(Appointment term: 2/8/16 to 9/9/18)**

Debra is a consumer representative. She originally trained as a teacher and has undertaken health curriculum development, policy and research. She was CEO of Asthma Australia, has been an NPS MedicineWise Board Director and works with The Smith Family. Debra is currently a Research Faculty consumer member of the South Australian Health and Medical Research Institute (SAHMRI); has several government committee appointments including as Chair of the MBS (Medicare) Review Consumer Panel; Chairs the Board of the Health Consumers Alliance of South Australia; and undertakes pro bono roles with a wide range of community organisations.



### **Ms Anne Dunn AM – Chair**

**(Appointment term: 29/05/2012 to 28/05/2016)**

Ms Dunn had a distinguished career in the public service and extensive experience in chairing boards and committees including the National Regional Women's Advisory Council, the Adelaide Festival centre Trust, the Australia Council for the Arts and the South Australian Training and Skills Commission. She previously served as a director of the Australian Rural Leadership Foundation, Australia Uniform Building Code Council, Local Government Grants Commission and the SA Government Management Board. Ms Dunn has also been CEO of the Port Phillip Council in Victoria and in South Australia she was the CEO of the Department of Arts and Cultural Heritage, the Department of Family and Community Services, the Department of Local Government and a Commissioner of the Public Service Board. She is currently the Managing Director of M.I. Murren Enterprises.



### **Ms Barbara Hartwig - Deputy Chair**

**(Appointment term: 02/08/2012 to 01/08/2016)**

Ms Hartwig has worked in the nursing profession since 1970. During her long career, she has been actively involved in the Australian Nursing Federation (SA Branch) and the Nurses Board of South Australia, holding various positions including Chair of the Board as well as Chair of various committees. Ms Hartwig was previously the Chair of the Country Health SA Board and Chair of the Mid North Regional Health Service Board. For the past eight years she has been working in Aged Care.



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# State of Our Health

PDF edition

10 September 2018

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## Acknowledgment

The Health Performance Council acknowledges the Aboriginal peoples of South Australia and their ongoing contributions to and participation in the life of South Australia. We acknowledge and respect their spiritual relationship with their respective countries.

We also acknowledge the diversity of Aboriginal people in South Australia. South Australia is estimated to be the area of 50 different language groups at the time of European colonisation and 36 continuing language groups (Reconciliation SA 2012). Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite the ongoing effects of colonisation and dispossession.



## Introduction

**State of Our Health** is an authoritative source of intelligence on health status and health outcomes in the South Australian population. It is one way that we continue to advise the Minister for Health and Wellbeing on the performance of the health system in responding to the health priorities and emerging trends in health outcomes of South Australians.

This edition of *State of Our Health* was last updated and published on 10 September 2018.

## Downloads

**PDF edition:** This is the Portable Document Format (PDF) version of State of Our Health made available for your convenience. The online version is available on the Health Performance Council website at: [hpcsa.com.au/state\\_of\\_our\\_health](http://hpcsa.com.au/state_of_our_health).

**Technical appendix:** This supporting document reports on quality, details of the primary sources used, and discloses important caveats and notes on the interpretation and use of data reported throughout State of Our Health. The Technical Appendix can also be downloaded via the State of Our Health website.

## The demographic profile of South Australia

### In summary

- The **population of South Australia** is just above **1.7 million people**, which represents about one in 14 (7%) of the total Australian population (24.6 million people).
- Over ten years, **South Australia's population has grown** at an average **1.0% per year**. Net overseas migration and natural increase has offset negative net interstate migration.
- The **Aboriginal population of South Australia is 40,646 people**, representing 2.4% of the state population.
- Over **a quarter** of South Australia's population live **outside of metropolitan Adelaide**.
- Over the last decade most of the **population growth** in South Australia has occurred in the **Barossa Hills Fleurieu Local Health Network**.
- South Australia has a relatively **older population** when compared nationally.
- **Almost a quarter** (24.4%) of South Australians were **born overseas**, and 15.2% of South Australians were born in predominantly non-English speaking countries.
- Around **one in six** (17.4%) South Australians **speak a language other than English** at home, including 2.2% who cannot speak English well, or cannot speak English at all.
- **Over one in seven** (14.7%) of the state's population are **carers**, and around a quarter of those are *primary* carers.
- Selected **median income measures** for South Australia are **below those for Australia** as a whole. Income measures for Aboriginal people/households in South Australia are significantly below the state and national benchmarks.
- The **economic and social conditions of people and households** within this state are **below the national average**.
- **More than half** (53.4%) of persons aged 15 years and over who are no longer attending primary or secondary school **have completed Year 12 or equivalent** as their highest year of school attainment, and around a third (32.2%) of Aboriginal people in South Australia aged 15 years and over have done so.
- **Under half** (45.5%) of the South Australian population **are insured with private hospital treatment cover**. This is slightly below the national average of 46.0%. There is a greater proportion (59.3%) of South Australians with *private general treatment* (i.e. ancillary) cover, and this is higher than the national average of 54.9%.
- **Average out-of-pocket payment for medical services** (where an out-of-pocket payment was payable) is **\$73.30 in South Australia**. This is well below the national average of \$155.72.

## 1-1. Population

At 30 June 2017, the estimated resident **population of South Australia** was just above **1.7 million people**, representing about one in 14 (7.0%) of the total Australian population (24.6 million people).<sup>1</sup>

**Over the decade 2007-2017, South Australia's population has grown by about 150,000 people**, or an average **1.0% per year**. This is less than the 1.7% annualised growth rate over the same period for Australia as a whole.<sup>1</sup>

Roughly speaking, out of every ten people that have joined the South Australian community over this time, around eight came via net overseas migration and five through natural increase, offset by three lost to net interstate migration.<sup>2</sup>

At 30 June 2015 (latest available), the estimated resident **Aboriginal population of South Australia** was **40,646 people**, representing 2.4% of the 2015 state population.<sup>3</sup>

### 1-1-1. Population by region

- Over a **quarter** of South Australia's population live **outside of metropolitan Adelaide**.
- Over the last decade, **Barossa Hills Fleurieu** Local Health Network has had the **fastest growing population**.

SA Health divides South Australia into local health networks (LHNs) to manage the delivery of public hospital services, and other community based health services, as determined by the South Australian state government. LHNs comprise single or groups of public hospitals, and have a geographical or functional connection.

The LHNs are accountable to the state government for performance management and planning.

In 2017, over a quarter (28.9%) of South Australia's population lived outside of metropolitan Adelaide, very slightly lower than a decade earlier. Since 2007, the biggest percentage increase in population growth amongst South Australia's Local Health Networks has been in the Barossa Hills Fleurieu LHN (up 14.3%).<sup>1</sup>

**Estimated Resident Population, 2017 and 2007**

<b>Local Health Network</b>	<b>no. persons, 2017</b>	<b>% persons, 2017</b>	<i>no. persons, 2007</i>	<i>% persons, 2007</i>
Northern Adelaide	399,635	23.2%	348,233	22.2%
Central Adelaide	460,589	26.7%	423,722	27.0%
Southern Adelaide	364,560	21.2%	335,078	21.3%
<b>Metropolitan Adelaide</b>	<b>1,224,784</b>	<b>71.1%</b>	<b>1,107,033</b>	<b>70.5%</b>
Barossa Hills Fleurieu	198,193	11.5%	172,591	11.0%
Eyre and Far North	40,514	2.4%	38,955	2.5%
Flinders and Upper North	44,732	2.6%	45,937	2.9%
Riverland Mallee Coorong	71,798	4.2%	68,741	4.4%
South East	66,743	3.9%	63,886	4.1%
Yorke & Northern	76,784	4.5%	73,476	4.7%
<b>Country Health SA</b>	<b>498,764</b>	<b>28.9%</b>	<b>463,586</b>	<b>29.5%</b>
<b>SOUTH AUSTRALIA</b>	<b>1,723,548</b>	<b>100.0%</b>	<b>1,570,619</b>	<b>100.0%</b>
<b>AUSTRALIA</b>	<b>24,598,933</b>		<b>20,827,622</b>	

Data source: ABS 2017a

**1-1-2. Population by age and sex**

- South Australia has an **older population** than Australia generally.

South Australia has an older population than Australia overall. In 2015, an estimated 17.4% of South Australians were aged 65 years or over, compared to 15.0% for the Australian population as a whole. Proportionally more of the 65 years and older population are female than male.<sup>3</sup>

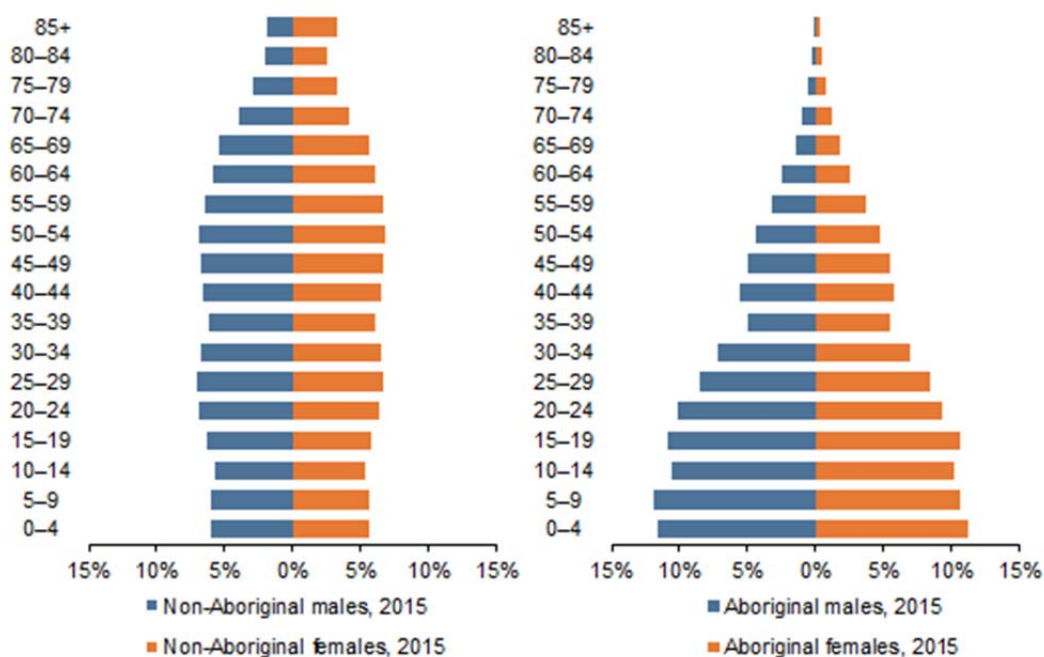
The age-sex profile of the Aboriginal population in South Australia is substantially different than the state's population overall. In 2015 (the latest year for which data is available), almost half (53.6%) of all Aboriginal people in South Australia were aged under 25 years compared to 30.5% of the overall state population. Proportionally, 4.1% of Aboriginal people in South Australia were aged 65 years and over in 2015, compared to 17.4% of the state's total population. This structural difference is also evident in the large gaps in estimated median ages between the Aboriginal and state population.<sup>3</sup>

**Estimated median age (years) by sex and region, 2015**

<b>Region</b>	<b>males</b>	<b>females</b>	<b>persons</b>
South Australia - all	39	41	40
South Australia - Aboriginal people	22	24	23
Australia - all	37	38	37

Data source: ABS 2017c

### South Australian population by age (years) and sex -- All SA (2015) and Aboriginal SA (2015\*)



\* 2015 latest available for comparison

### Sources

1. Based on Australian Bureau of Statistics (ABS 2017a), 'ERP by SA2 and above (ASGS 2016), 2001 onwards', [ABS.Stat \(beta\)](#), viewed 3 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2017b), 'TABLE 2. Population Change, Components - States and Territories (Number)', [Australian Demographic Statistics](#), cat. no. 3101.0, viewed 13 August 2018.
3. Based on Australian Bureau of Statistics (ABS 2017c), Customised Table, *Population, South Australia, 2015, Indigenous Status, age and sex*, viewed 22 May 2017.

## 1-2. Demographic profile

### 1-2-1. People born overseas

Almost a quarter (24.4%) of South Australians identified in the 2016 Census that they were born overseas. South Australia accounts for 6.2% of Australia's total population born overseas. South Australia has a lower proportion of its population born overseas compared to the national average (28.3%), and is ranked fifth highest when compared to all states and territories. Proportionally, the largest group of South Australians born overseas are aged between 25 and 44 years at 27.9%.<sup>1</sup>

The 2016 Census found that 15.2% of South Australians were born in predominantly non-English speaking countries. This is lower than the national average of 19.3%.<sup>1</sup>

### 1-2-2. Language spoken at home

Around one in six (17.4%) South Australians speak a language other than English at home, according to the 2016 Census. Italian and Mandarin are the most common at 10.4% of the non-English languages spoken at home, followed by Greek at 8.2%. At the time of the 2016 Census, 2.2% of the South Australian population could not speak English well, or could not speak English at all – predominantly persons born overseas and aged 45 years or older.<sup>1</sup>

### 1-2-3. Carers in the community

Data for 2015 shows that there are an estimated 242,400 carers in South Australia, representing 14.7% of people of the population. A higher proportion of South Australian females are carers than males (15.8% and 13.6% respectively). South Australia has the fourth highest proportion of carers when compared to all states and territories.<sup>2</sup>

Of the 242,400 carers in South Australia, 74,800 (or 30.9%) are primary carers. Primary carers are those aged 15 years and over who identified themselves as providing the most informal assistance with core activities to a person with a disability or to a person aged 60 years and over. A higher proportion of females are primary carers compared to their male counterparts (6.3% and 2.9% of all persons, respectively).<sup>2</sup>

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## Sources

1. Based on Australian Bureau of Statistics (ABS 2017), 'General Community Profile', [2016 Census of Population and Housing](#), cat. no. 2001.0, viewed 9 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2016), Data Cubes, 'Table 32.1 All persons, living in households, carer status, by age and sex–2015, estimate', [Disability, Ageing and Carers, Australia: Summary of Findings, 2015](#), cat. no. 4430.0, viewed 24 August 2018.

### 1-3. Determinants of Health

*Health status within a population typically follows a gradient, with overall health tending to improve with each step up the socioeconomic ladder. This is commonly known as the socio-economic gradient of health, or the social gradient of health, and is a global phenomenon seen in low, middle and high income countries.<sup>1</sup>*

#### 1-3-1. Income and households

At the 2016 Census, selected median income measures for South Australia are below those for Australia as a whole. Income measures for Aboriginal people/households in South Australia are significantly below the state and national benchmarks.<sup>2</sup>

#### Median income and housing payments, 2016 Census

Measure	South Australia (All)	South Australia (Aboriginal)	Australia (All)
Median total personal income	\$600 per week	\$413 per week	\$662 per week
Median total household income	\$1,206 per week	\$1,014 per week	\$1,438 per week
Median mortgage repayment*	\$373 per week	\$347 per week	\$439 per week
Median rent	\$260 per week	\$220 per week	\$335 per week
Average household size	2.4 persons	3.0 persons	2.6 persons

\* The HPC has estimated median weekly mortgage repayments here for comparison purposes by dividing monthly figures in the source data by four.

Data source: ABS 2017

#### 1-3-2. Socio-economic status

##### Introduction

A commonly used measure of socio-economic status in Australia is the Australian Bureau of Statistics' Socio-economic Index for Areas (SEIFA), Index of Relative Socio-economic Disadvantage (IRSD)...

The IRSD is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area. The IRSD is standardised so that the Australian mean is 1000, and individual regions are compared against that benchmark. That is, an area with economic and social indicators equal to the national average will receive a score of 1000.

- A lower score indicates relatively greater disadvantage in general. For example, an area could have a lower score if there are (among other things) more households with low income, many people with no qualifications, or an over-representation of people in low skill occupations.
- Conversely, a higher score indicates a relative lack of disadvantage in general.

It is important to remember that the scores are an ordinal measure, so care should be taken when comparing scores. For example, an area with a score of 500 is not twice as disadvantaged as an area with a score of 1000, it just had more markers of relative disadvantage.

## South Australia

Overall, in 2016 the SEIFA IRSD score for South Australia was 977, indicating that the economic and social conditions of people and households within this state are below the national average (1000).<sup>3</sup>

At the Australian Bureau of Statistics' Statistical Area Level 2 (SA2) geographic level, IRSD scores range from 1099 in Coromandel Valley, Belair and Aldgate-Stirling in the Southern Adelaide and Barossa Hills Fleurieu Local Health Network, down to 588 in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in outback South Australia.<sup>3</sup>

### SEIFA Index of Relative Socio-economic Disadvantage, 2016

Local Health Network	IRSD score (average)	Max. IRSD score (ABS SA2 level)	Min. IRSD score (ABS SA2 level)
Northern Adelaide	934	1079 ( <i>One Tree Hill</i> )	686 ( <i>Elizabeth</i> )
Central Adelaide	1005	1094 ( <i>Glenside-Beaumont</i> )	843 ( <i>The Parks</i> )
Southern Adelaide	1008	1099 ( <i>Belair, Coromandel Valley</i> )	849 ( <i>Hackham W.-Huntfield H.</i> )
<b>Metropolitan Adelaide</b>	<b>983</b>	<b>1099 (<i>Belair, Coromandel Valley</i>)</b>	<b>686 (<i>Elizabeth</i>)</b>
Barossa Hills Fleurieu	1010	1099 ( <i>Aldgate – Stirling</i> )	951 ( <i>Mallala</i> )
Yorke & Northern	931	1005 ( <i>Clare</i> )	865 ( <i>Port Pirie</i> )
Eyre and Far North	943	1000 ( <i>Kimba - Cleve - Franklin Harbour</i> )	588 ( <i>APY Lands</i> )
Flinders and Upper North	900	1039 ( <i>Roxby Downs</i> )	879 ( <i>Whyalla</i> )
South East	954	1039 ( <i>Naracoorte Region</i> )	905 ( <i>Millicent</i> )
Riverland Mallee Coorong	917	990 ( <i>Murray Bridge Region</i> )	849 ( <i>Renmark</i> )
<b>Country Health SA</b>	<b>962</b>	<b>1099 (<i>Aldgate-Stirling</i>)</b>	<b>588 (<i>APY Lands</i>)</b>
<b>SOUTH AUSTRALIA</b>	<b>977</b>	<b>1099 (<i>Aldgate-Stirling, Belair, Coromandel Valley</i>)</b>	<b>588 (<i>APY Lands</i>)</b>
<b>AUSTRALIA</b>	<b>1000</b>	<b>1183 (<i>Duntroon</i>)</b>	<b>420 (<i>Thamarrurr</i>)</b>

Data source: ABS 2018

### 1-3-3. Education attainment

As at the 2016 Census, more than half (53.4%)<sup>2</sup> of persons aged 15 years and over who were no longer attending primary or secondary school had completed Year 12 or equivalent as their highest year of school attainment. This percentage excludes people who did not state their highest year of school completed. The South Australian rate is lower than the national average of 59.0%.<sup>4</sup>

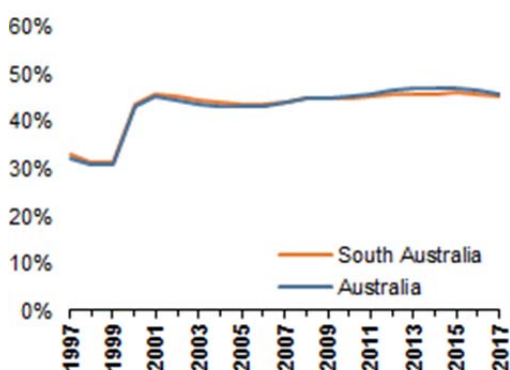


Approximately a third, or 32.2%, of Aboriginal people in South Australia aged 15 years and over who are no longer attending primary or secondary school have completed Year 12 or equivalent as their highest year of school attainment. Again, this excludes those who did not state their highest year of school completed.<sup>2</sup>

### 1-3-4. Level of private health insurance

At 30 June 2017, 45.5% of the South Australian population were insured with *private hospital treatment* cover, slightly below the Australia-wide rate of 46.0%.

**Fig A. Private hospital treatment cover**

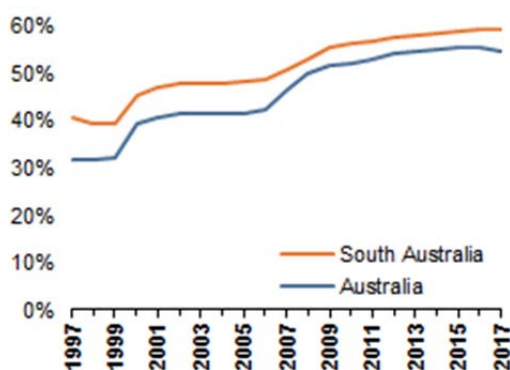


Data source: APRA 2018

Note: Introduction of 30% Rebate from 1 January 1999

Insurance with *private general treatment* (ancillary) cover was more common with 59.3% of South Australians covered, above the national rate of 54.9%. Coverage rates were almost unchanged compared to a year earlier.<sup>4</sup>

**Fig B. Private general treatment (GT) cover (ie. ancillary or extras cover)**



Data source: APRA 2018

Note 1: Introduction of Life Time Health Cover on 1 July 2000.

Note 2: The introduction of the *PHI Act 2007* caused an artificial increase in General Treatment and decrease in Hospital Treatment Only as a result of changes in definitions and reclassification of policies.

Where an out-of-pocket ('gap') payment was payable for an episode of hospital care or a medical service, the average amount of the gap in South Australia was \$73.30, well below the Australia-wide average gap payment of \$155.72. Medical gap payments varied according to specialty, both in amount and in proportion to the overall charge.<sup>4</sup>

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## Sources

1. Australian Institute of Health and Welfare (AIHW 2018), [Australia's health 2018](#), Australia's health series no.16, cat. no. AUS 221, Canberra, viewed 10 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2017), 'Aboriginal and Torres Strait Islander Peoples Profile', [2016 Census of Population and Housing](#), cat. no. 2002.0, viewed 10 August 2018.
3. Based on Australian Bureau of Statistics (ABS 2018), 'Socio-Economic Indexes for Areas (SEIFA), Australia, 2016', [2016 Census of Population and Housing](#), cat. no. 2033.0.55.001, viewed 10 August 2018.
4. Based on Australian Prudential Regulation Authority (APRA 2018), [Private Health Insurance Annual Survey](#), December 2017, viewed 6 August 2018.

## Starting well and the early years

### In summary

- South Australia's **total fertility rate** is **1.79 births per woman**, higher in Country SA than metropolitan Adelaide. The state's TFR is equal to the national average (also 1.79).
- The **median age at which women in South Australia give birth is 30.8 years**, comparable to the national median maternal age of 31.1 years.
- Only a **small fraction (2.4%) of births in South Australia are to women aged 19 years or less**, while around **one in five (21.3%) of births are to women aged 35 years or older**.
- Around **1 in 13 (7.7%) of South Australians are aware that a woman should take folic acid before pregnancy, and in the first three months of pregnancy**, to reduce her chance of having a baby with spina bifida. The level of **awareness** in the community of the benefits of folic acid before and during pregnancy **has decreased substantially** over recent years.
- Over **three quarters (78.2%) women who give birth in South Australia have their first antenatal visit within the first 14 weeks of pregnancy**, although the rate for Aboriginal women is significantly lower, at 56.5%.
- **One in eight (12.5%) women who give birth in South Australia report being smokers** at their first antenatal visit. The corresponding rate for Aboriginal women is higher at 48.4%.
- There has been a **more than doubling in the prevalence of gestational diabetes** among women who give birth in South Australia over the last decade, a condition that now affects **10.4% of women who give birth**.
- **Over a quarter (28.0%) of women in South Australia who give birth are overweight during their pregnancy and a similar proportion (24.4%) are recorded as being obese**.
- Around 20,000 people are born in South Australia every year into a total population of 1.7 million, representing a **crude birth rate of 11.5 births per 1000 population**. The crude birth rate in South Australia has been declining since 2008.
- The **average birthweight** of liveborn babies in South Australia is **3,324 grams**, while around **one in 14 (7.1%) babies are liveborn with low birthweight (<2,500g)**, a higher rate than the 6.5% nationally.
- **Over a third (35.1%) of all births in South Australia are by Caesarean section**.
- **A very small fraction (2.6%) of babies are born with congenital anomalies** in South Australia.
- **Over half (57.8%) of South Australian children receive a fourth year developmental health check** assessing their physical health, general wellbeing, and development.
- **Over nine in ten (93.5%) of children aged five years in South Australia are fully immunised**. Full vaccination coverage for Aboriginal children at age five has increased substantially over recent years and is now at 93.0%, comparable to the overall state figure.
- Around **a quarter (23.0%) of non-Aboriginal children aged 5-17 years in South Australia are overweight or obese**, while **over a third (37.6%) of Aboriginal children** in the same age cohort are also **overweight or obese**.

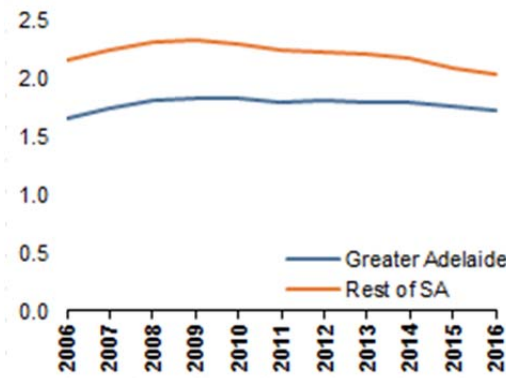
## 2-1. Fertility rate

### 2-1-1. Fertility rate in South Australia

- In 2016, South Australia's total fertility rate (TFR) was 1.79 births per woman (all ages). This is the same as the national average (also 1.79).<sup>1</sup>
- Total fertility rate is higher in Country SA (2.04) than in Greater Adelaide (1.74).<sup>1</sup>
- The trend in Country SA is statistically significantly downwards. No statistically significant underlying trend over the last decade was identified in the Greater Adelaide time series.<sup>1</sup>
- South Australia's total fertility rate of 1.79 births per woman ranks it fifth highest of the states and territories.<sup>1</sup>

#### Total Fertility Rate, 2016

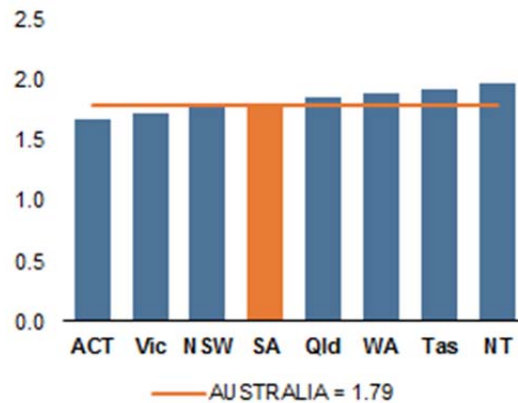
Region	TFR
Greater Adelaide	1.74
Country SA	2.04
<b>South Australia</b>	<b>1.79</b>
<b>Australia</b>	<b>1.79</b>



Data source: ABS 2017a

#### Total Fertility Rate, 2016

State/Territory	TFR
Australian Capital Territory	1.67
Victoria	1.73
New South Wales	1.77
<b>South Australia</b>	<b>1.79</b>
Western Australia	1.89
Queensland	1.86
Tasmania	1.92
Northern Territory	1.98
<b>Australia</b>	<b>1.79</b>



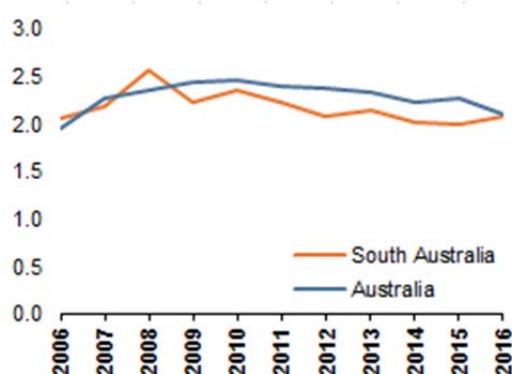
Data source: ABS 2017a

### 2-1-2. Aboriginal fertility rate

- In 2016, South Australia's Aboriginal total fertility rate (TFR) was 2.094 births per Aboriginal woman (all ages). This is below the national average of 2.115.<sup>2</sup>
- South Australia's Aboriginal total fertility rate of 2.094 births per woman is ranked third highest when compared to the Aboriginal TFR of other states and territories.<sup>2</sup>

**Aboriginal Total Fertility Rate, 2016**

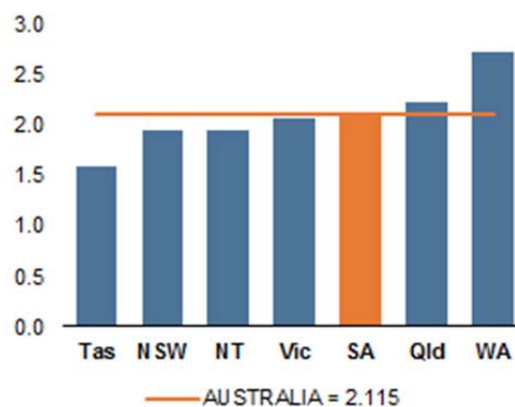
Region	TFR
Greater Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>2.094</b>
<b>Australia</b>	<b>2.115</b>



Data source: ABS 2017b

**Aboriginal Total Fertility Rate, 2016**

State/Territory	TFR
Tasmania	1.588
New South Wales	1.942
Northern Territory	1.955
Victoria	2.077
<b>South Australia</b>	<b>2.094</b>
Queensland	2.230
Western Australia	2.729
Australian Capital Territory	n.a.
<b>Australia</b>	<b>2.115</b>



Data source: ABS 2017b

**Sources**

1. Based on Australian Bureau of Statistics (ABS 2017a), 'Table 1.1 Births, Summary, Statistical Areas Level 4-2006 to 2016', [Births, Australia, 2016](#), cat. no. 3301.0, viewed 10 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2017b), 'Aboriginal and Torres Strait Islander fertility, by age, by state', [ABS.Stat \(beta\)](#), viewed 20 August 2018.

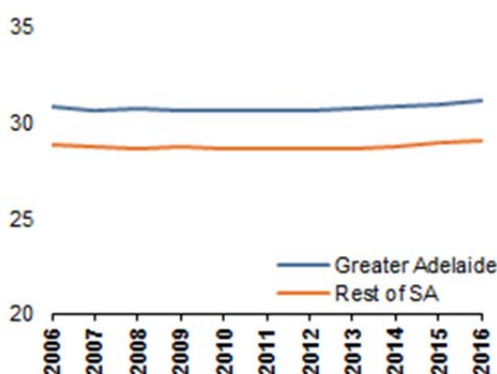
## 2-2. Maternal age

### 2-2-1. Maternal age in South Australia

- The median age at which women in South Australia gave birth was 30.8 years in 2016.<sup>1</sup>
- This is only slightly younger than the national median of 31.1 years.<sup>1</sup>
- In 2016, the median maternal age in South Australia was higher in Greater Adelaide (31.2 years) compared to Country SA (29.1 years).<sup>1</sup>
- No statistically significant underlying trend over the last decade was identified in either the Greater Adelaide or Country SA time series.
- South Australia's median maternal age is ranked equal fourth lowest (with Western Australia) compared to the other states and territories.

#### Median maternal age, 2016

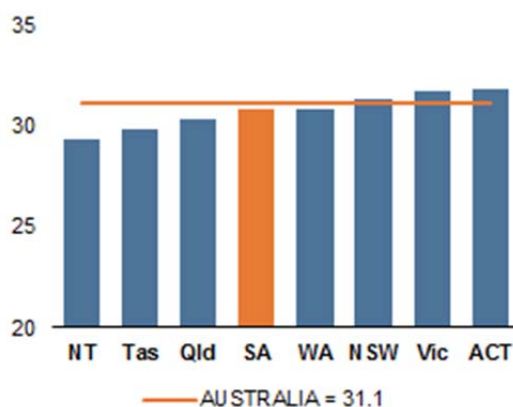
Region	Years
Greater Adelaide	31.2
Country SA	29.1
<b>South Australia</b>	<b>30.8</b>
<b>Australia</b>	<b>31.1</b>



Data source: ABS 2017a

#### Median maternal age, 2016

State/Territory	Years
Northern Territory	29.3
Tasmania	29.8
Queensland	30.3
<b>South Australia</b>	<b>30.8</b>
Western Australia	30.8
New South Wales	31.3
Victoria	31.7
Australian Capital Territory	31.8
<b>Australia</b>	<b>31.1</b>



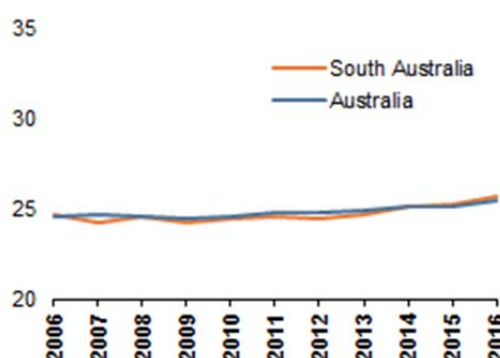
Data source: ABS 2017a

### 2-2-2. Aboriginal maternal age

- The median age at which Aboriginal women in South Australia gave birth in 2016 is significantly younger than the general population rate, at 25.7 years.<sup>2</sup>
- This age is the almost same as the national median for Aboriginal women giving birth (25.5 years).<sup>2</sup>
- The trend over the last decade has been gradually increasing.
- South Australia's median maternal age of Aboriginal mothers is ranked fourth highest compared to the other states and territories that reported data.<sup>2</sup>

**Aboriginal median maternal age, 2016**

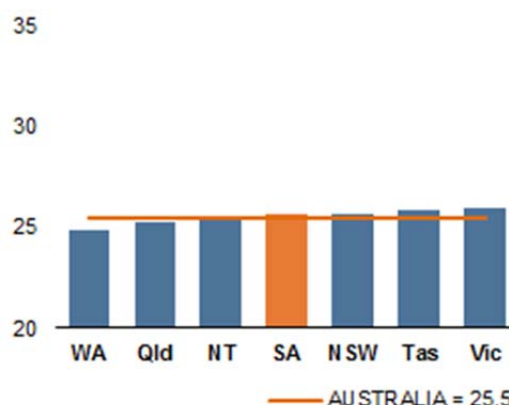
Region	Years
Greater Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>25.7</b>
<b>Australia</b>	<b>25.5</b>



Data source: ABS 2017b

**Aboriginal median maternal age, 2016**

State/Territory	Years
Northern Territory	25.5
Western Australia	24.9
Queensland	25.3
<b>South Australia</b>	<b>25.7</b>
Tasmania	25.9
New South Wales	25.7
Victoria	26.0
Australian Capital Territory	n.a.
<b>Australia</b>	<b>25.5</b>



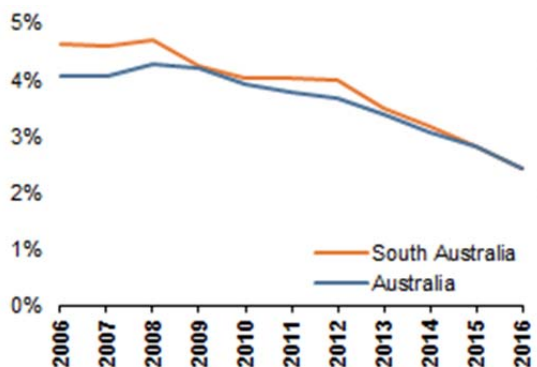
Data source: ABS 2017b

**2-2-3. Teenage women giving birth**

- In 2016, there were 481 births in South Australia where the mother was aged 19 years or less.<sup>3</sup>
- This represents 2.4% of all births in South Australia and is equal to the national rate of 2.4%.<sup>3</sup>
- Over the last decade there has been a downward trend, both in this state and nationally.
- South Australia ranks fourth lowest of the states and territories for proportion of births where the mother was aged 19 years or less.<sup>3</sup>

**Births, mother aged 19 years or less, 2016**

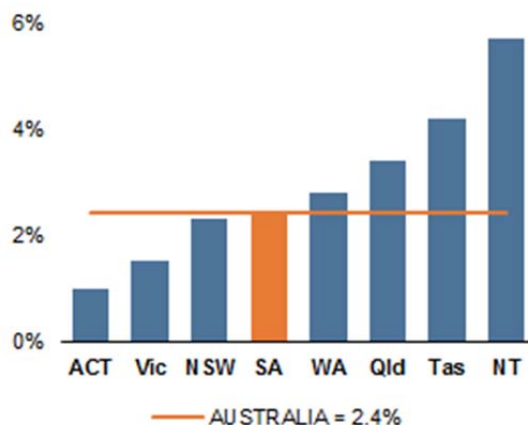
Region	%
Greater Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>2.4%</b>
<b>Australia</b>	<b>2.4%</b>



Data source: ABS 2017c

**Births, mother aged 19 years or less, 2016**

State/Territory	%
Australian Capital Territory	1.0%
Victoria	1.5%
New South Wales	2.3%
<b>South Australia</b>	<b>2.4%</b>
Western Australia	2.8%
Queensland	3.4%
Tasmania	4.2%
Northern Territory	5.7%
<b>Australia</b>	<b>2.4%</b>



Data source: ABS 2017c

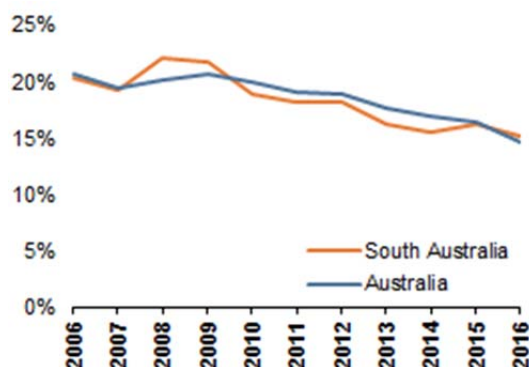
**2-2-4. Aboriginal teenage women giving birth**

- In 2016, there were 106 births in South Australia to Aboriginal mothers aged 19 years or less.<sup>4</sup>
- This represents 15.2% of all births in South Australia to Aboriginal mothers, slightly higher than the national rate of 14.6%.<sup>4</sup>
- Over the last decade there has been a downward trend, both in this state and nationally.
- In 2016, South Australia ranked second highest of the states and territories for the proportion of births to Aboriginal mothers aged 19 years or less.<sup>4</sup>



**Births, Aboriginal mother aged 19 years or less, 2016**

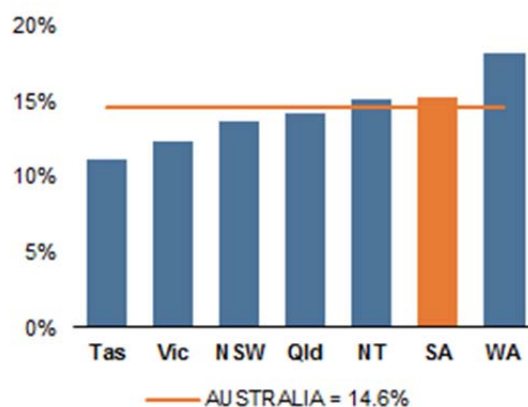
Region	%
Greater Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>15.2%</b>
<b>Australia</b>	<b>14.6%</b>



Data source: ABS 2017d

**Births, Aboriginal mother aged 19 years or less, 2016**

State/Territory	%
Tasmania	11.2%
Victoria	12.3%
New South Wales	13.7%
Queensland	14.2%
Northern Territory	15.1%
<b>South Australia</b>	<b>15.2%</b>
Western Australia	18.2%
Australian Capital Territory	n.a.
<b>Australia</b>	<b>14.6%</b>



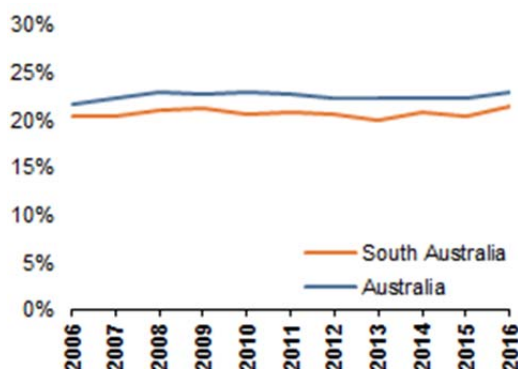
Data source: ABS 2017d

**2-2-5. Women aged 35 years and over giving birth**

- In 2016, there were 4,218 births in South Australia where the mother was aged 35 years or older.<sup>3</sup>
- This represents around one in five (21.3%) of all births in South Australia, lower than the national rate of 23.0%.<sup>3</sup>
- Since 2006, the proportion of has been relatively steady, both in this state and nationally.
- Compared to its interstate counterparts, South Australia ranks fourth lowest for the proportion of births to women aged 35 years and over.<sup>3</sup>

**Births, mother aged 35 years and over, 2016**

Region	%
Greater Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>21.3%</b>
<b>Australia</b>	<b>23.0%</b>



Data source: ABS 2017c

**Births, mother aged 35 years and over, 2016**

State/Territory	%
Northern Territory	17.3%
Tasmania	19.3%
Queensland	19.9%
<b>South Australia</b>	<b>21.3%</b>
Western Australia	21.5%
New South Wales	23.9%
Australian Capital Territory	25.4%
Victoria	25.7%
<b>Australia</b>	<b>23.0%</b>



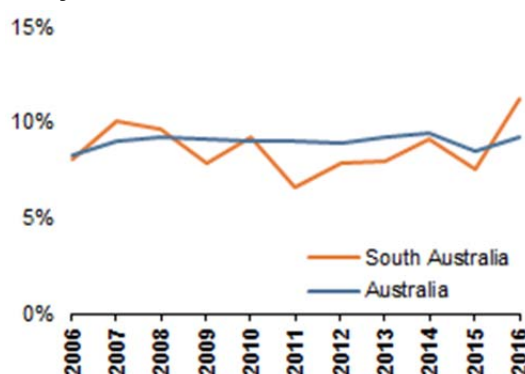
Data source: ABS 2017c

**2-2-6. Aboriginal women aged 35 years and over giving birth**

- In 2016, there were 78 births in South Australia to Aboriginal mothers aged 35 years or older.<sup>4</sup>
- This represents 11.2% of all births in South Australia to Aboriginal mothers, slightly greater than the national rate of 9.2%.<sup>4</sup>
- Over the last decade, the national rate has increased very slightly, although South Australia's trend is harder to discern.
- South Australia ranks highest of the states and territories that reported data (ACT did not publish figures) for the proportion of births to Aboriginal mothers aged 35 years and over.<sup>4</sup>

**Births, Aboriginal mother aged 35 years and over, 2016**

Region	%
Greater Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>11.2%</b>
<b>Australia</b>	<b>9.2%</b>



Data source: ABS 2017d

**Births, Aboriginal mother aged 35 years and over, 2016**

State/Territory	%
Northern Territory	8.0%
Western Australia	8.4%
Tasmania	8.8%
Queensland	9.0%
New South Wales	9.6%
Victoria	10.5%
<b>South Australia</b>	<b>11.2%</b>
Australian Capital Territory	n.a.
<b>Australia</b>	<b>9.2%</b>



Data source: ABS 2017d

**Sources**

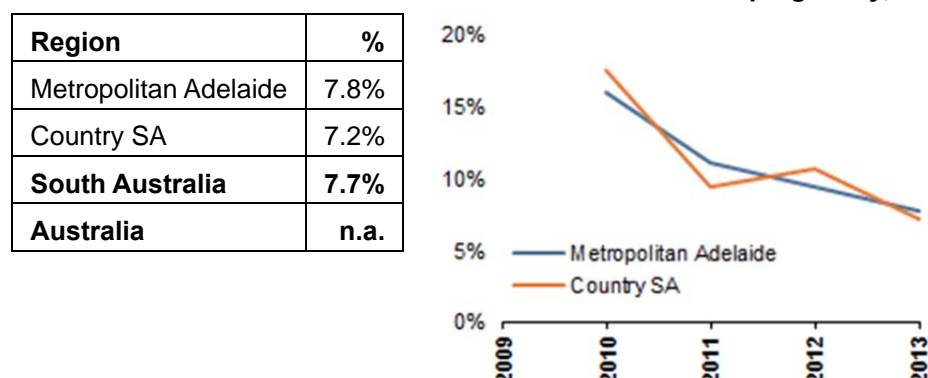
1. Based on Australian Bureau of Statistics (ABS 2017a), 'Table 1.1 Births, Summary, Statistical Areas Level 4-2006 to 2016', [Births, Australia, 2016](#), cat. no. 3301.0, viewed 20 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2017b), 'Aboriginal and Torres Strait Islander births and confinements, summary, by state', [ABS.Stat \(beta\)](#), viewed 20 August 2018.
3. Based on Australian Bureau of Statistics (ABS 2017c), 'Fertility, by age, by state', [ABS.Stat \(beta\)](#), viewed 20 August 2018.
4. Based on Australian Bureau of Statistics (ABS 2017d), 'Aboriginal and Torres Strait Islander fertility, by age, by state', [ABS.Stat \(beta\)](#), viewed 20 August 2018.

## 2-3. Folate intake before and during pregnancy

### 2-3-1. Awareness of benefits of folate intake – by region

- In 2013, around 1 in 13 (7.7%) of South Australians aged 16 years or more were aware that a woman should take folic acid before pregnancy, and in the first three months of pregnancy, to reduce her chance of having a baby with spina bifida.<sup>1</sup>
- There is no statistically significant difference between the rate reported by people in metropolitan Adelaide compared to Country SA residents.<sup>1</sup>
- The level of awareness in the South Australian community of the benefits of folic acid before and during pregnancy decreased significantly between 2010 and 2013.<sup>1</sup>

#### Awareness of benefits of folic acid intake before and after pregnancy, 2013

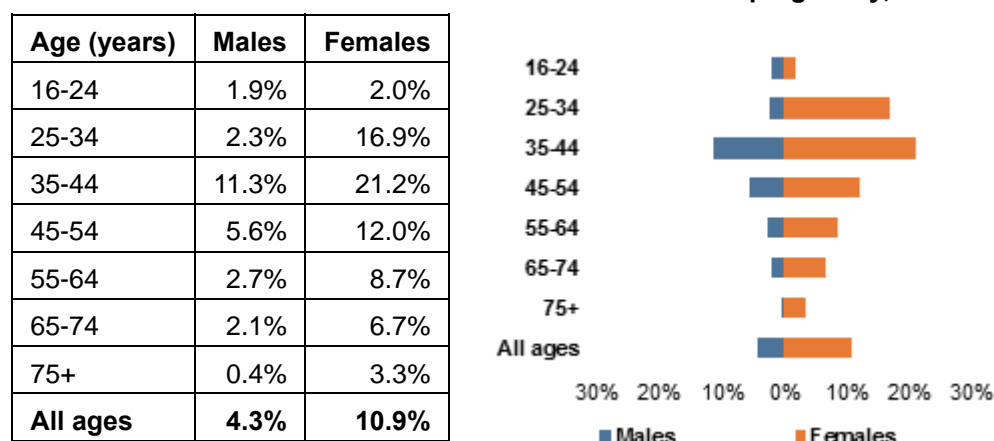


Data source: SA Health 2014

### 2-3-2. Awareness of benefits of folate intake – by age and sex

- In 2013, the proportion of people aware of the benefits of folic acid intake before and during pregnancy was double in the female population aged 16 years and over compared to their male counterparts.<sup>1</sup>
- The highest recorded proportion is in the female aged 35-44 years cohort, with the 25-34 year-old female cohort also represented relatively highly.<sup>1</sup>

#### Awareness of benefits of folic acid intake before and after pregnancy, 2013



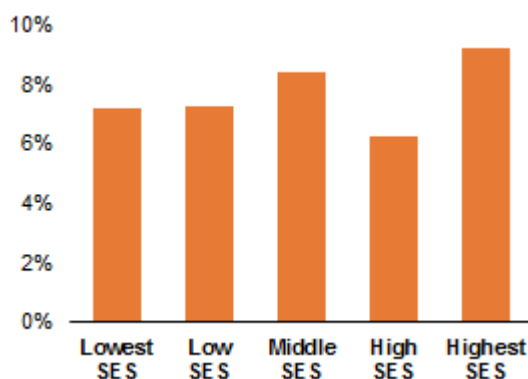
Data source: SA Health 2014

### 2-3-3. Awareness of benefits of folate intake – by socio-economic status

- Awareness of the benefits of folic acid intake before and after pregnancy is fairly consistent across the South Australian socio-economic quintiles.<sup>1</sup>

#### Awareness of benefits of folic acid intake before and after pregnancy, 2013

Socio-economic status (SES)	%
Lowest SES	7.2%
Low SES	7.3%
Middle SES	8.4%
High SES	6.2%
Highest SES	9.2%



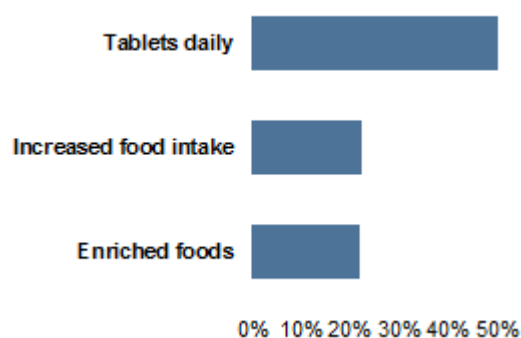
Data source: SA Health 2014

### 2-3-4. Type of folic acid intake

- The most common type of folic acid intake chosen by women before and during the first three months of pregnancy is daily folic acid tablets, accounting for over half of the types taken in South Australia in 2013.<sup>1</sup>

#### Type of folic acid intake, 2013

Folic acid intake type	%
Folic acid tablets every day	55.3%
Increased intake of foods rich in folate or folic acid, such as green leafy vegetables, cereals and fruits	22.5%
Eating cereals or other prepared foods/juices specially enriched with folic acid every day	22.2%



Data source: SA Health 2014

### Sources

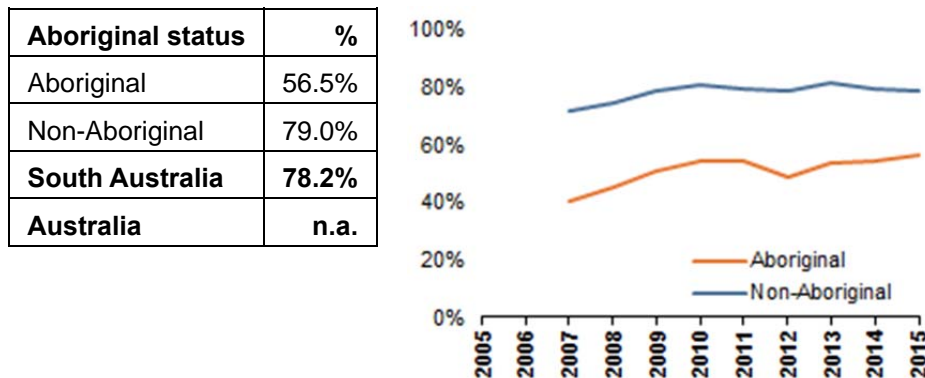
- Based on Health Information Portal database 2014, 'Management Reporting, Reports, South Australian Monitoring and Surveillance System Online, Folate Awareness', SA Health, Adelaide, viewed 13 October 2014.

## 2-4. Pregnancy outcomes

### 2-4-1. Antenatal visits

- More than three quarters (78.2%) of women who gave birth in South Australia in 2015 had their first antenatal visit within the first 14 weeks of pregnancy.<sup>1</sup>
- The rate for Aboriginal women is significantly lower, at just over half (56.5%).<sup>1</sup>
- The overall trend for Aboriginal and non-Aboriginal women has been trending up since 2007 when this time series began.

#### Antenatal visit within first 14 weeks of pregnancy, 2015



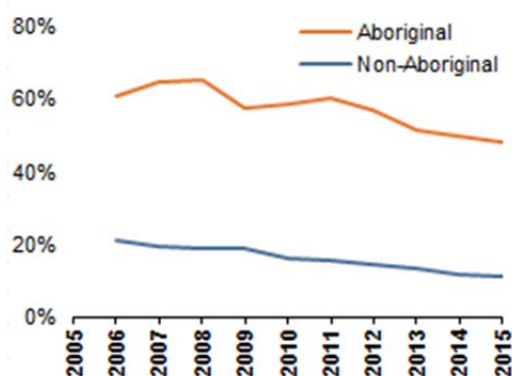
Data source: SA Health 2017a

### 2-4-2. Smoking during pregnancy

- Data for 2015 shows that one in eight (12.5%) women who gave birth in South Australia reported being smokers at their first antenatal visit.<sup>2</sup>
- To enable interstate comparison, this rate includes women who reported smoking during pregnancy, but had quit before their first antenatal visit.<sup>2</sup>
- The proportion of women smoking at the first antenatal visit (including quitters) continues to decline since 2006 when this time series (with Aboriginal and non-Aboriginal comparisons) began. In 2006 the state rate was 22.3%.<sup>2</sup>
- The corresponding rate for Aboriginal women also continues to decline, down from 60.8% in 2006 to 48.4% in 2015.
- Data for 2015 shows a drop in reported smoking rates between the first antenatal visit and second half of pregnancy.<sup>2</sup>
- Less than one in ten (8.5%) women who gave birth in South Australia report being smokers in the second half of their pregnancy, 4.1 percentage points lower than the 14.5% who reported smoking at (or before) their first antenatal visit.<sup>2</sup>
- However, South Australia ranks third-highest compared to the other states and territories for proportion of women who gave birth who reported being smokers during their pregnancy at their first antenatal visit.<sup>3</sup>
- Data for 2016 shows that the state rate of 12.0% is above the national average of 9.9%.<sup>3</sup>

**Smoking rate at first antenatal visit, 2015**

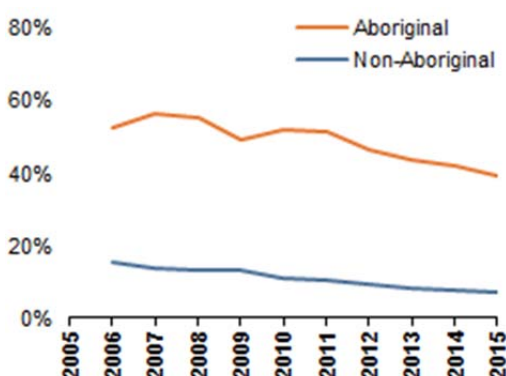
Aboriginal status	%
Aboriginal	48.4%
Non-Aboriginal	11.2%
<b>South Australia</b>	<b>12.5%</b>
<b>Australia (2016)</b>	<b>9.9%</b>



Data source: SA Health 2017b

**Smoking rate in second half of pregnancy, 2015**

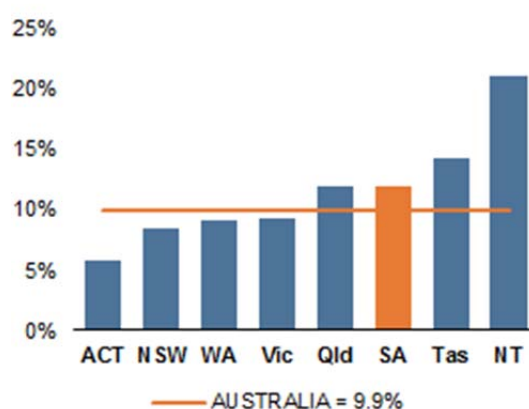
Aboriginal status	%
Aboriginal	39.1%
Non-Aboriginal	7.4%
<b>South Australia</b>	<b>8.5%</b>
<b>Australia</b>	<b>n.a.</b>



Data source: SA Health 2017b

**Smoking rate at first antenatal visit, 2016**

State/Territory	%
Australian Capital Territory	5.8%
New South Wales	8.4%
Western Australia	9.1%
Victoria	9.3%
Queensland	12.0%
<b>South Australia</b>	<b>12.0%</b>
Tasmania	14.2%
Northern Territory	21.1%
<b>Australia</b>	<b>9.9%</b>



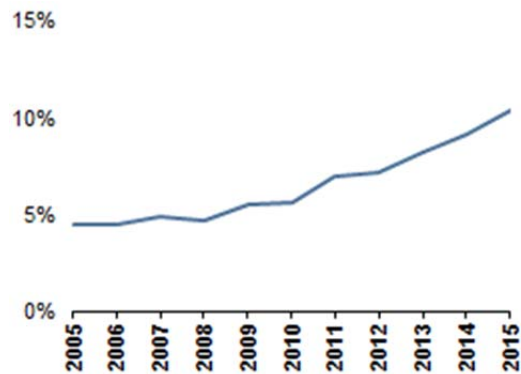
Data source: AIHW 2018a

**2-4-3. Gestational diabetes**

- There has been a more than doubling in the prevalence of gestational diabetes among women who give birth in South Australia over the last decade of collected data.
- In 2005, 4.5% of women who gave birth in South Australia experienced gestational diabetes as an obstetric complication.<sup>4</sup>
- By 2015, the prevalence in this state had more than doubled to 10.4%.<sup>4</sup>

**Gestational diabetes, 2015**

Region	% of women who gave birth
Metro. Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>10.4%</b>
<b>Australia</b>	<b>n.a.</b>



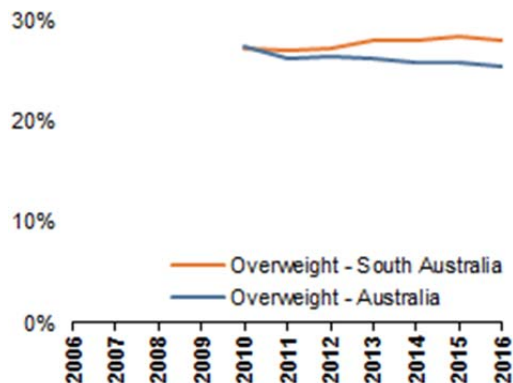
Data Source: SA Health 2017c

**2-4-4. Overweight and obesity in pregnancy**

- Body mass index or BMI is a measure of body fat based on the ratio of weight and height (bodyweight in kilograms divided by height in metres squared).
- The normal range of BMI for non-pregnant women is 18.5 to 24.9 kg/m<sup>2</sup>.
- BMI increases are expected in pregnancy. However, a BMI in the range 25.0 to 29.9 at the first antenatal consultation is defined as overweight, while a BMI of 30.0 or more is defined as obesity in pregnancy.
- In 2016, over a quarter (28.0%) of women in South Australia who gave birth were recorded as being overweight during their pregnancy, above the national average of 25.5%.<sup>5</sup>
- At the same time, a slightly lower proportion (24.4%) were recorded as being obese although again this was above the national average of 19.5%.<sup>5</sup>
- Over the last six years for which time series data is available, the trend in overweight and obesity in pregnancy has increased slightly in South Australia but fallen nationally.
- Of the states and territories, South Australia is ranked highest for overweight and second highest for obesity in pregnancy. However, readers should note that figures may not be directly comparable between jurisdictions due to differences in how and when data was collected.

**Overweight in pregnancy, 2016**

Region	%
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>28.0%</b>
<b>Australia</b>	<b>25.5%</b>

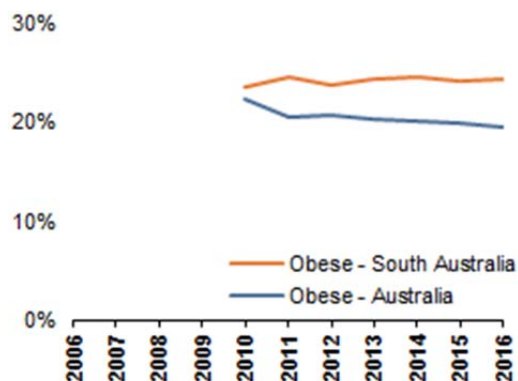


Data source: AIHW 2018b



**Obesity in pregnancy, 2016**

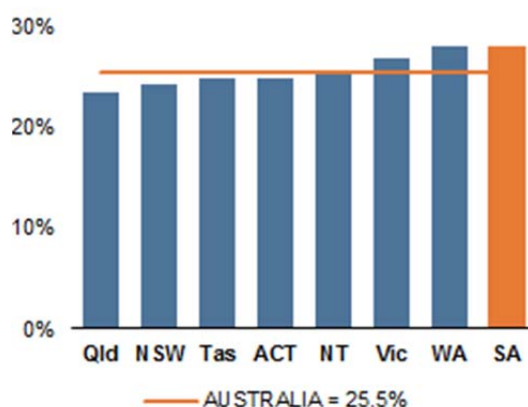
Region	%
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>24.4%</b>
<b>Australia</b>	<b>19.5%</b>



Data source: AIHW 2018b

**Overweight in pregnancy, 2016**

State/Territory	%
Queensland	23.4%
New South Wales	24.3%
Tasmania	24.8%
Australian Capital Territory	24.9%
Northern Territory	25.3%
Victoria	26.8%
Western Australia	28.0%
<b>South Australia</b>	<b>28.0%</b>
<b>Australia</b>	<b>25.5%</b>

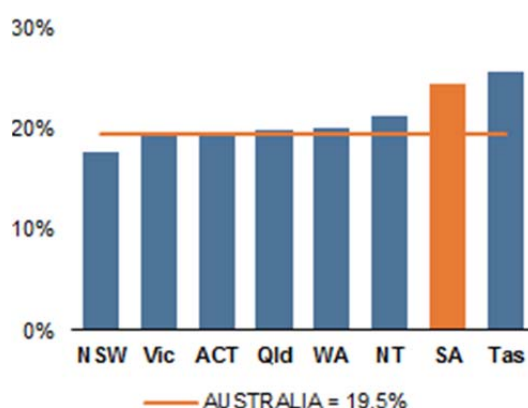


N.B. figures may not be directly comparable between jurisdictions due to differences in how and when data was collected.

Data source: AIHW 2018b

**Obesity in pregnancy, 2016**

State/Territory	%
New South Wales	17.8%
Victoria	19.5%
Australian Capital Territory	19.6%
Queensland	19.8%
Western Australia	20.1%
Northern Territory	21.3%
<b>South Australia</b>	<b>24.4%</b>
Tasmania	25.6%
<b>Australia</b>	<b>19.5%</b>



N.B. figures may not be directly comparable between jurisdictions due to differences in how and when data was collected.

Data source: AIHW 2018b

## Sources

1. Based on Pregnancy Outcome Unit, SA Health (SA Health 2017a), Government of South Australia 2015, 'Table 9a: Gestation at first antenatal visit, women who gave birth, by race, South Australia, 2015', [Pregnancy Outcome in South Australia 2015](#), Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R, viewed August 2018.
2. Based on Pregnancy Outcome Unit, SA Health (SA Health 2017b), Government of South Australia 2015, 'Table 20: Tobacco smoking status at first antenatal visit, non-Aboriginal and Aboriginal women who gave birth, South Australia, 2015' and 'Table 21: Average number of tobacco cigarettes smoked per day in the second half of pregnancy, non-Aboriginal and Aboriginal women who gave birth, South Australia, 2015', [Pregnancy Outcome in South Australia 2015](#), Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R, viewed August 2018.
3. Based on Australian Institute of Health and Welfare (AIHW 2018a) National Perinatal Data Collection, 'Table 14a: Trends for smoking anytime in pregnancy by selected maternal characteristics, 2005 to 2016', Antenatal period module, [Perinatal data portal](#), accessed 8 August 2018.
4. Based on Pregnancy Outcome Unit, SA Health (SA Health 2017c), Government of South Australia 2015, 'Table 23: Frequency of some obstetric complications, women who gave birth, South Australia, 2015', [Pregnancy Outcome in South Australia 2015](#), Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R, viewed August 2018.
5. Based on Australian Institute of Health and Welfare (AIHW 2018b), 'Table 12: Body mass index (BMI) by selected characteristics of women who gave birth, 2016', Antenatal period module, [Perinatal data portal](#), accessed 8 August 2018.

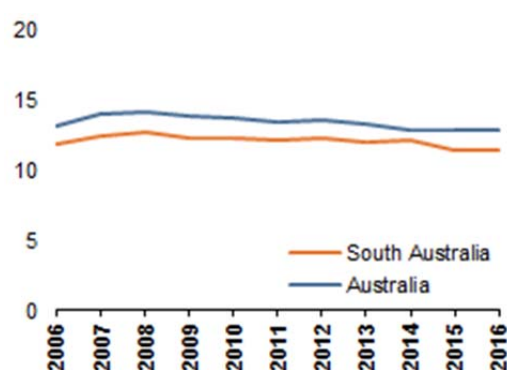
## 2-5. Birth rate

### 2-5-1. Birth rate

- In 2016, there were 19,765 people born in South Australia, into a total population of 1.71 million. This represents a crude rate of 11.5 births per 1000 population.<sup>1</sup>
- The crude birth rate in South Australia has been very slightly declining since 2008, down from 12.7 births per 1000 population recorded in that year.<sup>1</sup>
- The national crude birth rate remains above the state rate, but it too has been very slightly declining, down from 14.2 births per 1000 population in 2008 to 12.8 in 2016.<sup>1</sup>
- Of the states and territories, South Australia recorded the equal lowest (with Tasmania) crude birth rate in 2016.<sup>1</sup>

#### Crude birth rate, 2016

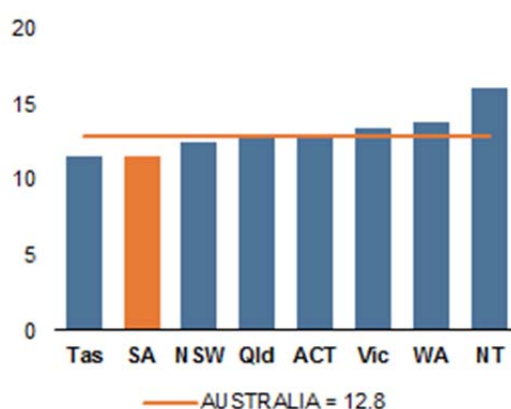
Local Health Network	Per 1000 popn.
Northern Adelaide	12.3
Central Adelaide	11.6
Southern Adelaide	11.0
<b>Metropolitan Adelaide</b>	<b>11.6</b>
Barossa Hills Fleurieu	11.2
Eyre and Far North	11.1
Flinders and Upper North	11.2
Riverland Mallee Coorong	11.6
South East	12.6
Yorke & Northern	11.0
<b>Country Health SA</b>	<b>11.5</b>
<b>South Australia</b>	<b>11.5</b>
<b>Australia</b>	<b>12.8</b>



Data source: ABS 2017a

#### Crude birth rate, 2016

State/Territory	Per 1000 popn.
Tasmania	11.5
<b>South Australia</b>	<b>11.5</b>
New South Wales	12.4
Queensland	12.8
Aust. Capital Territory	12.8
Victoria	13.4
Western Australia	13.8
Northern Territory	16.0
<b>Australia</b>	<b>12.8</b>



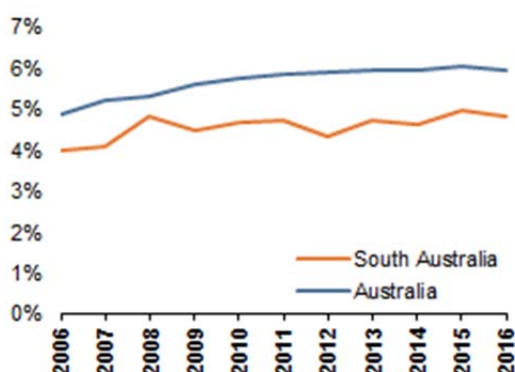
Data source: ABS 2017a

## 2-5-2. Aboriginal births

- In 2016, there were 957 births registered in South Australia where one or both parents identified themselves as being Aboriginal. This represents 4.8% of the 19,772 total births in this state during that year.<sup>2</sup>
- The trend in recorded Aboriginal births, as a percentage of all births, both in this state and nationally, has been increasing until 2015, with a slight decrease in 2016.<sup>2</sup>
- The Australian Bureau of Statistics caution that, due to changes over time in the completeness and coverage of responses by parents to the Aboriginal and Torres Strait Islander question on the birth registration form, care should be taken when interpreting changes in the data.
- Of the states and territories, South Australia ranks second lowest for percentage of Aboriginal births.<sup>2</sup>

### Aboriginal births, 2016

Region	% of all births
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>4.8%</b>
<b>Australia</b>	<b>6.0%</b>



Data source: ABS 2017b

### Aboriginal births, 2016

State/Territory	% of all births
Victoria	1.8%
<b>South Australia</b>	<b>4.8%</b>
New South Wales	6.0%
Western Australia	7.8%
Queensland	8.7%
Tasmania	9.8%
Northern Territory	35.0%
<b>Australia</b>	<b>6.0%</b>



Data source: ABS 2017b

## Sources

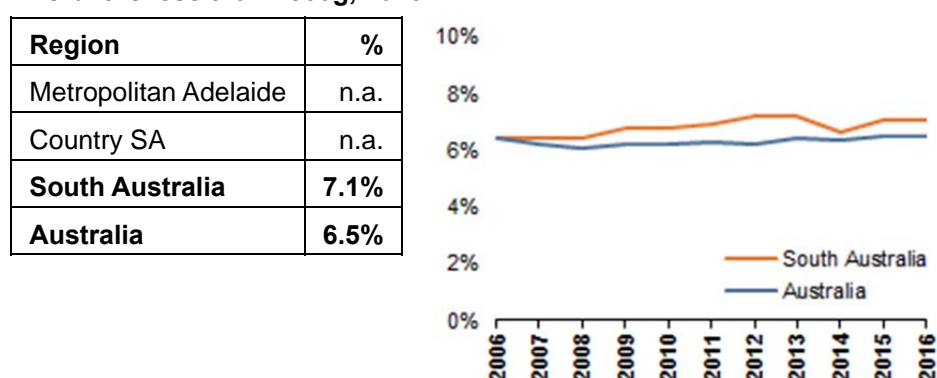
1. Based on Australian Bureau of Statistics (ABS 2017a), 'Table 1.1 Births, Summary, statistical Areas Level 4--2006 to 2016', [Births, Australia, 2016](#), cat. no. 3301.0, viewed 20 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2017b), 'Aboriginal and Torres Strait Islander births and confinements, summary, by state', [ABS.Stat \(beta\)](#), viewed 20 August 2018.

## 2-6. Low birthweight

### 2-6-1. Low birthweight

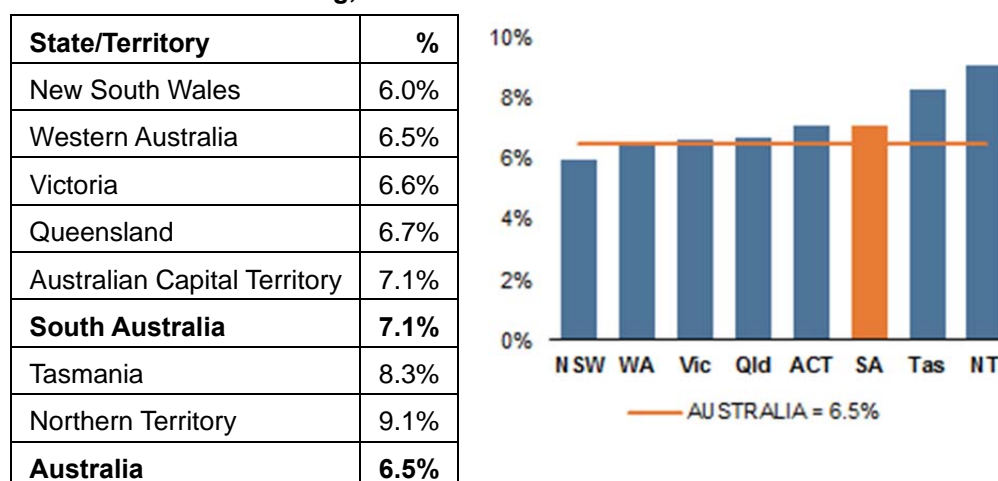
- A baby's birthweight is a key indicator of health status and babies are defined as low birthweight if their weight at birth is less than 2,500 grams.
- In 2016, the mean birthweight of liveborn babies in South Australia was 3,324 grams, compared to the Australian average of 3,336 grams.<sup>1</sup>
- Around one in 14 (7.1%) of those were low birthweight in South Australia during that year, greater than the 6.5% national average.<sup>1</sup>
- The trend in percentage of low birthweight liveborn babies in South Australia has been slightly increasing since 2008, compared to a relatively flat trend nationally over the last decade.<sup>1</sup>
- South Australia ranks third highest for proportion of low birthweight babies of the states and territories.

#### Live births less than 2500g, 2016



Data source: AIHW 2018

#### Live births less than 2500g, 2016



Data source: AIHW 2018

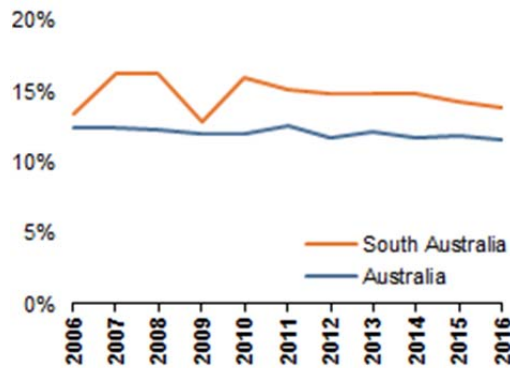
### 2-6-2. Aboriginal low birth weight

- A baby's birthweight is a key indicator of health status and babies are defined as low birthweight if their weight at birth is less than 2,500 grams.
- In 2016, the mean birthweight of liveborn babies to Aboriginal mothers in South Australia was 3,183 grams, less than the national mean for babies born to Aboriginal mothers (3,216 grams), and less than the South Australian average for all mothers of 3,324 grams (see 2-6-1 above).<sup>1</sup>

- Around one in seven (13.8%) of liveborn babies to Aboriginal mothers in South Australia during 2016 were low birthweight, a higher rate than the 11.6% recorded nationally.<sup>1</sup>
- The trend in percentage of low birthweight liveborn babies to Aboriginal mothers, both here in South Australia and nationally, has been slightly downwards over the last decade.
- Of the states and territories, South Australia ranks fourth highest for percentage of low birthweight liveborn babies to Aboriginal mothers.<sup>1</sup>

#### Live births less than 2500g, Aboriginal mothers, 2016

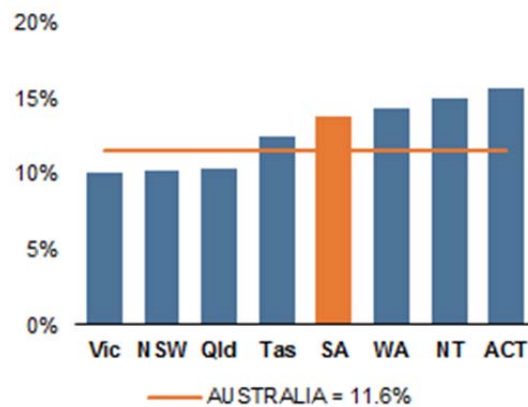
Region	%
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>13.8%</b>
<b>Australia</b>	<b>11.6%</b>



Data source: AIHW 2018

#### Live births less than 2500g, Aboriginal mothers, 2016

State/Territory	%
Victoria	10.1%
New South Wales	10.2%
Queensland	10.4%
Tasmania	12.5%
<b>South Australia</b>	<b>13.8%</b>
Western Australia	14.3%
Northern Territory	15.0%
Australian Capital Territory	15.6%
<b>Australia</b>	<b>11.6%</b>



Data source: AIHW 2018

#### Sources

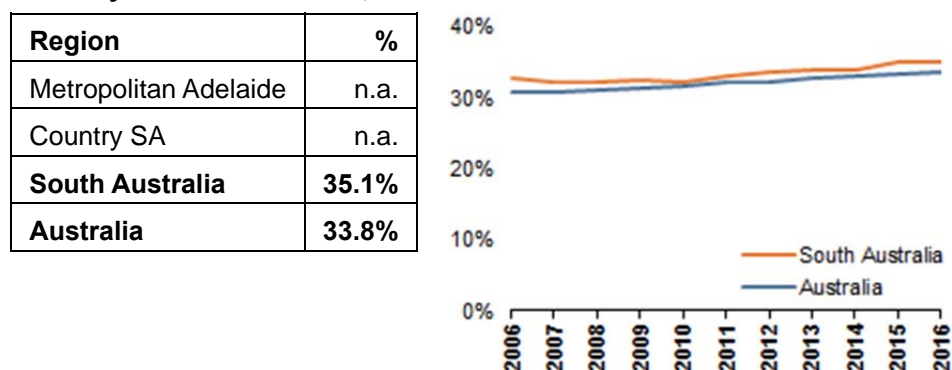
1. Based on Australian Institute of Health and Welfare (AIHW 2018), 'Table 3.8: Live births, by birthweight and state and territory, 2016' and 'Table 3.11: Live births of Aboriginal and Torres Strait Islander mothers, by birthweight and state and territory, 2016', [Australia's mothers and babies 2016 -- in brief, Supplementary tables](#), Perinatal statistics series no. 31, Cat no. PER 72, viewed 10 August 2018.

## 2-7. Caesarean births

### 2-7-1. Caesarean births

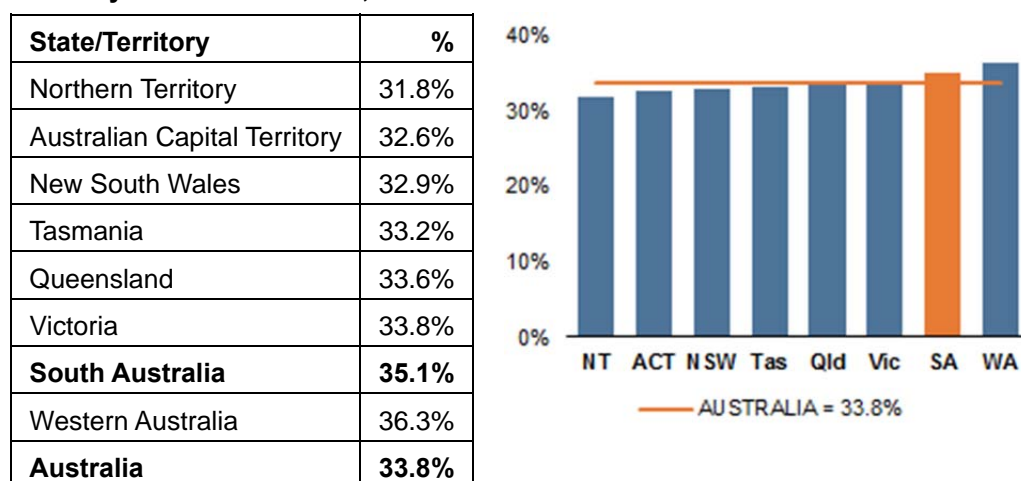
- In 2016, over a third (35.1%) of all births in South Australia were by caesarean section.<sup>1</sup>
- This is higher than the national average of 33.8%.<sup>1</sup>
- Over the last decade, the proportion of women who gave birth via caesarean procedure has increased, both in this state (up from 32.9% in 2006) and Australia-wide (up from 30.8% in 2006).<sup>1</sup>
- South Australia ranks second highest for proportion of births by caesarean procedure of the states and territories.<sup>1</sup>

#### Births by caesarean section, 2016



Data source: AIHW 2018

#### Births by caesarean section, 2016



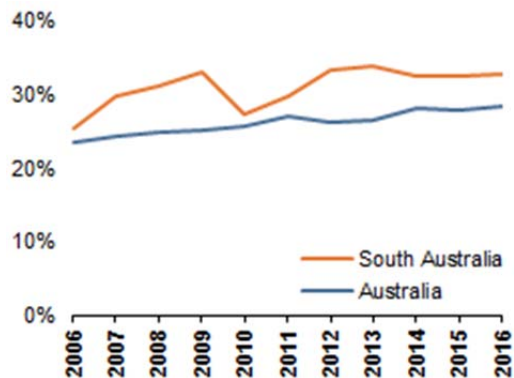
Data source: AIHW 2018

### 2-7-2. Aboriginal caesarean births

- In 2016, just over a third (32.7%) of women who identified as Aboriginal and who gave birth in South Australia did so by caesarean procedure.<sup>1</sup>
- This is significantly higher than the national average (28.5%) for Aboriginal women who gave birth during that year.<sup>1</sup>
- Over the last decade, the proportion of Aboriginal women who gave birth in South Australia via caesarean procedure has increased, up from 25.4% in 2006.<sup>1</sup>
- South Australia recorded the highest proportion of Aboriginal births by caesarean section of the states and territories in 2016.<sup>1</sup>

**Births by caesarean section, Aboriginal mothers, 2016**

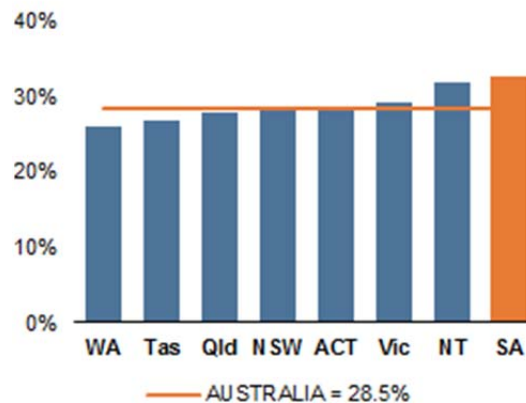
Region	%
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>32.7%</b>
<b>Australia</b>	<b>28.5%</b>



Data source: AIHW 2018

**Births by caesarean section, Aboriginal mothers, 2016**

State/Territory	%
Western Australia	26.1%
Tasmania	26.9%
Queensland	27.9%
New South Wales	28.4%
Australian Capital Territory	28.6%
Victoria	29.2%
Northern Territory	31.7%
<b>South Australia</b>	<b>32.7%</b>
<b>Australia</b>	<b>28.5%</b>



Data source: AIHW 2018

**Sources**

1. Based on Australian Institute of Health and Welfare (AIHW 2018), 'Table 2.36: Women who gave birth, by Indigenous status, method of birth and state and territory, 2016', [Australia's mothers and babies 2016 -- in brief, Supplementary tables](#), Cat no. PER 97, viewed 8 August 2018.

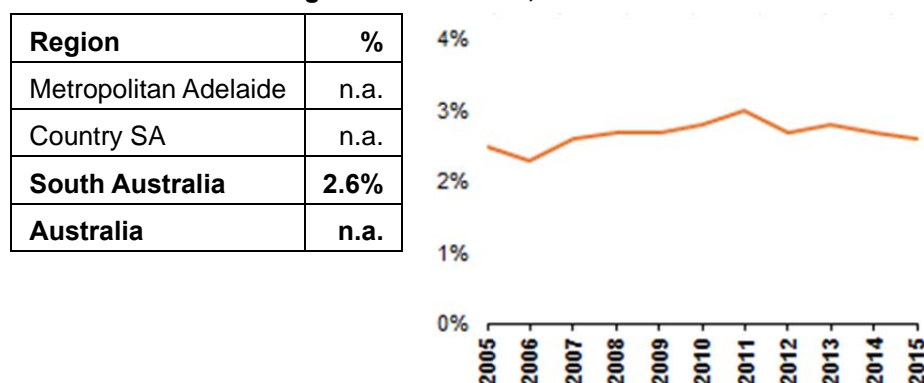


## 2-8. Congenital anomalies

### 2-8-1. Congenital anomalies in South Australia

- In 2015, there were 516 births (2.6%) in South Australia notified with congenital anomalies.<sup>1</sup>
- The trend over the last decade has been slightly increasing, up from 2.3% in 2006.<sup>1</sup>
- The top three congenital anomalies notified to South Australia's perinatal statistics collection in 2015 were: Hypospadias & epispadias (32 notified births); Cleft palate (17); Cleft lip and palate (Total cleft lip) (14). These classifications are based on the British Paediatric Association (BPA) Classification of Diseases.<sup>1</sup>

#### Births notified with congenital anomalies, 2015



Data source: SA Health 2017

#### Sources

1. Based on Pregnancy Outcome Unit, SA Health (SA Health 2017), Government of South Australia 2017, [Pregnancy outcome in South Australia 2015](#), Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R., viewed August 2018.

## 2-9. Childhood developmental health checks

### Introduction

Fourth year developmental health assessments are available to children under the Australian Government's Medicare Benefits Scheme (MBS)...

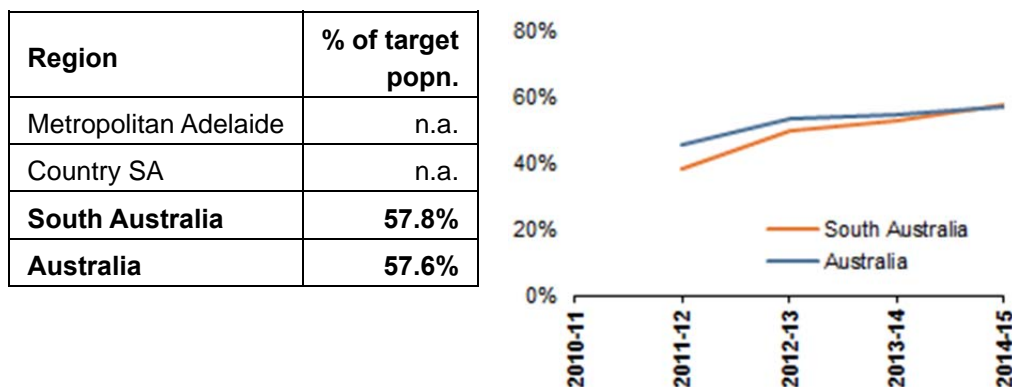
The *Healthy Kids Check* is available to children aged 3 or 4 years, while the *Aboriginal and Torres Strait Islander Peoples Health Assessment* item is available to Aboriginal and Torres Strait Islander people of all ages. The proportion of Aboriginal and Torres Strait Islander children aged 3 to 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is reported as a proxy for the proportion of Aboriginal and Torres Strait Islander children who received a fourth year developmental health assessment. The proportion of other children who received either a Healthy Kids Check (at the age of 3 or 4 years), or a Health assessment at the age of 5 years, is reported as a proxy for the proportion of other children who received a fourth year developmental health assessment.

Fourth year developmental health assessments are intended to assess children's physical health, general wellbeing and development. They enable identification of children who are at high risk for, or have early signs of, delayed development and/or illness.

### 2-9-1. Childhood developmental health checks

- In 2014-15, well over half (57.8%) of South Australian children in the target population had received a fourth year developmental health check ("Healthy Kids Check").<sup>1</sup>
- Over the last four years of comparable data, South Australia's rate has been increasing, and now sits slightly above the national average of 57.6%.<sup>1</sup>
- Of the states and territories, South Australia ranks third highest for proportion of children in the target cohort who received a fourth year developmental Health Kids Check.<sup>1</sup>

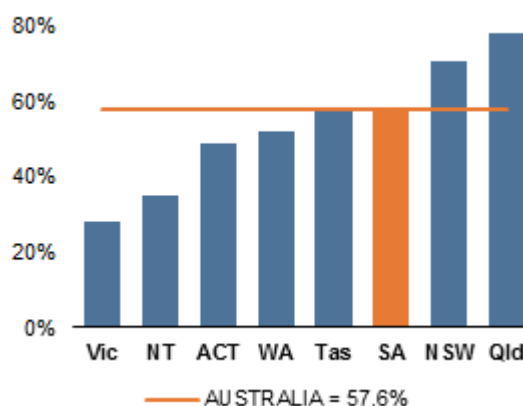
#### Children receiving a Health Kids Check, 2014-15



Data source: Productivity Commission 2016

### Children receiving a Health Kids Check, 2014-15

State/Territory	% of target popn.
Victoria	28.2%
Northern Territory	34.8%
Aust. Capital Territory	48.9%
Western Australia	52.1%
Tasmania	57.2%
<b>South Australia</b>	<b>57.8%</b>
New South Wales	70.7%
Queensland	78.1%
<b>Australia</b>	<b>57.6%</b>



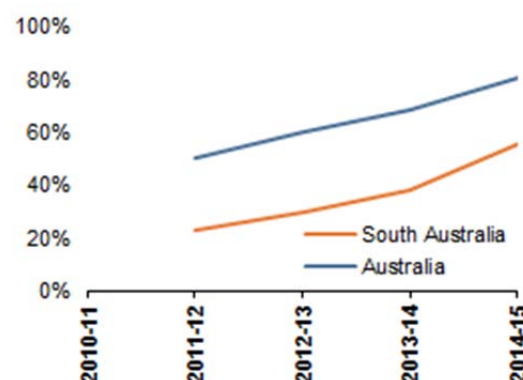
Data source: Productivity Commission 2016

### 2-9-2. Aboriginal childhood developmental health checks

- In 2014-15, over half (55.9%) of Aboriginal children in South Australia in the target cohort had received a fourth year developmental health check ("Aboriginal and Torres Strait Islander Child Health Check").<sup>1</sup>
- Over the last four years of comparable data, South Australia's rate has been increasing, but is still well below the national average rate (80.9%).<sup>1</sup>
- South Australia is ranked third lowest of the states and territories for proportion of Aboriginal children in the target cohort receiving fourth year developmental Aboriginal and Torres Strait Islander Child Health Checks.<sup>1</sup>

### Children receiving an Aboriginal and Torres Strait Islander Child Health Check, 2014-15

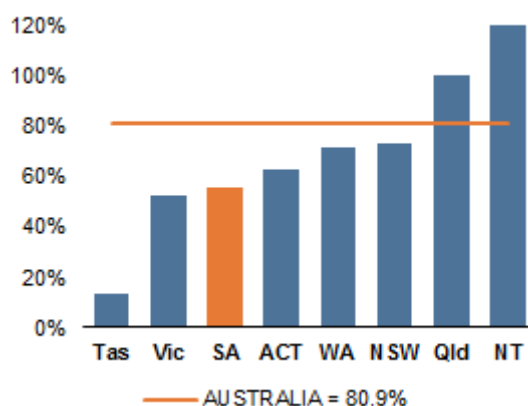
Region	% of target popn.
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>55.9%</b>
<b>Australia</b>	<b>80.9%</b>



Data source: Productivity Commission 2016

### Children receiving an Aboriginal and Torres Strait Islander Child Health Check, 2014-15

State/Territory	% of target popn.
Tasmania	13.8%
Victoria	52.3%
<b>South Australia</b>	<b>55.9%</b>
Aust. Capital Territory	62.7%
Western Australia	71.9%
New South Wales	73.5%
Queensland	100.1%*
Northern Territory	124.8%*
<b>Australia</b>	<b>80.9%</b>



Data source: Productivity Commission 2016

\* For Queensland and the Northern Territory in 2014-15, data for the proportion of Aboriginal and Torres Strait Islander children who received a health check exceeds 100 per cent...

This is largely because numerator and denominator are not directly comparable — children are eligible to receive this health assessment at the age of 3, 4 or 5 years. However, a child is eligible to receive it once only (children may also be eligible for other health checks) — hence, the denominator uses population estimates and projections for a single year of age — 4 years. Using this methodology, the total number of children aged 3, 4 and 5 years who received a check in 2014-15 exceeds the derived population of Aboriginal and Torres Strait Islander children aged 4 years.

### Sources

1. Based on Productivity Commission 2016, 'Volume E: Health, Chapter 10, Primary and community health, Attachment tables, Table 10A.34 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)', Government of Australia, Canberra, viewed 10 March 2016.

## 2-10. Childhood immunisation coverage

### Introduction

The definition of *fully immunised* for measuring coverage rates includes vaccination against: hepatitis B, diphtheria, tetanus, pertussis, haemophilus influenzae type b, polio, measles, mumps and rubella, pneumococcal, varicella and meningococcal C.

Hepatitis B was not included in the Australian Childhood Immunisation Register until 2002.

The definition of fully immunised for measuring coverage rates was most recently expanded in 2013 and 2014 to accommodate changes to the National Immunisation Program Schedule:

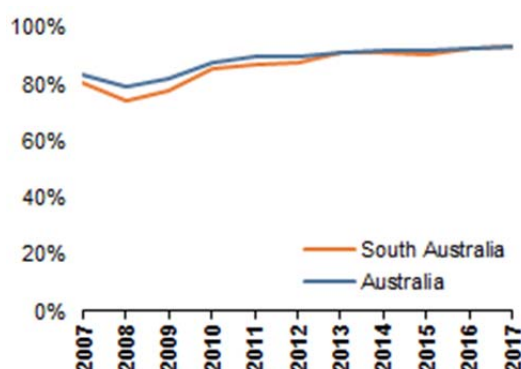
- December 2013 - pneumococcal vaccine for children aged 12-15 months was added.
- December 2014 - measles, mumps, rubella dose 2 (previously dose 1 was measured), varicella and meningococcal C for children aged 24 -27 months was included.

### 2-10-1. Children aged 5 years fully immunised

- As at June 2017, 93.5% of children aged five years in South Australia were fully immunised.<sup>1</sup>
- Fully immunised includes vaccination against: hepatitis B, diphtheria, tetanus, pertussis, haemophilus influenzae type b, polio, measles, mumps and rubella, pneumococcal, varicella and meningococcal C.
- South Australia's rate is equal to the national average of 93.5%.<sup>1</sup>
- Over the last decade, the trend in percentage of fully immunised children by age five years in this state has been increasing, up from 80.5% in 2007.<sup>1</sup>
- South Australia technically ranks fourth highest of the states and territories for proportion of five year olds fully vaccinated, but there isn't a great deal of difference between the jurisdictions.<sup>1</sup>

#### Children aged 5 years fully immunised, 2017

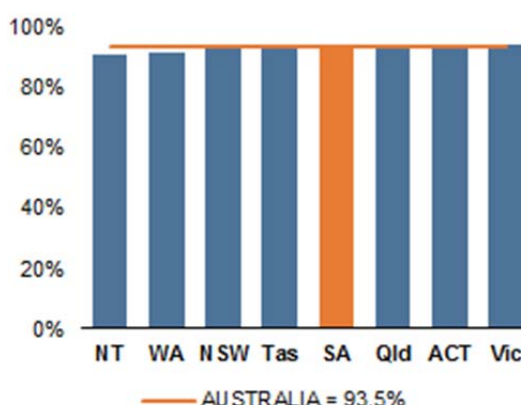
Region	%
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>93.5%</b>
<b>Australia</b>	<b>93.5%</b>



Data source: AIHW 2018

**Children aged 5 years fully immunised, 2017**

State/Territory	%
Northern Territory	90.7%
Western Australia	91.6%
New South Wales	93.0%
Tasmania	93.4%
<b>South Australia</b>	<b>93.5%</b>
Queensland	93.9%
Australian Capital Territory	93.9%
Victoria	94.0%
<b>Australia</b>	<b>93.5%</b>



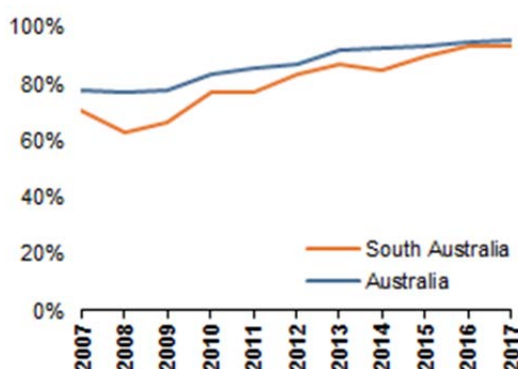
Data source: AIHW 2018

**2-10-2. Aboriginal children aged 5 years fully immunised**

- As at June 2017, 93.0% of Aboriginal children aged five years in South Australia were fully immunised.<sup>1</sup>
- Fully immunised includes vaccination against: hepatitis B, diphtheria, tetanus, pertussis, haemophilus influenzae type b, polio, measles, mumps and rubella, pneumococcal, varicella and meningococcal C.
- South Australia's proportion of Aboriginal children aged five years fully immunised is slightly below this state's overall figure of 93.5% (see 2-10-1 above).<sup>1</sup>
- The trend in percentage of Aboriginal children fully immunised by age five years in this state has increased significantly over the last decade (up from 70.4% in 2007).<sup>1</sup>
- South Australia technically ranks third lowest of the states and territories for proportion of Aboriginal children aged five year olds fully vaccinated, but there isn't a great deal of difference between the jurisdictions.<sup>1</sup>

**Aboriginal children aged 5 years fully immunised, 2017**

Region	%
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>93.0%</b>
<b>Australia</b>	<b>95.7%</b>



Data source: AIHW 2018

**Aboriginal children aged 5 years fully immunised, 2017**

State/Territory	%
Tasmania	92.5%
Victoria	92.6%
<b>South Australia</b>	<b>93.0%</b>
Western Australia	94.4%
Northern Territory	94.7%
Australian Capital Territory	95.0%
New South Wales	96.2%
Queensland	96.3%
<b>Australia</b>	<b>95.7%</b>



Data source: AIHW 2018

**Sources**

1. Based on Australian Institute of Health and Welfare (AIHW 2018), MyHealthyCommunities, [Immunisation rates for children from 2011–12 to 2016–17](#), Canberra, Australia, viewed 9 August 2018.

## 2-11. Childhood overweight and obesity

### Introduction

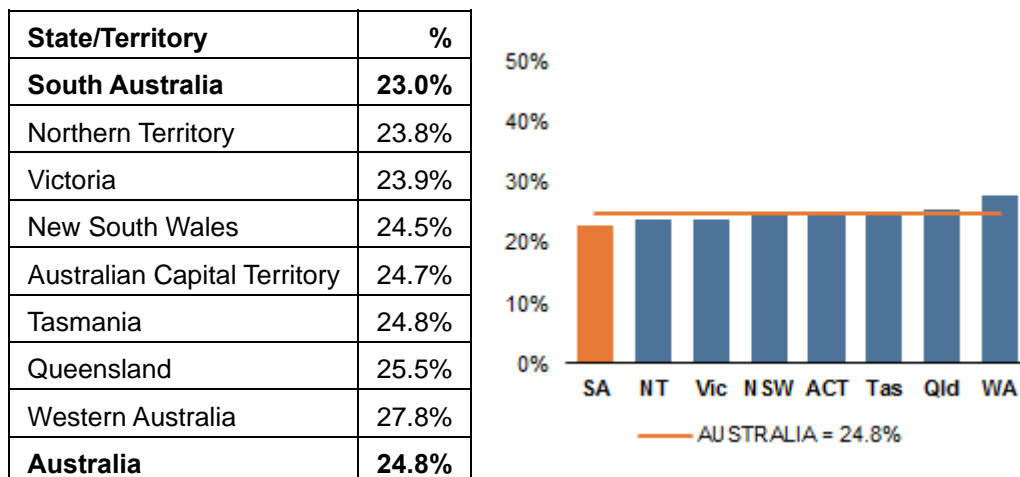
Body mass index or BMI is a measure of body fat based on the ratio of weight and height (bodyweight in kilograms divided by height in metres squared). The normal range of BMI for an adult is 18.5 to 24.9 kg/m<sup>2</sup>.

Overweight for children is defined as a BMI (appropriate for age and sex) that is likely to be equal to 25 but less than 30 at age 18 years. Obesity for children is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

#### 2-11-1. Overweight and obesity in non-Aboriginal children

- Around a quarter (23.0%) of non-Aboriginal children aged 5-17 years in South Australia were overweight or obese when the Australian Bureau of Statistics conducted its 2011-13 *Australian Health Survey*.<sup>1</sup>
- This is slightly below the national average for non-Aboriginal children (24.8%).<sup>1</sup>
- Compared to non-Aboriginal children in other states and territories, South Australia is ranked lowest for prevalence of childhood overweight and obesity.<sup>1</sup>

#### Non-Aboriginal children aged 5-17 years overweight or obese, 2011-13



Data source: Productivity Commission 2016

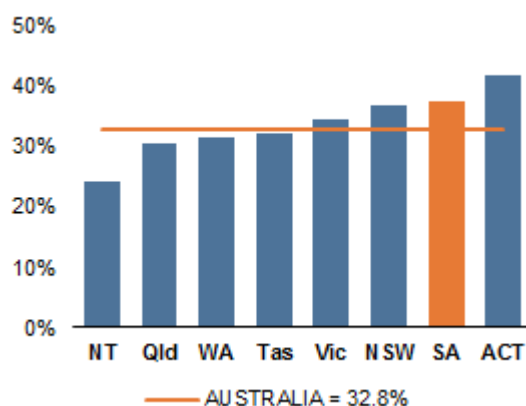
#### 2-11-2. Overweight and obesity in Aboriginal children

- Over a third (37.6%) of Aboriginal children aged 5-17 years in South Australia were overweight or obese when the Australian Bureau of Statistics conducted its 2011-13 *Australian Health Survey*.<sup>1</sup>
- This is above the national average for Aboriginal children (32.8%), and well above the non-Aboriginal rate for South Australia (23.0%).<sup>1</sup>
- Compared to Aboriginal children in other states and territories, South Australia is ranked second highest for prevalence of Aboriginal childhood overweight and obesity.<sup>1</sup>



**Aboriginal children aged 5-17 years overweight or obese, 2011-13**

State/Territory	%
Northern Territory	24.2%
Queensland	30.4%
Western Australia	31.6%
Tasmania	32.1%
Victoria	34.5%
New South Wales	36.7%
<b>South Australia</b>	<b>37.6%</b>
Australian Capital Territory	41.9%
<b>Australia</b>	<b>32.8%</b>



Data source: Productivity Commission 2016

**Sources**

1. Based on Productivity Commission 2016, 'Volume E: Health, Overview, Attachment tables, Table EA.20 Rate of overweight and obesity for children by Indigenous status, 2011-13,' [Report on Government Services 2016](#), Government of Australia, Canberra, viewed 10 March 2016.

## Staying healthy and ageing well

### In summary

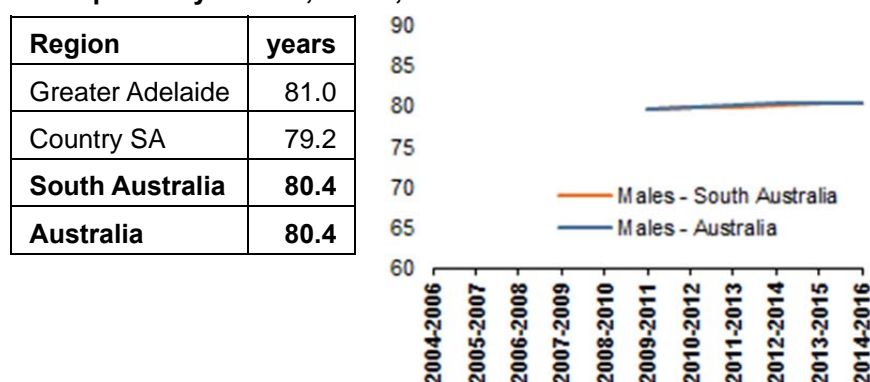
- The **life expectancy** of a **male** baby born in South Australia is **80.4 years**.
- The **life expectancy** of a **female** baby born in South Australia is **84.5 years**.
- **Aboriginal life expectancy** data is unavailable for South Australia specifically, but **nationally** stands at **69.1 years** for **Aboriginal males** at birth and **73.7 years** for **Aboriginal females** at birth.
- The **vast majority** (80.8%) of South Australians self-report that their **general health status is good, very good, or excellent**.
- **Less than half** (42.1%) of South Australians are eating the recommended **two or more serves of fruit per day**.
- Around **one in ten** (9.9%) South Australians report eating **five or more serves of vegetables per day**.
- **Under half** (45.0%) of South Australians undertake 150 minutes or more of walking, moderate or vigorous physical activity per week.
- Around **a quarter** (22.9%) of South Australians have a **disability** – defined in this context as a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities.
- A smaller percentage, around **one in twenty** (5.5%), are in need of assistance with core activities due to **profound or severe disability**.
- **About a third** (32.7%) of South Australians are living with two or more of the following risk factors: (i) current high blood pressure; (ii) current high cholesterol; (iii) undertakes less than 150 minutes per week of walking, moderate or vigorous physical activity; (iv) overweight or obese; (v) current smoker; (vi) long-term alcohol risk; and/or (vii) insufficient consumption of fruit and vegetables.
- **Around a quarter** (24.6%) of South Australians drink at levels on a single occasion that puts them at **risk of an alcohol-related injury** arising from that particular event.
- **About one in six** (15.6%) South Australians are consuming alcohol at levels that puts them at **lifetime risk of harm** from alcohol-related disease or injury.
- **Approximately two-thirds** (63.7%) of South Australians have a Body Mass Index which the World Health Organisation defines as **overweight or obese**.
- **Around a quarter** (22.3%) of South Australians have **high blood pressure** and/or are on medication for high blood pressure.
- About **one in six** (17.5%) South Australians have **high cholesterol** and/or are on medication for high cholesterol. The trend has been increasing in metropolitan Adelaide over the last five years.
- **One in six** (16.5%) South Australians are current **smokers**.
- Approximately **one in eight** (11.9%) South Australians have recently experienced high or very high levels of **psychological distress**.
- Roughly **one in ten** (9.7%) South Australians have ever been told by a doctor that they have (or had) **cancer**.
- Just under **one in six** (15.7%) South Australians aged 14 years and older **reported using drugs illicitly**, including the use of pharmaceuticals for non-medical purposes, in the previous 12 months.

### 3-1. Life expectancy

#### 3-1-1. Male life expectancy

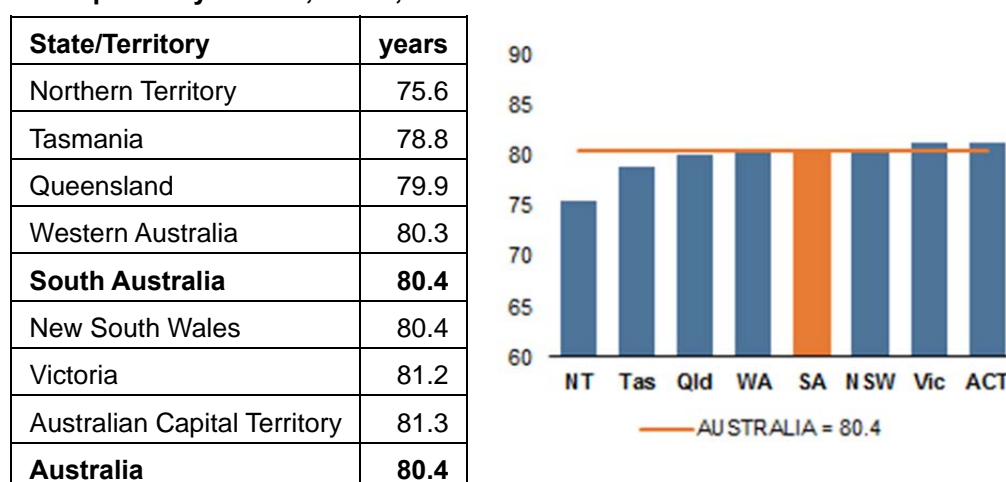
- The life expectancy of males in South Australia has increased very slightly since 2009-2011, but is lower than their female counterparts<sup>1</sup>.
- A male baby born in South Australia in the period 2014-2016 has a total life expectancy of 80.4 years (81.0 for Greater Adelaide vs. 79.2 for Country SA)<sup>1</sup>.
- At 80.4 years, total male life expectancy at birth in South Australia is equivalent to the national average for males (also 80.4 years)<sup>1</sup>.
- A male aged 65 years living in South Australia in 2014-2016 can expect to live another 19.6 years, a male aged 75 years another 12.1 years and a male aged 85 years another 6.2 years<sup>1</sup>.
- Apart from the Northern Territory, there's not a great deal of variation between the states and territories for total male life expectancy at birth in the period 2014-2016<sup>1</sup>.
- The graphs below do not start at the origin to show detail.

#### Life expectancy at birth, Males, 2014-2016



Data source: ABS 2017

#### Life expectancy at birth, Males, 2014-2016



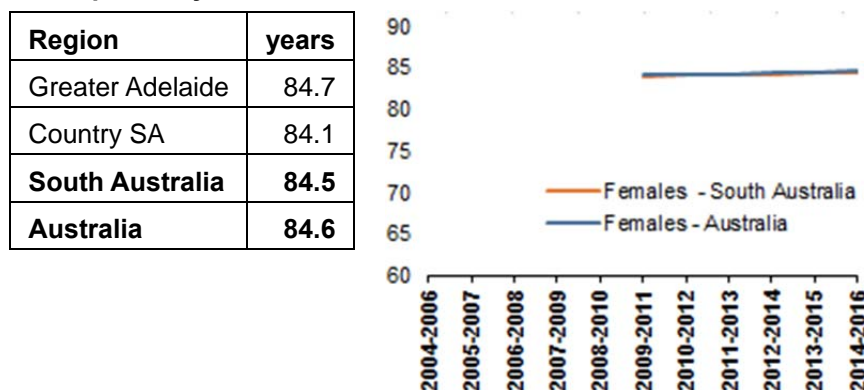
Data source: ABS 2017

#### 3-1-2. Female life expectancy

- At 84.5 years, a female born in South Australia in the period 2014-2016 can expect to live almost half a decade longer than her male counterpart<sup>1</sup>.

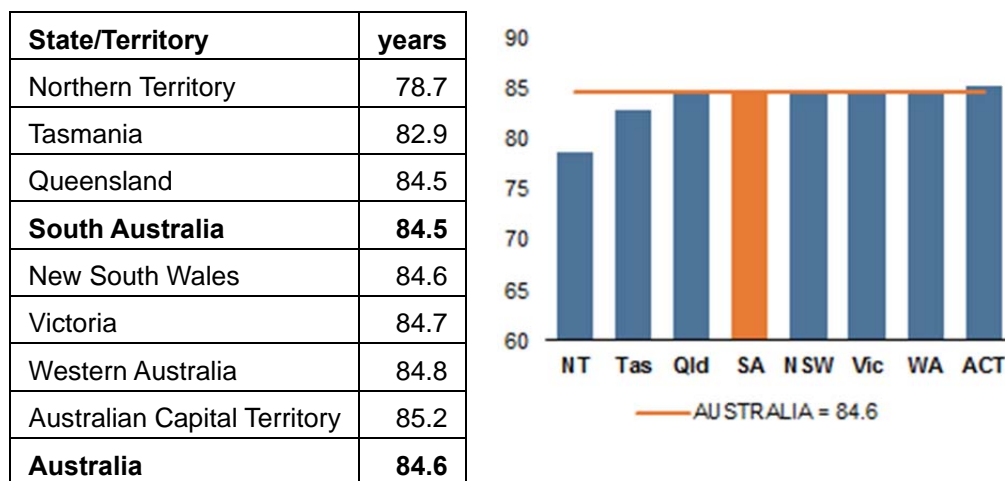
- There is a slight gap in total female life expectancy at birth in the period 2014-2016, depending on whether the location is Greater Adelaide (84.7 years) or Country SA (84.1 years)<sup>1</sup>.
- Female life expectancy in South Australia (84.5 years) is roughly equivalent to the national average for females (84.6 years)<sup>1</sup>.
- A female aged 65 years living in South Australia in the period 2014-2016 can expect to live another 22.3 years, a female aged 75 years another 14.0 years and a female aged 85 years another 7.3 years<sup>1</sup>.
- Apart from the Northern Territory, there's not a great deal of variation between the states and territories for total female life expectancy at birth in the period 2014-2016<sup>1</sup>.
- The graphs below do not start at the origin to show detail.

#### Life expectancy at birth, Females, 2014-2016



Data source: ABS 2017

#### Life expectancy at birth, Females, 2014-2016



Data source: ABS 2017

#### 3-1-3. Aboriginal life expectancy

- Aboriginal life expectancy at birth data is *unavailable for South Australia*.
- However, the *national* Aboriginal life expectancy compared to the total is provided here to give an indication of the gap between the populations.
- Australia-wide, the total life expectancy of Aboriginal males (69.1 years) and females (73.7 years) born in the years 2010-2012 is more than a decade lower than for all persons (79.9 and 84.3 years for all males and females, respectively)<sup>2</sup>.
- The graph below does not start at the origin to show detail.

**Life expectancy at birth\*, National data, 2010-2012**

Region	years
<b>Aboriginal males - Australia</b>	<b>69.1*</b>
All males - Australia	79.9
<b>Aboriginal females - Australia</b>	<b>73.7*</b>
All females - Australia	84.3



\* Aboriginal life expectancy reported here is based on the Australian Bureau of Statistics' headline estimates for Australia, calculated using an improved methodology (taking into account age-specific identification rates) that could not be applied at the state and territory or remoteness area levels. Therefore this data should not be compared with data for any state or territory, or remoteness area.

Data source: ABS 2013

**Sources**

1. Based on Australian Bureau of Statistics (ABS 2017), 'Table 2.1 Life tables, Statistical Area Level 4-2009-2011 to 2014-2016', and 'Table 1.4 Life Tables, South Australia, 2014-2016', [Life Tables States and Territories and Australia 2014-2016](#), cat. no. 3302.0.55.001, viewed 23 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2013) 2013, 'Table 1.1 Life tables for Aboriginal and Torres Strait Islander Australians, Headline Australia estimates(a)-2010-2012', [Life Tables for Aboriginal and Torres Strait Islander Australians, 2010-2012](#), cat. no. 3302.0.55.003, viewed 16 March 2016.

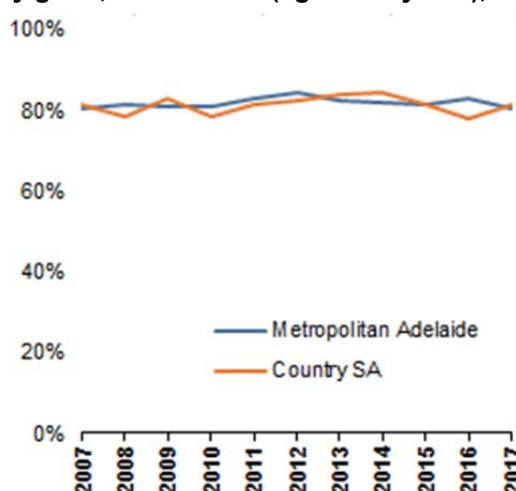
### 3-2. Health status

#### 3-2-1. Health status in South Australia – by Local Health Network

- In 2017, the vast majority (80.8%) of South Australians aged 18 years or more self-reported that their general health status is good, very good, or excellent<sup>1</sup>.
- The rate varies between the local health networks (LHNs), from 72.2% in the Riverland Mallee Coorong LHN up to 84.3% in the Barossa Hills Fleurieu LHN<sup>1</sup>.
- The rate is not statistically significantly higher in Country SA (81.2%) than metropolitan Adelaide (80.6%)<sup>1</sup>.
- No statistically significant underlying trend over the last decade in the proportion of people reporting their general health status as good, very good, or excellent was identified, either for metropolitan Adelaide or Country SA residents<sup>1</sup>.

#### Self-reported health status is good, very good, or excellent (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	79.0%
Central Adelaide	80.9%
Southern Adelaide	81.6%
<b>Metropolitan Adelaide</b>	<b>80.6%</b>
Barossa Hills Fleurieu	84.3%
Eyre and Far North	77.0%
Flinders and Upper North	83.9%
Riverland Mallee Coorong	72.2%
South East	81.2%
Yorke & Northern	82.5%
<b>Country SA</b>	<b>81.2%</b>
<b>South Australia</b>	<b>80.8%</b>
<b>Australia</b>	<b>n.a.</b>



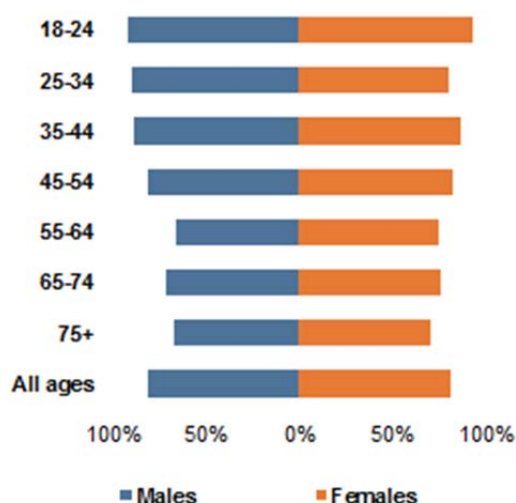
Data source: SA Health 2018

#### 3-2-2. Health status in South Australia – by age and sex

- In 2017, the proportion of people in South Australia who self-reported their general health status as good, very good, or excellent was effectively equivalent between males (80.6%) and females (81.4%) aged 18 years and over<sup>1</sup>.
- The proportion decreased with age, from well over 90% among people aged 18-24 years to around two-thirds of men and women aged 75 years or more<sup>1</sup>.

**Self-reported health status is good, very good, or excellent (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	91.8%	93.2%
25-34	89.2%	80.5%
35-44	88.5%	86.7%
45-54	80.6%	82.9%
55-64	65.7%	74.6%
65-74	71.0%	76.4%
75+	66.6%	70.8%
<b>All ages</b>	<b>80.6%</b>	<b>81.4%</b>



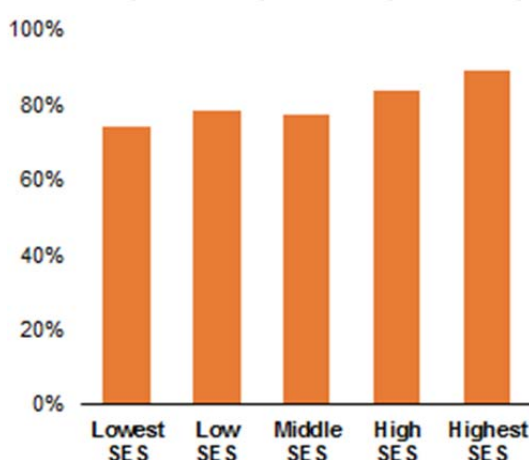
Data source: SA Health 2018

**3-2-3. Health status in South Australia – by socio-economic status**

- There is a statistically significant correlation between the proportion of people aged 18 years and over who self-report their general health status as good, very good, or excellent and the socio-economic status (SES) of the area in which they live<sup>1</sup>.

**Self-reported health status is good, very good, or excellent (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	74.1%
Low SES	78.4%
Middle SES	77.2%
High SES	83.5%
Highest SES	89.0%



Data source: SA Health 2018

**3-2-4. Health status in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people aged 15 years and over and is not directly comparable to the information presented in 3-2-1 to 3-2-3 above which is sourced via the South Australian Monitoring and Surveillance System survey of persons aged 18 years and older.
- However, the national survey corroborates the findings from the South Australian survey with a large majority (83.5% of those aged 15 and over) self-assessing their health status as good, very good or excellent<sup>2</sup>.
- The South Australia rate was estimated to be below the Australia-wide rate of 85.2% and towards the lower end of the scale for the states and territories, although the differences are only small and may not be significant once margins for error in the estimation are taken into account<sup>2</sup>.

**Self-assessed health status is good, very good, or excellent (aged 15+ years), 2014–15**

State/Territory	%
Tasmania	80.8%
<b>South Australia</b>	<b>83.5%</b>
Victoria	84.5%
Queensland	84.6%
New South Wales	85.5%
Northern Territory	86.3%
Western Australia	87.5%
Australian Capital Territory	87.8%
<b>Australia</b>	<b>85.2%</b>



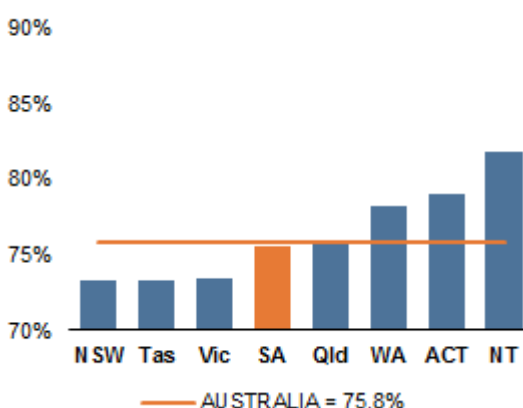
Data source: ABS 2016

**3-2-5. Health status of Aboriginal people**

- In 2012-13, 75.6% of Aboriginal people in South Australia aged 15 years and over self-assessed their health status as being good, very good, or excellent<sup>3</sup>.
- This is 7.9 percentage points below the 83.5% recorded for *all* South Australians aged 15 years or more in the ABS 2014-15 Australian Health Survey<sup>2</sup>.
- South Australia's proportion of Aboriginal people in good or better general health is effectively equivalent to the national average for Aboriginal people (75.8%)<sup>3</sup>.
- Please note that the graph below does not start at the origin to show detail.

**Aboriginal self-assessed health status is good, very good, or excellent (aged 15+ years), 2012-13**

State/Territory	%
New South Wales	73.3%
Tasmania	73.3%
Victoria	73.5%
<b>South Australia</b>	<b>75.6%</b>
Queensland	76.0%
Western Australia	78.2%
Australian Capital Territory	79.0%
Northern Territory	81.8%
<b>Australia</b>	<b>75.8%</b>



Data source: ABS 2014

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2016), 'Table 2.1 Summary health characteristics — States and territories, Persons (estimate)', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, 8 December 2015.



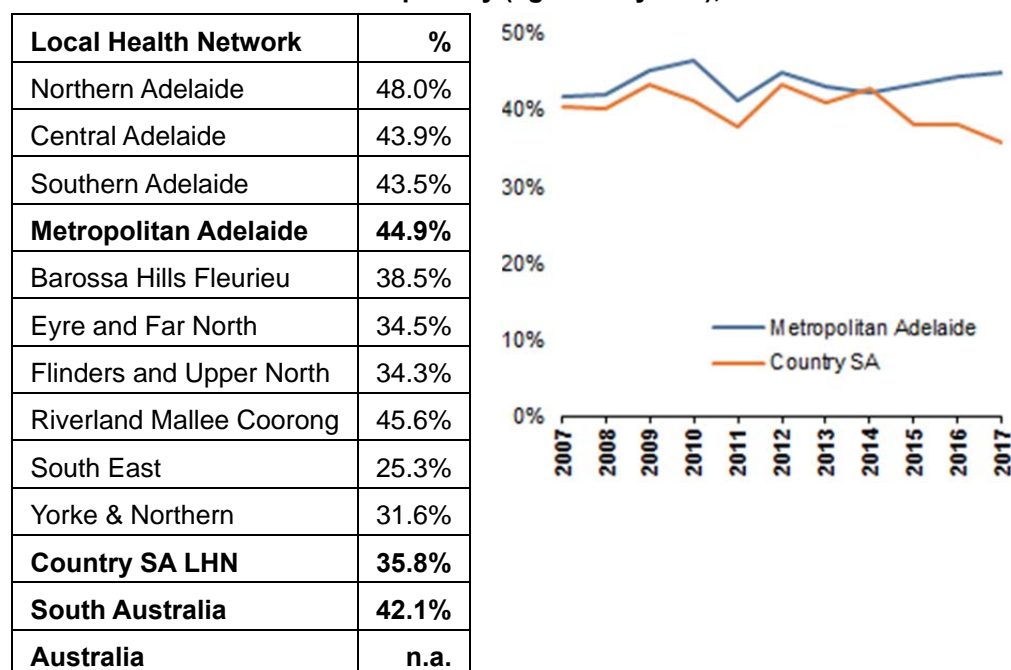
3. Based on Australian Bureau of Statistics (ABS 2014), 'Table 3.3 Selected health characteristics, by State/Territory, Proportion of Aboriginal and Torres Strait Islander persons', [\*Australian Aboriginal and Torres Strait Islander Health Survey: Updated Results, 2012-13\*](#), cat no 4727.0.55.006, 6 June 2014.

### 3-3. Nutrition – Fruit intake

#### 3-3-1. Fruit intake in South Australia – by Local Health Network

- In 2017, under half (42.1%) of South Australians aged 18 years or more reported eating the recommended two or more serves of fruit per day<sup>1</sup>.
- The rate varies between the local health networks (LHNs) from 25.3% in the South East LHN up to 48.0% in the Northern Adelaide LHN<sup>1</sup>.
- There is a statistically significant difference between the rate reported by people that live in metropolitan Adelaide (44.9%) compared to Country SA residents (35.8%)<sup>1</sup>.
- No statistically significant underlying trend over the last decade in the proportion of people reporting eating the recommended two or more serves of fruit per day was identified, either for metropolitan Adelaide or Country SA residents<sup>1</sup>.

#### Eat two or more serves of fruit per day (aged 18+ years), 2017



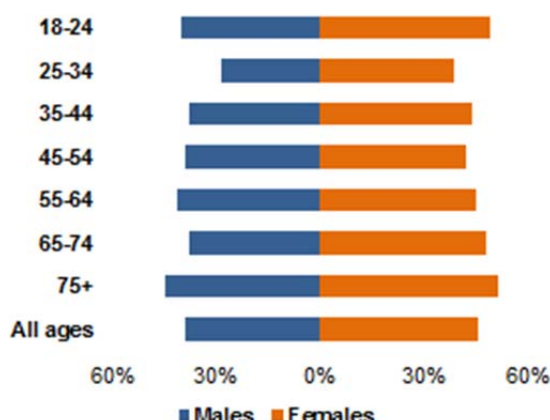
Data source: SA Health 2018

#### 3-3-2. Fruit intake in South Australia – by age and sex

- In 2017, the proportion of females in South Australia aged 18 years or more who reported eating two or more serves of fruit per day (45.6%) was 7.1 percentage points higher than their male counterparts (38.5%)<sup>1</sup>.
- The proportion also varies with age<sup>1</sup>.

**Eat two or more serves of fruit per day (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	40.1%	49.2%
25-34	28.3%	38.6%
35-44	37.3%	44.1%
45-54	39.0%	42.3%
55-64	41.3%	45.4%
65-74	37.4%	48.3%
75+	44.8%	51.7%
<b>All ages</b>	<b>38.5%</b>	<b>45.6%</b>



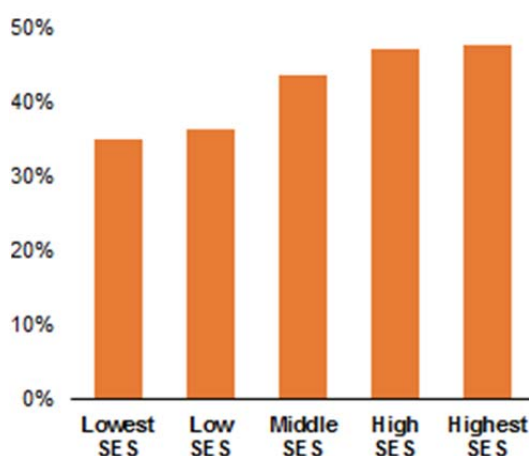
Data source: SA Health 2018

**3-3-3. Fruit intake in South Australia – by socio-economic status**

- There is statistically significant correlation between the proportion of people aged 18 years and over who report eating the recommended two or more serves of fruit per day and the socio-economic status of the area in which they live<sup>1</sup>.

**Eat two or more serves of fruit per day (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	34.9%
Low SES	36.1%
Middle SES	43.6%
High SES	46.9%
Highest SES	47.6%



Data source: SA Health 2018

**3-3-4. Fruit intake in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey and is not directly comparable to the information presented in 3-3-1 to 3-3-3 above which is sourced via the South Australian Monitoring and Surveillance System survey.
- However, the national survey corroborates the state-specific survey with around half (48.7%) of South Australian adults reporting eating the recommended two or more serves of fruit per day, a little higher than the 46.1% reported in the previous survey (2011-12)<sup>2</sup>.
- The South Australian rate is almost the same as the national rate of 49.8%. There was a little variation between the states and territories, and South Australia sits in the middle in comparison with the other jurisdictions<sup>2</sup>.

**Eat two or more serves of fruit per day (aged 18+ years), 2014–15**

State/Territory	%
Tasmania	47.1%
Northern Territory	47.4%
Victoria	48.0%
<b>South Australia</b>	<b>48.7%</b>
New South Wales	49.2%
Australian Capital Territory	49.7%
Queensland	51.2%
Western Australia	54.2%
<b>Australia</b>	<b>49.8%</b>



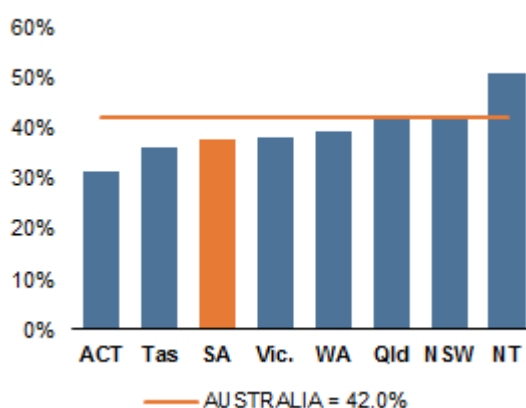
Data source: ABS 2015

**3-3-5. Fruit intake – Aboriginal people**

- In 2012-13, 37.8% of Aboriginal people in South Australia aged 15 years and over reported eating the recommended two or more serves of fruit per day<sup>3</sup>.
- This is 8.3 percentage points below the 46.1% recorded for *all* South Australians aged 15 years or more in the ABS 2011-12 Australian Health Survey (see 3-3-4 above)<sup>3</sup>.
- South Australia's proportion of Aboriginal people who eat the recommended two or more serves of fruit per day is also below the national average for Aboriginal people (42.0%)<sup>3</sup>.

**Eat two or more serves of fruit per day - Aboriginal people (aged 15+ years), 2012-13**

State/Territory	%
Australian Capital Territory	31.5%
Tasmania	36.3%
<b>South Australia</b>	<b>37.8%</b>
Victoria	38.0%
Western Australia	39.2%
Queensland	42.3%
New South Wales	42.5%
Northern Territory	51.0%
<b>Australia</b>	<b>42.0%</b>



Data source: ABS 2014

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 12.1 Daily intake of fruit and vegetables, Persons (estimate)' and in Tables 20-27 for each jurisdiction, [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 3 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2014), 'Table 3.3 Selected health characteristics, by State/Territory, Proportion of Aboriginal and Torres Strait Islander persons',

[\*Australian Aboriginal and Torres Strait Islander Health Survey: Updated Results, 2012-13\*](#), cat no 4727.0.55.006, viewed 18 August 2014.

### 3-4. Nutrition – Vegetable intake

#### Important notes on the data: 'Recommended' serves of vegetables per day under Australian Dietary Guidelines...

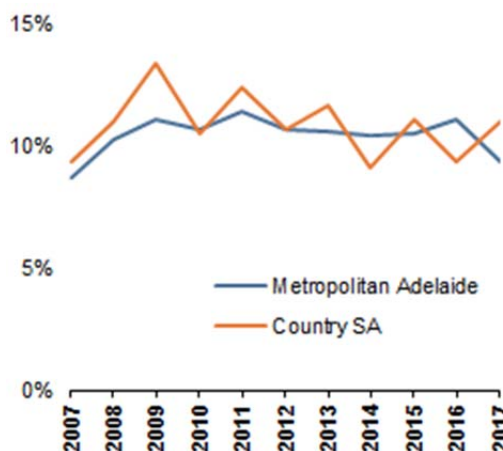
Due to changes in the Australian Dietary Guidelines 2013, five serves of vegetables per day is no longer the 'recommended' amount for all adults at all life stages. Depending on age and gender this can increase up to six serves for males aged 19 to 50 years and 7.5 serves for breastfeeding mothers. State of Our Health is reporting overall percentage of the South Australian population aged 18 years and over who eat five serves of vegetables per day for consistency with previous reports and other data sources such as the Australian Bureau of Statistics.

#### 3-4-1. Vegetable intake in South Australia – by Local Health Network

- In 2017, around one in ten (9.9%) South Australians aged 18 years or more reported eating five or more serves of vegetables per day<sup>1</sup>.
- The rate varies between local health networks (LHNs) from 5.6% in the Yorke and Northern LHN up to 14.0% in the Barossa Hills Fleurieu LHN.
- The rate for people that live in metropolitan Adelaide (9.4%) is statistically significantly lower compared to Country SA residents (11.0%)<sup>1</sup>.
- No statistically significant underlying trend over the last decade in the proportion of people reporting eating five or more serves of vegetables per day was identified, either for metropolitan Adelaide or Country SA residents.<sup>1</sup>

#### Eat five or more serves of vegetables per day (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	10.4%
Central Adelaide	9.9%
Southern Adelaide	7.9%
<b>Metropolitan Adelaide</b>	<b>9.4%</b>
Barossa Hills Fleurieu	14.0%
Eyre and Far North	7.9%*
Flinders and Upper North	10.2%*
Riverland Mallee Coorong	13.7%
South East	8.6%
Yorke & Northern	5.6%
<b>Country SA LHN</b>	<b>11.0%</b>
<b>South Australia</b>	<b>9.9%</b>
<b>Australia</b>	<b>n.a.</b>



\* Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

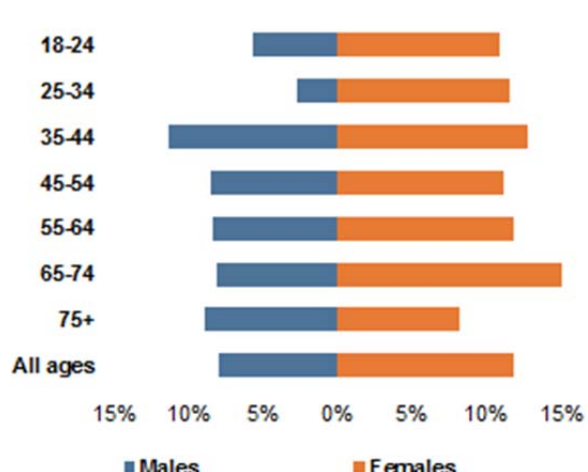
Data source: SA Health 2018

#### 3-4-2. Vegetable intake in South Australia – by age and sex

- In 2017, the proportion of females in South Australia aged 18 years or more who reported eating five or more serves of vegetables per day (11.9%) was higher than that of their male counterparts (7.9%)<sup>1</sup>.
- The proportion also varies with age<sup>1</sup>.

**Eat five or more serves of vegetables per day (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	5.6%	10.9%
25-34	2.7%	11.6%
35-44	11.3%	12.8%
45-54	8.4%	11.2%
55-64	8.4%	11.8%
65-74	8.0%	15.9%
75+	8.8%	8.2%
<b>All ages</b>	<b>7.9%</b>	<b>11.9%</b>



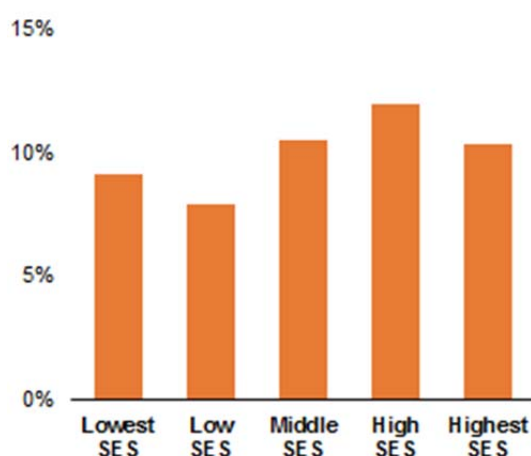
Data source: SA Health 2018

**3-4-3. Vegetable intake in South Australia – by socio-economic status**

- There is no statistically significant correlation between the proportion of people aged 18 years and over who reported eating five or more serves of vegetables per day and the socio-economic status of the area in which they live<sup>1</sup>.
- The proportion recorded in areas constituting South Australia's highest socio-economic (SES) quintile (10.3%) is around one percentage points higher than that of the lowest SES quintile (9.1%)<sup>1</sup>.

**Eat five or more serves of vegetables per day (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	9.1%
Low SES	7.9%
Middle SES	10.4%
High SES	11.9%
Highest SES	10.3%



Data source: SA Health 2018

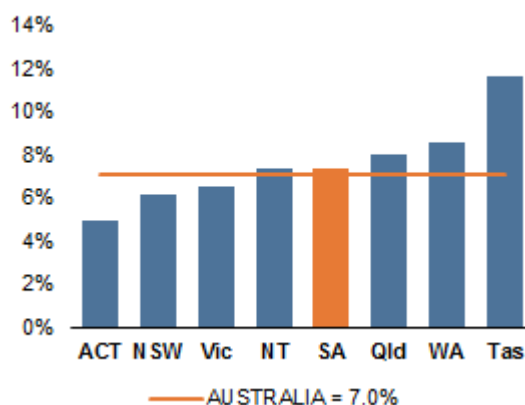
**3-4-4. Vegetable intake in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people aged 18 years and over and is not directly comparable to the information presented in 3-4-1 to 3-4-3 above which is sourced via the South Australian Monitoring and Surveillance System survey.
- However, the national survey broadly corroborates the state-specific survey, with an estimated one in 14 (7.3%) of South Australian adults self-reporting eating five or more serves of vegetables per day, a little lower than the 10.0% reported in the previous survey (for 2011-12)<sup>2</sup>.

- The South Australian rate is almost the same as the national rate of 7.0%. Most of the states and territories sit within a similar range, but Tasmanians do have a notably higher fraction of the population (11.6%)<sup>2</sup>.

### Eat five or more serves of vegetables per day (aged 18+ years), 2014–15

State/Territory	%
Australian Capital Territory	5.0%
New South Wales	6.1%
Victoria	6.5%
Northern Territory	7.3%
<b>South Australia</b>	<b>7.3%</b>
Queensland	8.0%
Western Australia	8.5%
Tasmania	11.6%
<b>Australia</b>	<b>7.0%</b>



Data source: ABS 2015

### 3-4-5. Vegetable intake – Aboriginal people

- In 2012-13, just 4.1% of Aboriginal people in South Australia aged 15 years and over reported eating five or more serves of vegetables per day<sup>3</sup>.
- This is less than half of the 10.0% rate recorded for *all* South Australians aged 15 years or more in the ABS 2011-12 Australian Health Survey (see 3-4-4 above)<sup>3</sup>.
- South Australia's proportion of Aboriginal people who eat five or more serves of vegetables per day is also below the national average for Aboriginal people (4.8%)<sup>3</sup>.

### Eat five or more serves of vegetables per day - Aboriginal people (aged 15+ years), 2012-13

State/Territory	%
Northern Territory	2.9%
Australian Capital Territory	4.1%
<b>South Australia</b>	<b>4.1%</b>
Queensland	4.4%
Western Australia	4.9%
Victoria	5.3%
New South Wales	5.6%
Tasmania	6.6%
<b>Australia</b>	<b>4.8%</b>



Data source: ABS 2014

### Sources

- Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.



2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 12.1 Daily intake of fruit and vegetables, Persons (estimate)' and in Tables 20-27 for each jurisdiction, [\*National Health Survey: First Results, 2014-15\*](#), cat. no. 4364.0.55.001, viewed 3 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2014), 'Table 3.3 Selected health characteristics, by State/Territory, Proportion of Aboriginal and Torres Strait Islander persons', [\*Australian Aboriginal and Torres Strait Islander Health Survey: Updated Results, 2012-13\*](#), cat no 4727.0.55.006, viewed 18 August 2014.

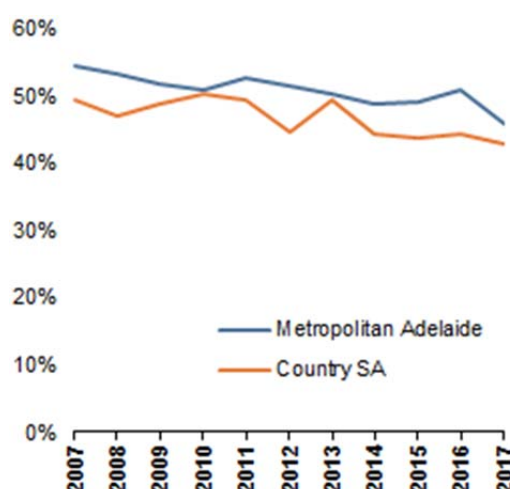
### 3-5. Physical activity (exercise)

#### 3-5-1. Physical activity in South Australia – by Local Health Network

- In 2017, under half (45.0%) of South Australians aged 18 years and older reported undertaking 150 minutes or more of walking, moderate or vigorous physical activity in the week prior to the survey<sup>1</sup>.
- The rate varies between local health networks (LHNs), from 26.2% in the Flinders and Upper North LHN up to 49.7% in the Barossa Hills Fleurieu LHN.
- The rate in metropolitan Adelaide (45.9%) is statistically significantly higher compared to Country SA (42.9%)<sup>1</sup>.
- A statistically significant declining trend over the last decade in the proportion of people reporting undertaking 150 minutes of physical activity per week was identified, both for metropolitan Adelaide and Country SA residents.<sup>1</sup>

#### Undertake at least 150 minutes of moderate or vigorous physical activity per week (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	42.3%
Central Adelaide	48.8%
Southern Adelaide	45.6%
<b>Metropolitan Adelaide</b>	<b>45.9%</b>
Barossa Hills Fleurieu	49.7%
Eyre and Far North	42.6%
Flinders and Upper North	26.2%
Riverland Mallee Coorong	39.6%
South East	36.3%
Yorke & Northern	43.6%
<b>Country SA</b>	<b>42.9%</b>
<b>South Australia</b>	<b>45.0%</b>
<b>Australia</b>	<b>n.a.</b>



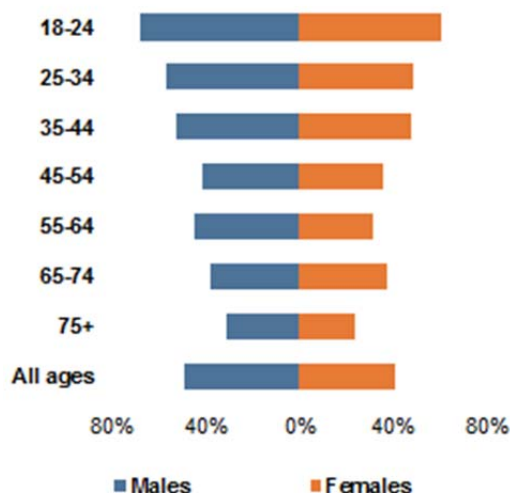
Data source: SA Health 2018

#### 3-5-2. Physical activity in South Australia – by age and sex

- In 2017, the proportion of males in South Australia aged 18 years or more who reported undertaking 150 minutes or more of walking, moderate or vigorous physical activity in the week prior to the survey (49.4%) was higher than their female counterparts (41.0%)<sup>1</sup>.
- The proportion is also inversely correlated with age<sup>1</sup>.

### Undertake at least 150 minutes of moderate or vigorous physical activity per week (aged 18+ years), 2017

Age (years)	Males	Females
18-24	68.5%	61.2%
25-34	56.7%	48.5%
35-44	52.9%	47.8%
45-54	41.2%	36.1%
55-64	44.8%	31.7%
65-74	38.4%	38.1%
75+	31.4%	24.1%
<b>All ages</b>	<b>49.4%</b>	<b>41.0%</b>



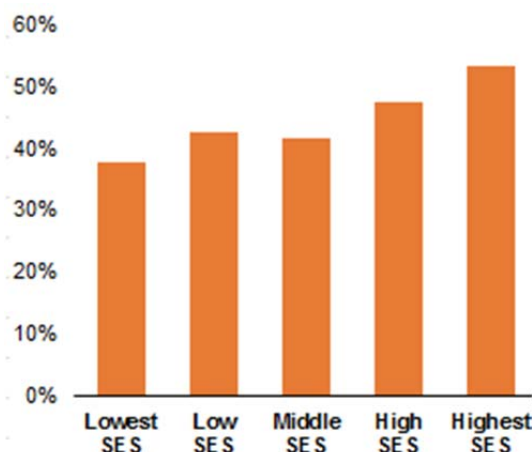
Data source: SA Health 2018

### 3-5-3. Physical activity in South Australia – by socio-economic status

- In 2017 there was a statistically significant correlation between the proportion of people aged 18 years and over who reported undertaking 150 minutes or more of walking, moderate or vigorous physical activity in the week prior to the survey and the socio-economic status of the area in which they live<sup>1</sup>.
- The proportion recorded in areas constituting South Australia's top socio-economic (SES) quintile (53.1%) is 15.5 percentage points higher than the lowest SES quintile (37.6%)<sup>1</sup>.

### Undertake at least 150 minutes of moderate or vigorous physical activity per week (aged 18+ years), 2017

Socio-economic status (SES)	%
Lowest SES	37.6%
Low SES	42.4%
Middle SES	41.7%
High SES	47.4%
Highest SES	53.1%



Data source: SA Health 2018

### 3-5-4. Physical activity in Australia – by state and territory

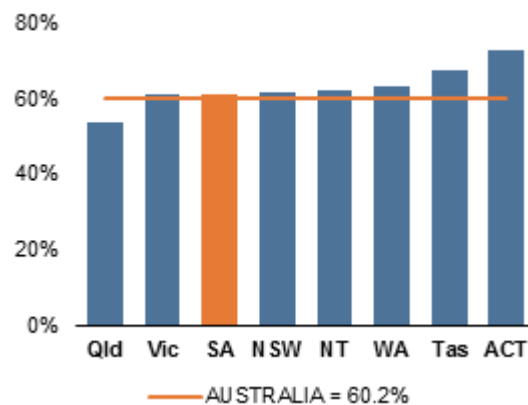
- Data presented here is from the Australian Bureau of Statistics' 2013-14 Participation in Sport and Physical Activity survey of people aged 15 years. It is therefore not directly comparable to the information presented in 3-5-1 to 3-5-3 above from the South Australian Monitoring and Surveillance System survey.
- The national survey found that three out of every five (60.9%) South Australians aged 15 years and over participated in a sport or physical activity at least once during the 12 months

prior to the survey. This is slightly lower than the 62.3% reported in the previous release of survey data (for 2011-12)<sup>2</sup>.

- The South Australian rate is about the same as the Australia-wide rate of 60.2% and, although higher than Queensland, is towards the lower end of the scale when considered against the other states and territories<sup>2</sup>.

### Participated in a sport or physical recreational activity at least once in previous year (aged 15+ years), 2013-14

State/Territory	%
Queensland	53.6%
Victoria	60.9%
<b>South Australia</b>	<b>60.9%</b>
New South Wales	61.4%
Northern Territory	62.1%
Western Australia	63.0%
Tasmania	67.3%
Australian Capital Territory	72.9%
<b>Australia</b>	<b>60.2%</b>



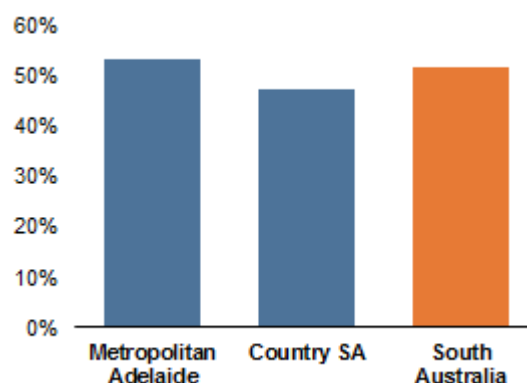
Data source: ABS 2015

### 3-5-5. Physical activity – Aboriginal people

- In 2012, just over half of Aboriginal people in South Australia aged 15 years or more reported undertaking sufficient physical activity – 150 minutes or more of walking, moderate or vigorous physical activity – in the week prior to the survey<sup>3</sup>.
- However, the rates varied across the regions of South Australia covered by the survey, with metropolitan Adelaide recording the highest rate at 53.3% and Remote SA recording the lowest at 37.9%<sup>3</sup>.
- The overall Country SA rate of 47.3% is not statistically significantly lower than the metropolitan Adelaide rate of 53.3%<sup>3</sup>.

### Undertake sufficient physical activity per week - Aboriginal people (aged 15+ years), 2012

Region	%
<b>Metropolitan Adelaide</b>	<b>53.3%</b>
Rural SA	51.1%
Remote SA	37.9%*
<b>Country SA</b>	<b>47.3%</b>
<b>South Australia</b>	<b>51.6%</b>
Australia	n.a.



\* Survey did not include APY Lands

Data source: University of Adelaide 2012

## Sources

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2 PERSONS PARTICIPATING IN SPORT AND PHYSICAL RECREATION, Top 55 activities, By sex', [Participation in Sport and Physical Recreation, Australia, 2013-14](#), cat. no. 4177.0, viewed 1 June 2016.
3. Based on Taylor, A, Marin, T, Avery, J & Dal Grande, E 2012, 'Appendix A: A10.3 Physical activity,' *South Australian Aboriginal health survey*, Population research and outcome studies, University of Adelaide, Adelaide.

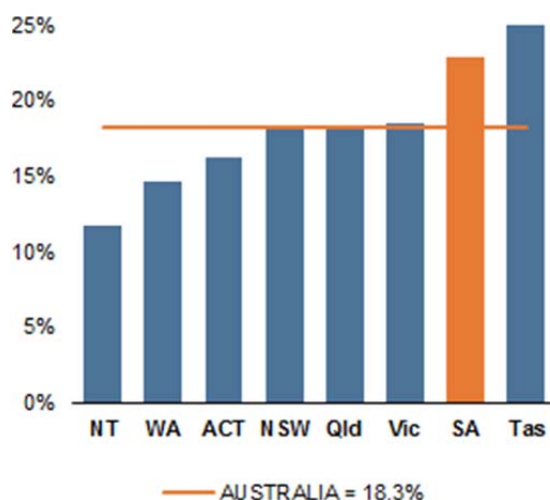
### 3-6. Disability

#### 3-6-1. Disability in South Australia

- In 2015, around one in four (22.9%) South Australians of all ages reported having a disability – defined here as a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities<sup>1</sup>.
- The South Australian rate is above the national average of 18.3%, and ranks second-highest of the states and territories<sup>1</sup>.

#### Prevalence of disability (all ages), 2015

State/Territory	%
Northern Territory	11.7%
Australian Capital Territory	14.6%
Western Australia	16.2%
Queensland	18.1%
New South Wales	18.3%
Victoria	18.5%
<b>South Australia</b>	<b>22.9%</b>
Tasmania	25.8%
<b>Australia</b>	<b>18.3%</b>



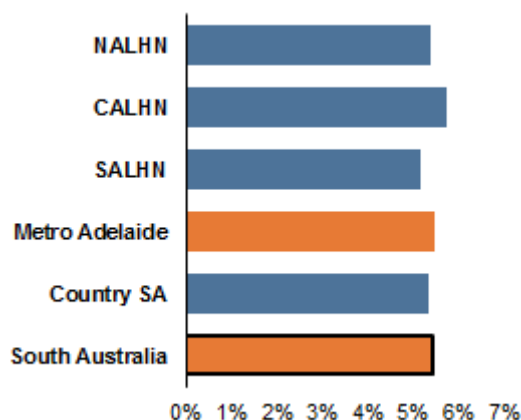
Data source: ABS 2017a

#### 3-6-2. Need for assistance due to profound or severe disability in South Australia – by Local Health Network

- As at the 2016 Census, around one in 16 (6.0%) of South Australians of all ages reported being in need of assistance with core activities due to profound or severe disability<sup>2</sup>.
- South Australia's rate is more than the national average of 5.1%, and ranks it second-highest of the states and territories<sup>2</sup>.

#### Need assistance with core activities due to profound or severe disability (all ages), 2011

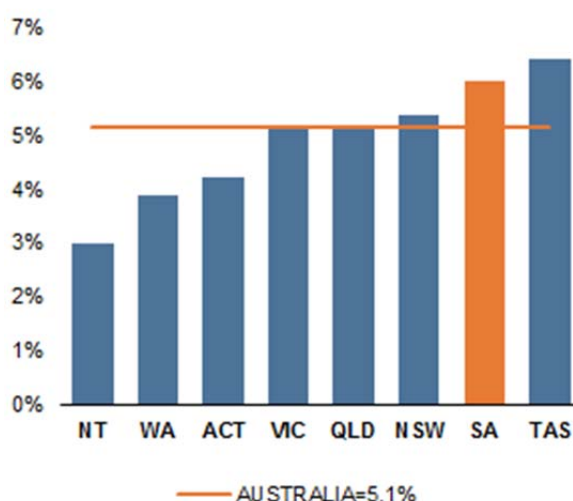
Local Health Network	%
Northern Adelaide	5.4%
Central Adelaide	5.7%
Southern Adelaide	5.2%
<b>Metropolitan Adelaide</b>	<b>5.5%</b>
<b>Country SA LHN</b>	<b>5.4%</b>
<b>South Australia</b>	<b>5.5%</b>



Data source: ABS 2017b

**Need assistance with core activities due to profound or severe disability (all ages), 2016**

State/Territory	%
Northern Territory	3.0%
Western Australia	3.9%
Australian Capital Territory	4.2%
Victoria	5.1%
Queensland	5.2%
New South Wales	5.4%
<b>South Australia</b>	<b>6.0%</b>
Tasmania	6.4%
<b>Australia</b>	<b>5.1%</b>



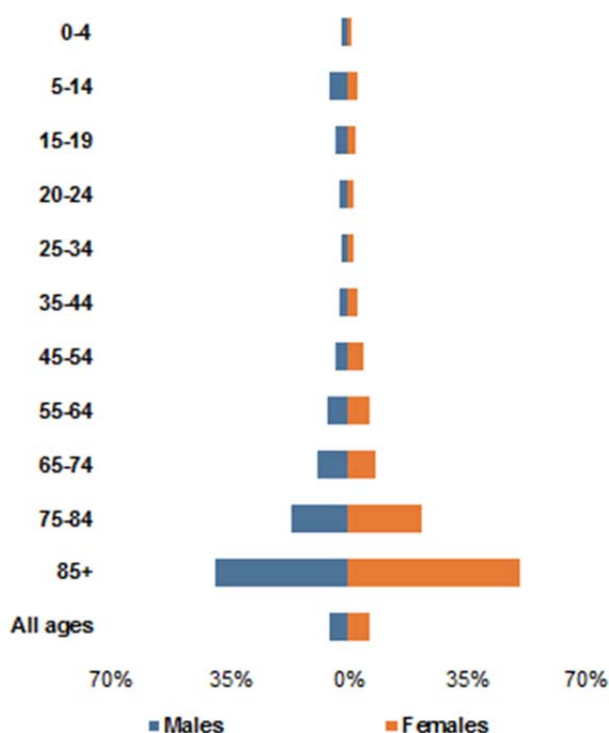
Data source: ABS 2017b

**3-6-3. Need for assistance due to profound or severe disability in South Australia – by age and sex**

- As at the 2016 Census, the proportion of males in South Australia of all ages who reported needing assistance with core activities due to profound or severe disability (5.6%) was slightly lower than their female counterparts (6.4%)<sup>2</sup>.
- The proportion increases significantly with age, with the highest rate among both males and females belonging to the 85 years and over age cohort (39.3% and 50.9%, respectively)<sup>2</sup>.

**Need assistance with core activities due to profound or severe disability (all ages), 2016**

Age (years)	Males	Females
0-14	1.9%	1.1%
5-14	5.7%	2.7%
15-19	3.8%	2.2%
20-24	2.4%	1.8%
25-34	2.1%	1.8%
35-44	2.6%	2.7%
45-54	3.9%	4.3%
55-64	5.9%	6.1%
65-74	9.0%	8.3%
75-84	16.8%	21.9%
85+	39.3%	50.9%
<b>All ages</b>	<b>5.6%</b>	<b>6.4%</b>



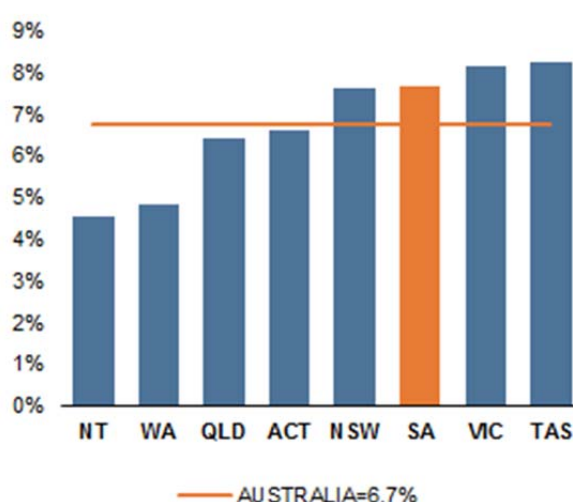
Data source: ABS 2017b

### 3-6-4. Need for assistance due to profound or severe disability in South Australia – Aboriginal people

- As at the 2016 Census, the 7.7% of Aboriginal people in South Australia of all ages requiring assistance with core activities due to profound or severe disability was above the national average for Aboriginal people of 6.7%<sup>3</sup>.
- South Australia was ranked third highest for this indicator when compared to all states and territories<sup>3</sup>.
- The variation between the states and territories for this indicator was relatively small, ranging from 4.5% in the Northern Territory to 8.3% in Tasmania<sup>3</sup>.
- The gap between Aboriginal and all-person prevalence of need for assistance due to profound or severe disability was relatively small, with the all-person rate at 6.0% (see above)<sup>3</sup>.

#### Need assistance with core activities due to profound or severe disability - Aboriginal people (all ages), 2016

State/Territory	%
Northern Territory	4.5%
Western Australia	4.9%
Queensland	6.4%
Australian Capital Territory	6.6%
New South Wales	7.6%
<b>South Australia</b>	<b>7.7%</b>
Victoria	8.2%
Tasmania	8.3%
<b>Australia</b>	<b>6.7%</b>



Data source: ABS 2017c

#### Sources

1. Based on Australian Bureau of Statistics (ABS 2017a), 'Table 4.1 All persons, disability rates by sex and selected demographic characteristics—2015, proportion of persons', Data Cubes, 'Disability Tables', [Disability, Ageing and Carers, Australia: Summary of Findings, 2015](#), cat. no. 44300DO001\_2012, viewed 23 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2017b), 'Table G18 CORE ACTIVITY NEED FOR ASSISTANCE(a) BY AGE BY SEX', 'General Community Profile', [2016 Census Community Profiles](#), viewed 23 August 2018.
3. Based on Australian Bureau of Statistics (ABS 2017c), 'Table I08 CORE ACTIVITY NEED FOR ASSISTANCE(a) BY AGE BY SEX FOR ABORIGINAL AND/OR TORRES STRAIT ISLANDER PERSONS', 'Aboriginal and Torres Strait Islander Peoples Profile', [2016 Census Community Profiles](#), viewed 23 August 2018.



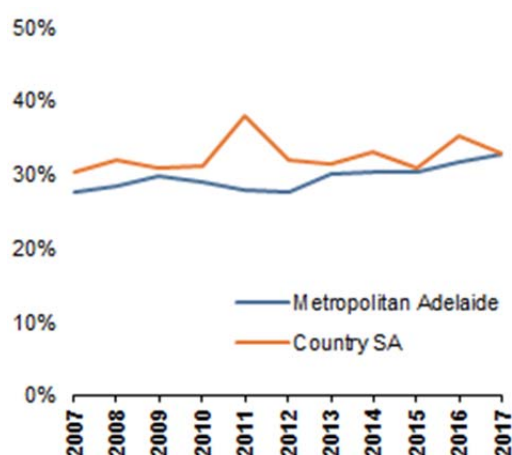
### 3-7. People living with multiple risk factors

#### 3-7-1. People living with multiple risk factors in South Australia – by Local Health Network

- In 2017, around a third (32.7%) of South Australians aged 18 years or more were living with two or more of the following risk factors: (i) current high blood pressure; (ii) current high cholesterol; (iii) undertakes less than 150 minutes per week of walking, moderate or vigorous physical activity; (iv) overweight or obese; (v) current smoker; (vi) long-term alcohol risk; and/or (vii) insufficient consumption of fruit and vegetables<sup>1</sup>.
- The rate varies between the local health networks (LHNs) from 23.3% in the Barossa Hills Fleurieu LHN to 47.4% in the Eyre and Far North LHN<sup>1</sup>.
- The proportion of people that live with multiple risk factors in Country SA (32.7%) is equivalent to metropolitan Adelaide (also 32.7%)<sup>1</sup>.
- A statistically significant increasing trend over the last decade in the proportion of people reporting living with two or more risk factors was identified in the metropolitan Adelaide time series but not for Country SA<sup>1</sup>.

#### Living with two or more risk factors (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	41.8%
Central Adelaide	29.6%
Southern Adelaide	29.5%
<b>Metropolitan Adelaide</b>	<b>32.7%</b>
Barossa Hills Fleurieu	23.3%
Eyre and Far North	47.4%
Flinders and Upper North	39.1%
Riverland Mallee Coorong	39.7%
South East	37.4%
Yorke & Northern	32.8%
<b>Country SA</b>	<b>32.7%</b>
<b>South Australia</b>	<b>32.7%</b>
<b>Australia</b>	<b>n.a.</b>



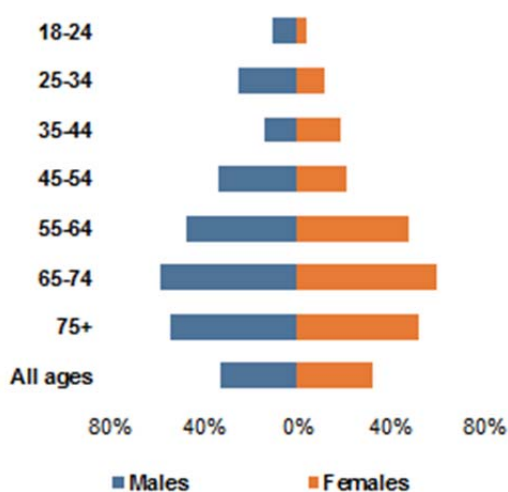
Data source: SA Health 2018

#### 3-7-2. People living with multiple risk factors in South Australia – by age and sex

- In 2017, the proportion of males (33.2%) living with two or more of the following risk factors: (i) current high blood pressure; (ii) current high cholesterol; (iii) undertakes less than 150 minutes per week of walking, moderate or vigorous physical activity; (iv) overweight or obese; (v) current smoker; (vi) long-term alcohol risk; and/or (vii) insufficient consumption of fruit and vegetables was statistically not significantly higher than the female rate (32.3%)<sup>1</sup>.
- The proportion is correlated with age<sup>1</sup>.

**Living with two or more risk factors (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	10.8%	4.0%
25-34	25.2%	12.2%
35-44	13.5%	18.8%
45-54	33.6%	21.0%
55-64	47.8%	47.9%
65-74	59.0%	60.0%
75+	54.1%	52.7%
<b>All ages</b>	<b>33.2%</b>	<b>32.3%</b>



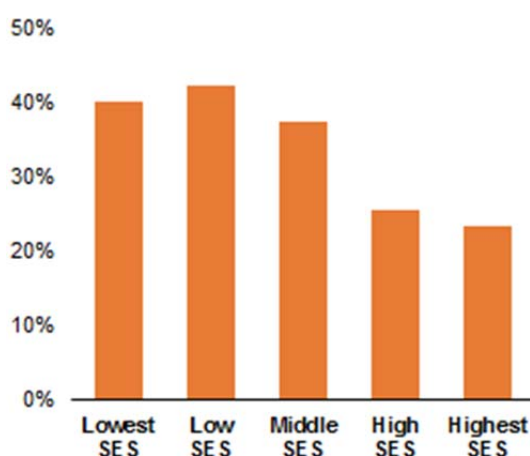
Data source: SA Health 2018

**3-7-3. People living with multiple risk factors in South Australia – by socio-economic status**

- There is a statistically significant inverse correlation between the proportion of people aged 18 years and over living with two or more of the following risk factors: (i) current high blood pressure; (ii) current high cholesterol; (iii) undertakes less than 150 minutes per week of walking, moderate or vigorous physical activity; (iv) overweight or obese; (v) current smoker; (vi) long-term alcohol risk; and/or (vii) insufficient consumption of fruit and vegetables and the socio-economic status of the area in which they live<sup>1</sup>.
- The proportion recorded in areas constituting South Australia's highest socio-economic (SES) quintile (23.2%) is around half that for the lowest SES quintile (40.1%)<sup>1</sup>.

**Living with two or more risk factors (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	40.1%
Low SES	42.2%
Middle SES	37.3%
High SES	25.5%
Highest SES	23.2%



Data source: SA Health 2018

**3-7-4. People living with multiple risk factors – by state and territory**

Data not available for this indicator.

### **3-7-5. Aboriginal people living with multiple risk factors**

Data not available for this indicator.

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#### **Sources**

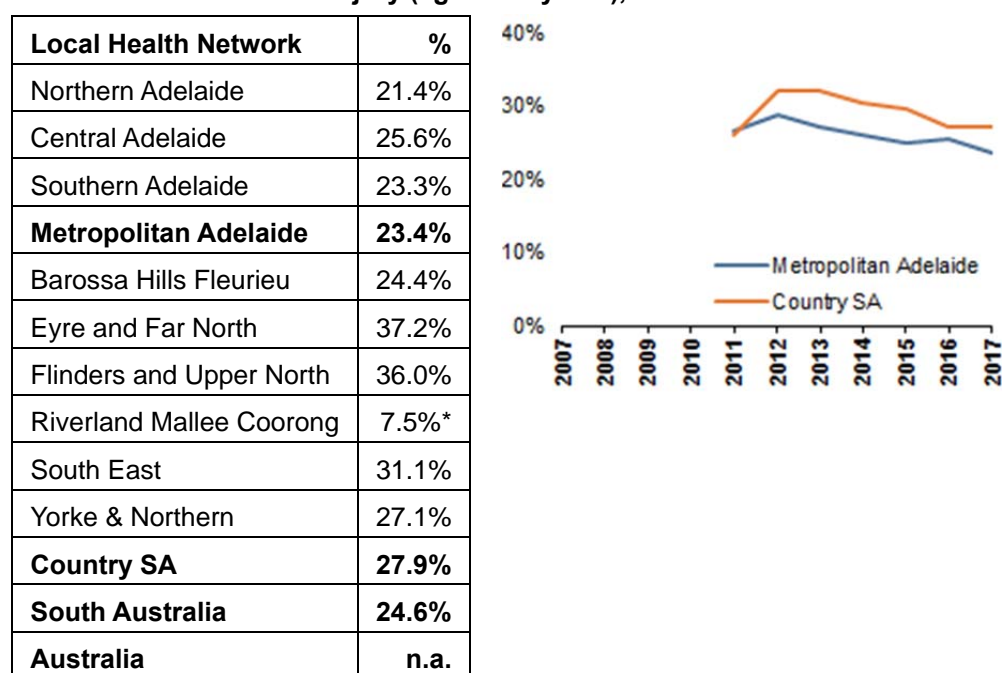
1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.

### 3-8. Alcohol-related risk

#### 3-8-1. Alcohol-related single occasion injury risk in South Australia – by Local Health Network

- Under current guidelines on alcohol consumption produced by the National Health and Medical Research Council (NHMRC), for healthy men and women, drinking no more than **four standard drinks on a single occasion at least monthly** reduces the **risk of alcohol-related injury** arising from that occasion.
- In 2017, around a quarter (24.6%) of South Australians aged 15 years or more reported drinking more than four standard alcoholic drinks on a single occasion at least monthly, putting them at risk of alcohol-related injury<sup>1</sup>.
- The rate varies between the local health networks (LHNs), from 7.5%\* in the Riverland Mallee Coorong LHN to 37.2% in the Eyre and Far North LHN<sup>1</sup>.
- Please note that SA Health LHN geographies differ from Australian Bureau of Statistics SA4 regions reported elsewhere.
- The rate reported by people that live in Country SA (27.9%) is statistically significantly higher compared to metropolitan Adelaide (23.4%)<sup>1</sup>.
- A statistically significant downward trend was identified in the time series of available data for metropolitan Adelaide but not Country SA<sup>1</sup>.
- Please note that data prior to 2011 is not available.

#### At risk of alcohol-related injury (aged 15+ years), 2017



N.B. SA Health local health network geographies differ from Australian Bureau of Statistics SA4 regions reported elsewhere.

\* Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

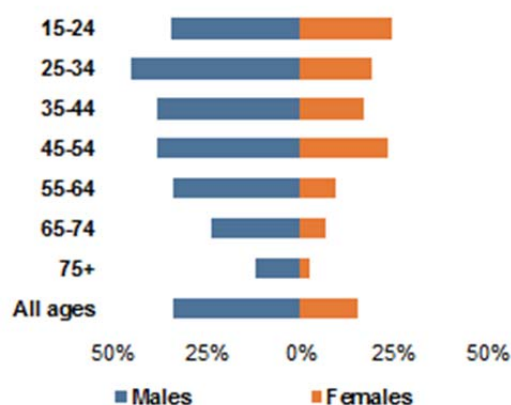
Data source: SA Health 2018

#### 3-8-2. Alcohol-related single occasion injury risk in South Australia – by age and sex

- Under current guidelines on alcohol consumption produced by the National Health and Medical Research Council (NHMRC), for healthy men and women, drinking no more than **four standard drinks on a single occasion at least monthly** reduces the **risk of alcohol-related injury** arising from that occasion.
- In 2017, the proportion of males aged 15 years or more who reported drinking on a single occasion at least monthly at levels that puts them at risk of alcohol-related injury (34.1%) was more than double the female rate (15.5%)<sup>1</sup>.

**At risk of alcohol-related injury (aged 15+ years), 2017**

Age (years)	Males	Females
15-24	34.6%	24.4%
25-34	45.4%	19.1%
35-44	38.1%	17.2%
45-54	38.1%	23.3%
55-64	33.7%	9.7%
65-74	23.8%	6.7%
75+	11.7%	2.7%
<b>All ages</b>	<b>34.1%</b>	<b>15.5%</b>



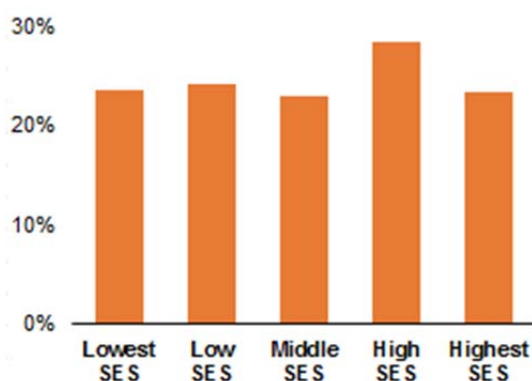
Data source: SA Health 2018

**3-8-3. Alcohol-related single occasion injury risk in South Australia – by socio-economic status**

- Under current guidelines on alcohol consumption produced by the National Health and Medical Research Council (NHMRC), for healthy men and women, drinking no more than **four standard drinks on a single occasion at least monthly** reduces the **risk of alcohol-related injury** arising from that occasion.
- There is no clear correlation between proportion of people aged 15 years or more who report drinking on a single occasion at least monthly that puts them at risk of alcohol-related injury and the socio-economic status (SES) of the area in which they live<sup>1</sup>.

**At risk of alcohol-related injury (aged 15+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	23.6%
Low SES	24.2%
Middle SES	23.0%
High SES	28.5%
Highest SES	23.3%



Data source: SA Health 2018

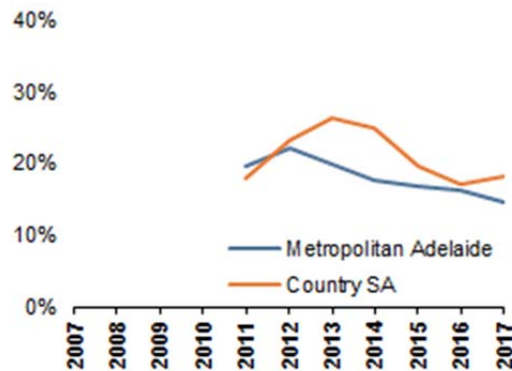
**3-8-4. Alcohol-related lifetime risk in South Australia – by Local Health Network**

- Under current guidelines on alcohol consumption produced by the National Health and Medical Research Council (NHMRC), for healthy men and women, drinking no more than **two standard drinks on any day** reduces the **lifetime risk** of harm from alcohol-related disease or injury.
- In 2017, roughly one in six (15.6%) South Australians aged 15 years or more reported drinking more than two standard alcoholic drinks on any day, putting them at lifetime risk of harm from alcohol-related disease or injury<sup>1</sup>.
- The rate varies between local health networks (LHNs), from 9.9%\* in the Riverland Mallee Coorong LHN to 31.1% in the Eyre and Far North LHN<sup>1</sup>.
- Please note that SA Health LHN geographies differ from Australian Bureau of Statistics SA4 regions reported elsewhere.

- The rate reported by people that live in Country SA (19.1%) is statistically significantly higher compared to metropolitan Adelaide (14.4%)<sup>1</sup>.
- A statistically significant downward trend was identified in the time series of available data for metropolitan Adelaide but not Country SA<sup>1</sup>.
- Please note that data prior to 2011 is not available.

#### At lifetime risk of alcohol-related disease or injury (aged 15+ years), 2017

Local Health Network	%
Northern Adelaide	14.2%
Central Adelaide	15.5%
Southern Adelaide	13.6%
<b>Metropolitan Adelaide</b>	<b>14.4%</b>
Barossa Hills Fleurieu	15.3%
Eyre and Far North	31.1%
Flinders and Upper North	26.8%
Riverland Mallee Coorong	9.9%*
South East	18.1%
Yorke & Northern	16.4%
<b>Country SA</b>	<b>19.1%</b>
<b>South Australia</b>	<b>15.6%</b>
<b>Australia</b>	<b>n.a.</b>



N.B. SA Health local health network geographies differ from Australian Bureau of Statistics SA4 regions reported elsewhere.

\* Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

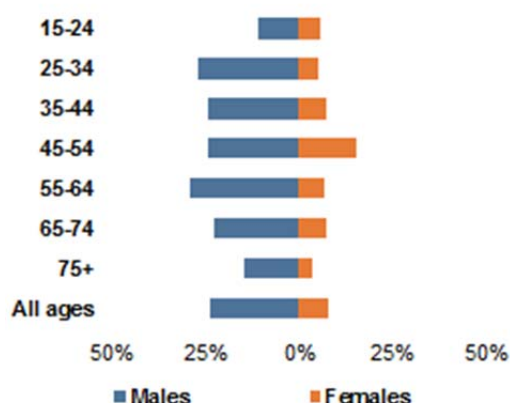
Data source: SA Health 2018

#### 3-8-5. Alcohol-related lifetime risk in South Australia – by age and sex

- Under current guidelines on alcohol consumption produced by the National Health and Medical Research Council (NHMRC), for healthy men and women, drinking no more than **two standard drinks on any day** reduces the **lifetime risk** of harm from alcohol-related disease or injury.
- In 2017, around a quarter (23.7%) of males aged 15 years or more reported drinking on a day at levels that puts them at lifetime risk of alcohol-related disease or injury, more than triple the corresponding female rate (7.8%)<sup>1</sup>.
- The disproportionate levels of lifetime risk of harm from alcohol for males compared to females is recorded across all age cohorts<sup>1</sup>.

**At lifetime risk of alcohol-related disease or injury (aged 15+ years), 2017**

Age (years)	Males	Females
15-24	10.7%	5.9%
25-34	26.9%	5.3%
35-44	24.1%	7.6%
45-54	24.1%	15.6%
55-64	29.2%	6.9%
65-74	22.5%	7.4%
75+	14.7%	3.8%
<b>All ages</b>	<b>23.7%</b>	<b>7.8%</b>



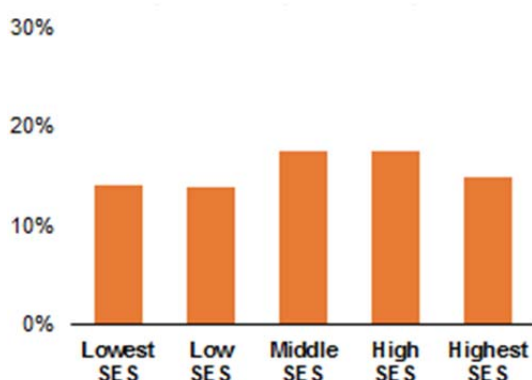
Data source: SA Health 2018

**3-8-6. Alcohol-related lifetime risk in South Australia – by socio-economic status**

- Under current guidelines on alcohol consumption produced by the National Health and Medical Research Council (NHMRC), for healthy men and women, drinking no more than **two standard drinks on any day** reduces the **lifetime risk** of harm from alcohol-related disease or injury.
- There is no clear correlation between proportion of people aged 15 years or more who report drinking at levels that put them at a lifetime risk of harm from alcohol and the socio-economic status (SES) of the area in which they live<sup>1</sup>.

**At lifetime risk of alcohol-related disease or injury (aged 15+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	14.1%
Low SES	13.8%
Middle SES	17.4%
High SES	17.4%
Highest SES	14.9%



Data source: SA Health 2018

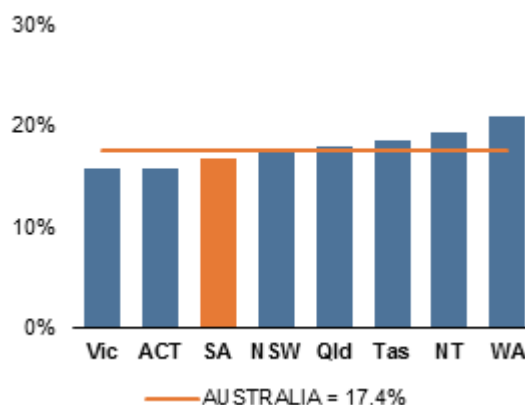
**3-8-7. Long-term risk of harm from alcohol – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people aged 18 years and over. Therefore it is not directly comparable to the information presented in 3-8-4 to 3-8-6 above from the South Australian Health Omnibus Survey which is for persons aged 15 years and over. However, the survey uses the same guidelines on alcohol consumption produced by the National Health and Medical Research Council (NHMRC). i.e., that for healthy men and women, drinking no more than **two standard drinks on any day** reduces the **lifetime risk** of harm from alcohol-related disease or injury.
- The national survey found that about one in six (16.8%) of South Australians aged 18 years and over had average daily consumption of alcohol that puts them at lifetime risk of alcohol-related disease or injury. This is a reduction from the 18.1% reported in the previous survey (for 2011-12)<sup>2</sup>.

- The rate for South Australians was at the lower end nationally, only Victoria and the Australian Capital Territory having lower reported rates<sup>2</sup>.

### Average daily alcohol consumption exceeding lifetime risk guidelines (aged 18+ years), 2014-15

State/Territory	%
Victoria	15.6%
Australian Capital Territory	15.7%
<b>South Australia</b>	<b>16.8%</b>
New South Wales	17.6%
Queensland	18.0%
Tasmania	18.6%
Northern Territory	19.3%
Western Australia	20.8%
<b>Australia</b>	<b>17.4%</b>



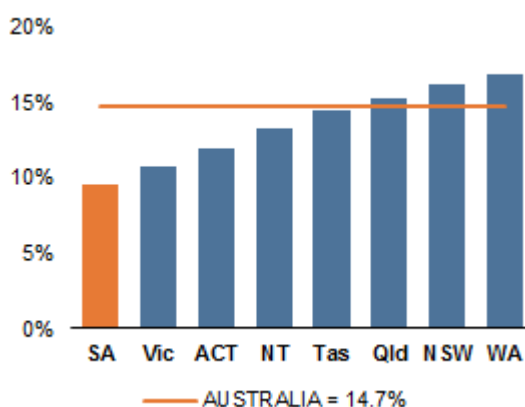
Data source: ABS 2015

### 3-8-8. Long-term risk of harm from alcohol – Aboriginal people

- Under current guidelines on alcohol consumption produced by the National Health and Medical Research Council (NHMRC), for healthy men and women, drinking no more than **two standard drinks on any day** reduces the **lifetime risk** of harm from alcohol-related disease or injury.
- Less than one in ten (9.6%) Aboriginal people in South Australia aged 15 years or more reported exceeding lifetime risk guidelines (2009 NHMRC guidelines) for alcohol consumption, well below the national average for Aboriginal people of 14.7%<sup>3</sup>.
- Compared to Aboriginal people aged 15 years and over in other states and territories, South Australia was ranked the lowest for this indicator<sup>3</sup>.
- The 2014-15 rate for Aboriginal people (ages 15 years and over) of 9.6% was also below the 2014-15 all-population rate reported above in 3-8-7 for South Australia (ages 18 years and over) of 16.8%<sup>3</sup>.

### At lifetime risk of alcohol-related disease or injury - Aboriginal people (aged 15+ years), 2014-15

State/Territory	%
<b>South Australia</b>	<b>9.6%</b>
Victoria	10.8%
Australian Capital Territory	12.0%
Northern Territory	13.3%
Tasmania	14.5%
Queensland	15.2%
New South Wales	16.2%
Western Australia	16.8%
<b>Australia</b>	<b>14.7%</b>



Data source: ABS 2016



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## Sources

1. Based on Health Omnibus Survey customised extract 2018, Drug and Alcohol Services South Australia, SA Health, Adelaide, 24 July 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 10.1 Alcohol consumption — Longer term/Lifetime risk, Persons (estimate)' and in Tables 20-27 for each jurisdiction, [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 1 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2016), 'Table 2.3 Selected characteristics, by state or territory of usual residence, Aboriginal and Torres Strait Islander persons aged 15 years and over – 2014-15, Proportion of persons', [National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014-15](#), cat. no. 4714.0, viewed 6 September 2016.

### 3-9. Overweight and Obesity

#### Introduction

Body mass index (BMI) is a measure of body fat based on the ratio of weight and height (bodyweight in kilograms divided by height in metres squared). The normal range of BMI for an adult is 18.5 to 24.9 kg/m<sup>2</sup>. 'Overweight' is defined by the World Health Organisation as a BMI in the range of 25 to less than 30. 'Obesity' is a BMI of 30 or higher.

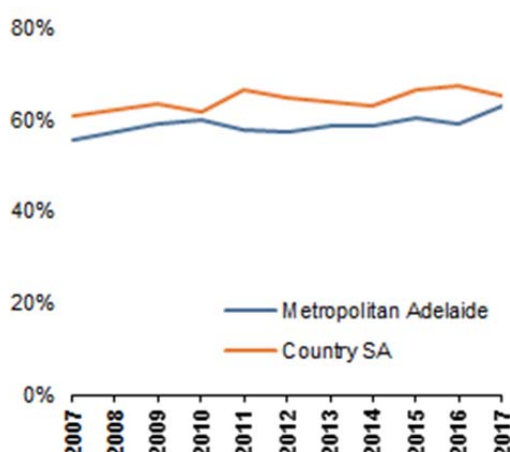
For overweight and obesity rates in children, please refer to [Chapter 2-11](#).

#### 3-9-1. Overweight and Obesity in South Australia – by Local Health Network

- In 2017, around two-thirds (63.7%) of South Australians aged 18 years or more were either overweight or obese<sup>1</sup>.
- The rate varies between the local health networks (LHNs) from 57.8% in the Barossa Hills Fleurieu LHN to 74.6% in the Flinders and Upper North LHN<sup>1</sup>.
- The overweight/obesity rate among Country SA residents (65.4%) is not statistically significantly higher than the metropolitan Adelaide rate (62.9%)<sup>1</sup>.
- Over the last decade the rates of overweight and obesity in both the metropolitan Adelaide and Country SA time series have statistically significantly increased<sup>1</sup>.

#### Overweight or obese (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	70.7%
Central Adelaide	59.4%
Southern Adelaide	60.6%
<b>Metropolitan Adelaide</b>	<b>62.9%</b>
Barossa Hills Fleurieu	57.8%
Eyre and Far North	66.7%
Flinders and Upper North	74.6%
Riverland Mallee Coorong	71.0%
South East	71.1%
Yorke & Northern	68.0%
<b>Country SA LHN</b>	<b>65.4%</b>
<b>South Australia</b>	<b>63.7%</b>
<b>Australia</b>	<b>n.a.</b>



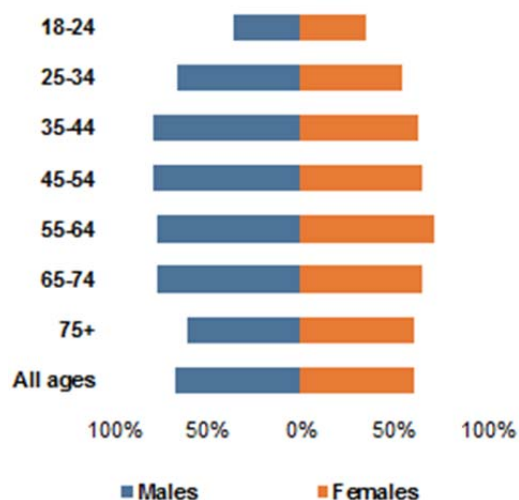
Data source: SA Health 2018

#### 3-9-2. Overweight and Obesity in South Australia – by age and sex

- In 2017, the proportion of males aged 18 years and over who were overweight or obese (67.0%) was higher than the corresponding female rate (60.5%)<sup>1</sup>.

**Overweight or obese (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	35.8%	35.1%
25-34	65.3%	54.8%
35-44	79.1%	62.6%
45-54	78.3%	64.7%
55-64	76.5%	72.1%
65-74	76.3%	65.3%
75+	60.9%	60.8%
<b>All ages</b>	<b>67.0%</b>	<b>60.5%</b>



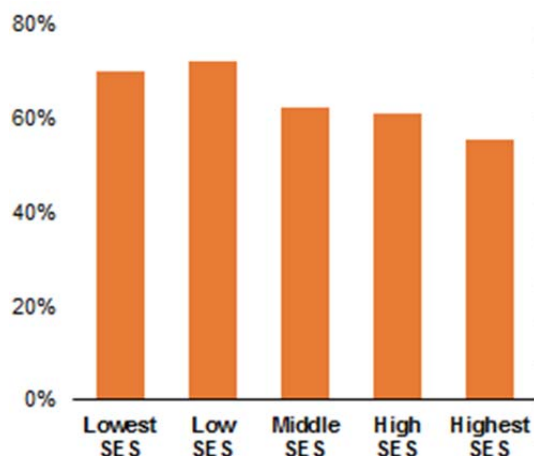
Data source: SA Health 2018

**3-9-3. Overweight and Obesity in South Australia – by socio-economic status**

- There is a statistically significant inverse correlation between the proportion of people aged 18 years and over who are classified as overweight or obese and the socio-economic status of the area in which they live<sup>1</sup>.

**Overweight or obese (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	69.7%
Low SES	71.9%
Middle SES	62.4%
High SES	61.0%
Highest SES	55.6%



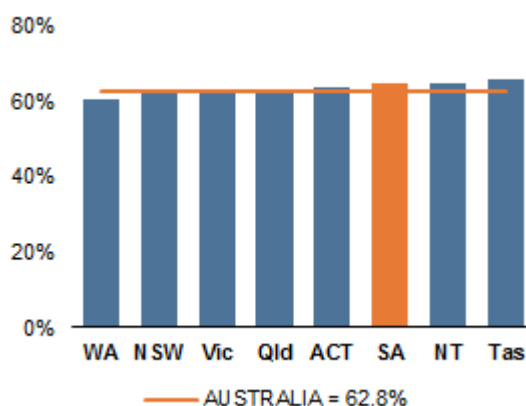
Data source: SA Health 2018

**3-9-4. Overweight and Obesity in Australia – by state and territory**

- The data below comes from the Australian Bureau of Statistics' 2014-15 National Health Survey. It is therefore not *directly* comparable to the information presented in 3-9-1 to 3-9-3 above which is sourced via the South Australian Monitoring and Surveillance System.
- However, the national survey does largely corroborate the state-specific survey, with 64.5% (age standardised) of South Australians aged 18 years and over reporting a BMI that classifies them as overweight or obese<sup>2</sup>.
- Nationally, the South Australian overweight/obesity rate is slightly above the Australia-wide average of 62.8% (age standardised), and is ranked third-highest of the states and territories<sup>2</sup>.

**Overweight or obese (aged 18+ years), 2014-15, age standardised**

State/Territory	%
Western Australia	60.3%
New South Wales	62.6%
Victoria	62.8%
Queensland	63.3%
Australian Capital Territory	63.5%
<b>South Australia</b>	<b>64.5%</b>
Northern Territory	64.6%
Tasmania	65.9%
<b>Australia</b>	<b>62.8%</b>



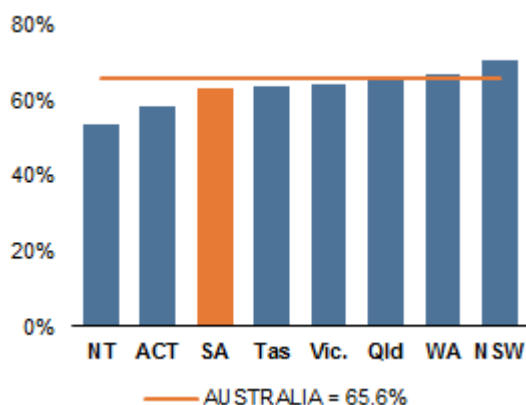
Data source: ABS 2015

**3-9-5. Overweight and Obesity – Aboriginal people**

- In 2012-13, 62.9% of Aboriginal people in South Australia aged 15 years and older had a BMI classified as overweight or obese<sup>3</sup>.
- Although not strictly comparable, this is lower than the 64.5% overweight/obesity rate recorded for *all* South Australians aged 18 years or more in the ABS 2014-15 National Health Survey (see 3-9-4 above)<sup>3</sup>.
- South Australia's overweight/obesity rate among Aboriginal people is below the national average for Aboriginal people (65.6%)<sup>3</sup>.

**Aboriginal people overweight or obese (aged 15+ years), 2012-13**

State/Territory	%
Northern Territory	53.7%
Australian Capital Territory	58.3%
<b>South Australia</b>	<b>62.9%</b>
Tasmania	63.7%
Victoria	64.4%
Queensland	65.7%
Western Australia	66.7%
New South Wales	70.6%
<b>Australia</b>	<b>65.6%</b>



Data source: ABS 2013

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics – States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 17 March 2016.

3. Based on Australian Bureau of Statistics (ABS 2013), 'Table 3.3 Selected health characteristics, by State/Territory – 2012-13, Proportion of Aboriginal and Torres Strait Islander persons', [\*Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13\*](#), cat no 4727.0.55.001, viewed 2 September 2015.

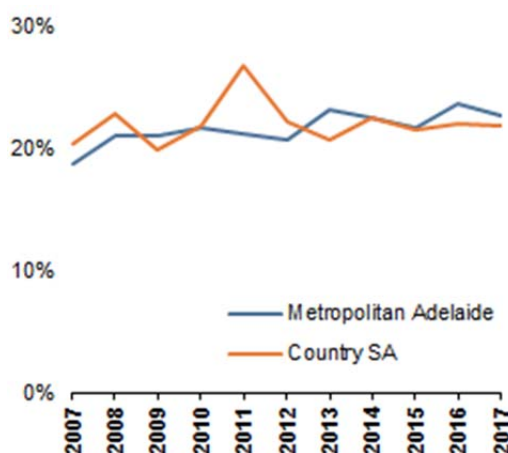
### 3-10. High blood pressure

#### 3-10-1. High blood pressure in South Australia – by Local Health Network

- In 2017, around a quarter (22.3%) of South Australians aged 18 years or more self-reported that they had current doctor-diagnosed high blood pressure and/or were on medication for high blood pressure<sup>1</sup>.
- The rate varies between the local health networks (LHNs) from 17.7% in the Barossa Hills Fleurieu LHN to 27.0% in the Flinders and Upper North LHN.
- The prevalence of high blood pressure among Country SA residents (21.8%) is essentially equivalent (no statistically significant difference) to the overall metropolitan Adelaide rate of 22.6%<sup>1</sup>.
- A statistically significant increasing trend over the last decade in the proportion of people reporting high blood pressure and/or on medication for high blood pressure (aged 18+ years) was identified in the metropolitan Adelaide time series. No statistically significant trend was identified in the Country SA time series<sup>1</sup>.

#### High blood pressure and/or on medication for high blood pressure (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	24.1%
Central Adelaide	22.4%
Southern Adelaide	21.5%
<b>Metropolitan Adelaide</b>	<b>22.6%</b>
Barossa Hills Fleurieu	17.7%
Eyre and Far North	25.9%
Flinders and Upper North	27.0%
Riverland Mallee Coorong	24.9%
South East	24.5%
Yorke & Northern	21.8%
<b>Country SA</b>	<b>21.8%</b>
<b>South Australia</b>	<b>22.3%</b>
<b>Australia</b>	<b>n.a.</b>



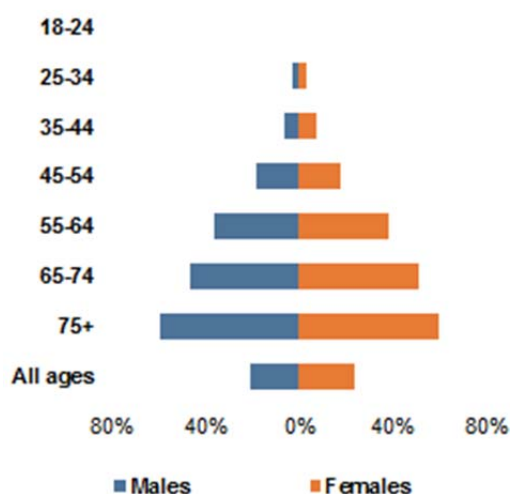
Data source: SA Health 2018

#### 3-10-2. High blood pressure in South Australia – by age and sex

- In 2017, the proportion of females aged 18 years and over who self-reported that they were living with doctor-diagnosed high blood pressure and/or were on medication for high blood pressure (24.0%) was higher than the corresponding male rate (20.4%)<sup>1</sup>.
- The prevalence of high blood pressure is correlated with age<sup>1</sup>.

**High blood pressure and/or on medication for high blood pressure (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	0.0%	0.0%
25-34	3.1%	2.9%
35-44	5.9%	7.6%
45-54	18.1%	17.6%
55-64	36.2%	38.1%
65-74	46.5%	51.7%
75+	59.6%	59.6%
<b>All ages</b>	<b>20.4%</b>	<b>24.0%</b>



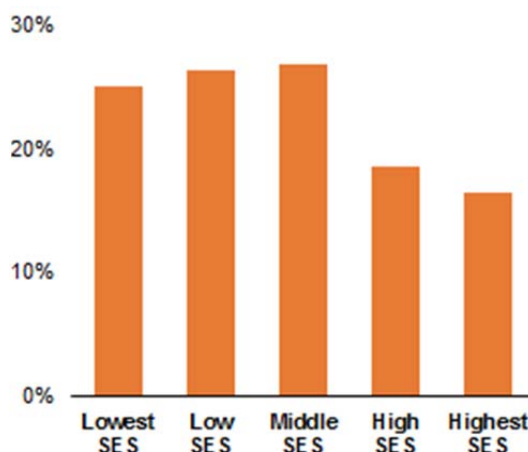
Data source: SA Health 2018

**3-10-3. High blood pressure in South Australia – by socio-economic status**

- There is no statistically significant correlation between the proportion of people aged 18 years and over who self-report that they are living with doctor-diagnosed high blood pressure and/or are on medication for high blood pressure and the socio-economic status of the area in which they live<sup>1</sup>.

**High blood pressure and/or on medication for high blood pressure (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	25.0%
Low SES	26.2%
Middle SES	26.8%
High SES	18.5%
Highest SES	16.4%



Data source: SA Health 2018

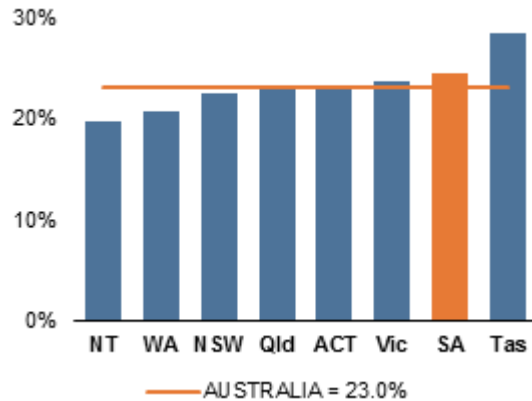
**3-10-4. High blood pressure in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people aged 18 years and over and is based on *measured* blood pressure which is 140/90 mmHg or higher. This is, therefore, not directly comparable to the information in 3-8-4 to 3-8-6 above which is based on people aged 18 years and over who self-reported having doctor-diagnosed high blood pressure and/or being on medication for high blood pressure.
- The national survey does corroborate the findings from the state-specific survey, with about a quarter (24.5%) of South Australians estimated to be living with high blood pressure<sup>2</sup>.
- The South Australian rate is similar, given margins for error in the estimation, to the Australia-wide figure of 23.0% but it is – as was the case for the previous survey for 2011-12 – the state

with the second-highest estimated prevalence rate of high blood pressure of the reported jurisdictions, only Tasmania having a higher rate<sup>2</sup>.

### High blood pressure ( $\geq 140/90$ mmHg) (aged 18+ years), 2014–15

State/Territory	%
Northern Territory	19.7%
Western Australia	20.6%
New South Wales	22.5%
Queensland	23.2%
Australian Capital Territory	23.2%
Victoria	23.7%
<b>South Australia</b>	<b>24.5%</b>
Tasmania	28.4%
<b>Australia</b>	<b>23.0%</b>



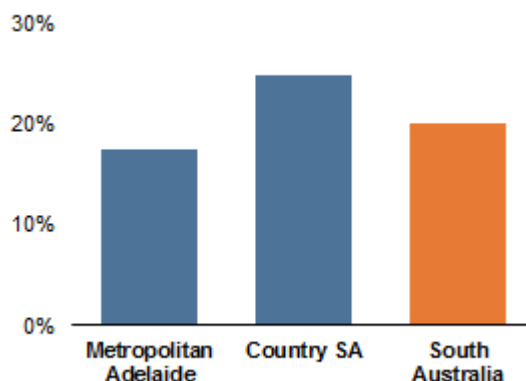
Data source: ABS 2015

### 3-10-5. High blood pressure – Aboriginal people

- In 2012, one in five (20.0%) Aboriginal people aged 15 years and over in South Australia self-reported that they were living with doctor-diagnosed high blood pressure and/or were on medication for high blood pressure<sup>3</sup>.
- Although the survey from which this data was drawn did not include the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, the Country SA rate as a whole (24.8%) is not statistically significantly higher than metropolitan Adelaide (17.6%)<sup>3</sup>.
- However, the prevalence of high blood pressure amongst Aboriginal people in remote South Australia is extremely high at 39.8%<sup>3</sup>.
- The Aboriginal rate of persons aged 15 years and over for 2012 is roughly comparable to the 16 years and over all-population rate for 2014 reported for South Australia in 3-10-1 above (21.3%)<sup>3</sup>.

### Aboriginal people with high blood pressure and/or on medication for high blood pressure (aged 15+ years), March 2012

Region	%
<b>Metropolitan Adelaide</b>	<b>17.6%</b>
Rural SA	16.9%
Remote SA	39.8%*
<b>Country SA</b>	<b>24.8%</b>
<b>South Australia</b>	<b>20.0%</b>
<b>Australia</b>	<b>n.a.</b>



\* Survey did not include APY Lands

Data source: University of Adelaide 2012



## Sources

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.
3. Based on Taylor, A, Marin, T, Avery, J & Dal Grande, E 2012, 'Appendix A: A5.6 High blood pressure,' *South Australian Aboriginal health survey*, Population research and outcome studies, University of Adelaide, Adelaide.

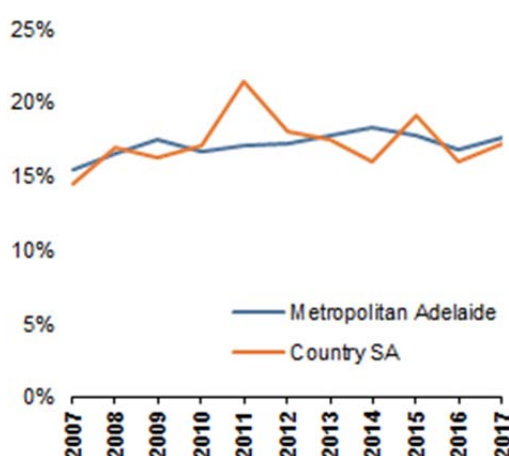
### 3-11. High cholesterol

#### 3-11-1. High cholesterol in South Australia – by Local Health Network

- In 2017, under one in six (17.5%) of South Australians aged 18 years or more self-reported that they had current doctor-diagnosed high cholesterol and/or were on medication for high cholesterol<sup>1</sup>.
- The rate varies between local health networks (LHNs) from 14.6% in the Flinders and Upper North LHN to 21.1% in the Northern Adelaide LHN.
- The prevalence of high cholesterol self-reported by Country SA residents (17.2%) is not statistically significantly lower than their metropolitan Adelaide counterparts (17.6%)<sup>1</sup>.
- Over the last decade the proportion of people reporting living with high cholesterol has statistically significantly increased for metropolitan Adelaide residents but not Country SA residents<sup>1</sup>.

#### High cholesterol and/or on medication for high cholesterol (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	21.1%
Central Adelaide	16.2%
Southern Adelaide	16.4%
<b>Metropolitan Adelaide</b>	<b>17.6%</b>
Barossa Hills Fleurieu	17.3%
Eyre and Far North	20.1%
Flinders and Upper North	14.6%
Riverland Mallee Coorong	15.8%
South East	18.0%
Yorke & Northern	17.5%
<b>Country SA</b>	<b>17.2%</b>
<b>South Australia</b>	<b>17.5%</b>
<b>Australia</b>	<b>n.a.</b>



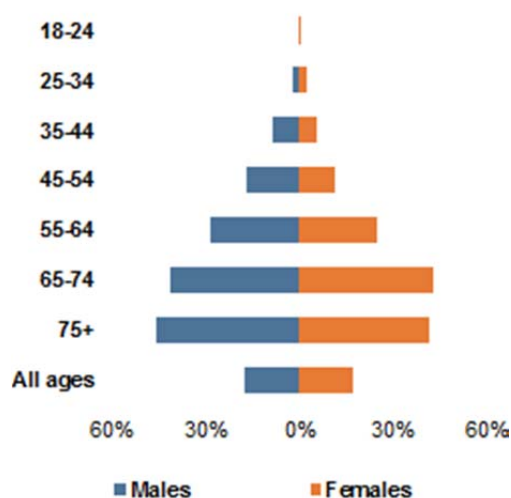
Data source: SA Health 2018

#### 3-11-2. High cholesterol in South Australia – by age and sex

- In 2017, the proportion of males aged 18 years and over who self-reported that they were living with doctor-diagnosed high cholesterol and/or were on medication for high cholesterol (17.7%) was roughly equivalent to the rate of their female counterparts (17.2%)<sup>1</sup>.
- The prevalence of high cholesterol is correlated with age<sup>1</sup>.

**High cholesterol and/or on medication for high cholesterol (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	0.0%	0.3%
25-34	2.3%	2.5%
35-44	8.2%	5.7%
45-54	17.1%	11.2%
55-64	28.6%	25.0%
65-74	41.3%	43.0%
75+	46.0%	41.6%
<b>All ages</b>	<b>17.7%</b>	<b>17.2%</b>



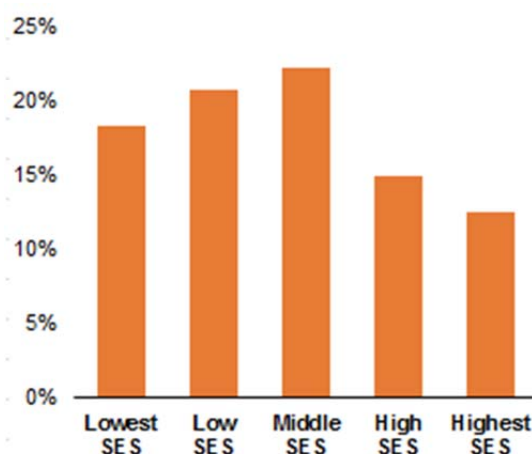
Data source: SA Health 2018

**3-11-3. High cholesterol in South Australia – by socio-economic status**

- In 2017, there was no statistically significant correlation between the proportion of people aged 18 years and over who self-report that they are living with doctor-diagnosed high cholesterol and/or are on medication for high cholesterol and the socio-economic status of the area in which they live<sup>1</sup>.

**High cholesterol and/or on medication for high cholesterol (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	18.2%
Low SES	20.6%
Middle SES	22.2%
High SES	14.9%
Highest SES	12.5%



Data source: SA Health 2018

**3-11-4. High cholesterol in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey reporting high cholesterol. It is not directly comparable to the information in 3-11-1 to 3-11-3 above which is for people who self-report having current doctor-diagnosed high cholesterol and/or being on medication for high cholesterol.
- The national survey reports that around one in 12 (8.4%) South Australians are living with high cholesterol as a condition which has lasted, or is expected to last, for 6 months or more<sup>2</sup>.
- The South Australian population high cholesterol rate is higher than the Australia-wide rate of 7.1%, and is towards the top end of the range reported for the states and territories<sup>2</sup>.

**High cholesterol (aged 18+ years), 2014–15**

State/Territory	%
Northern Territory	4.4%
Western Australia	6.0%
Queensland	6.4%
New South Wales	7.2%
Victoria	7.3%
<b>South Australia</b>	<b>8.4%</b>
Australian Capital Territory	8.6%
Tasmania	9.4%
<b>Australia</b>	<b>7.1%</b>



Data source: ABS 2015

**3-11-5. High cholesterol – Aboriginal people**

Data not available for this indicator.

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 3.3 Long-term health conditions, Proportion of persons — Persons' and in Tables 20-27 for each jurisdiction, [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.

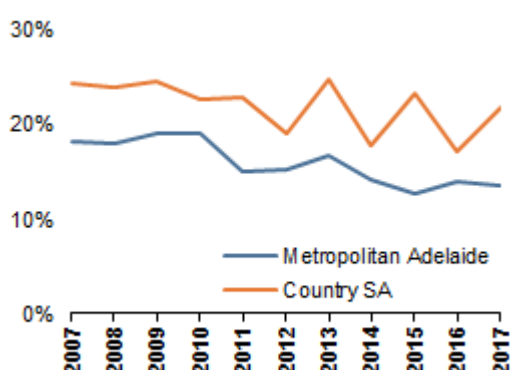
### 3-12. Smoking prevalence

#### 3-12-1. Smoking prevalence in South Australia – by Local Health Network

- In 2017, around one in six (16.5%) South Australians aged 15 years or older reported smoking daily, weekly or less often than weekly<sup>1</sup>.
- The rate varies between local health networks (LHNs), from 10.3% in the Central Adelaide LHN up to 34.0% in the Yorke & Northern LHN.
- There is a statistically significant difference between the rates reported by people living in Country SA (21.8%) compared to metropolitan Adelaide residents (13.5%) in 2017<sup>1</sup>.
- Over the last decade, smoking prevalence has statistically significantly decreased in metropolitan Adelaide. No statistically significant trend was identified in the Country SA time series<sup>1</sup>.
- **E-cigarettes:** In 2017, 75.6% of the South Australian population reported that they had heard of e-cigarettes but only 1.0% were current users of e-cigarettes<sup>1</sup>.

#### All smoking prevalence (ages 15+ years), 2017

Local Health Network	%
Northern Adelaide	20.9%
Central Adelaide	10.3%
Southern Adelaide	10.6%
<b>Metropolitan Adelaide</b>	<b>13.5%</b>
Barossa Hills Fleurieu	11.9%
Eyre and Far North	31.4%
Flinders and Upper North	23.7%
Riverland Mallee Coorong	24.3%
South East	28.9%
Yorke & Northern	34.0%
<b>Country SA</b>	<b>21.8%</b>
<b>South Australia</b>	<b>16.5%</b>
<b>Australia</b>	<b>n.a.</b>



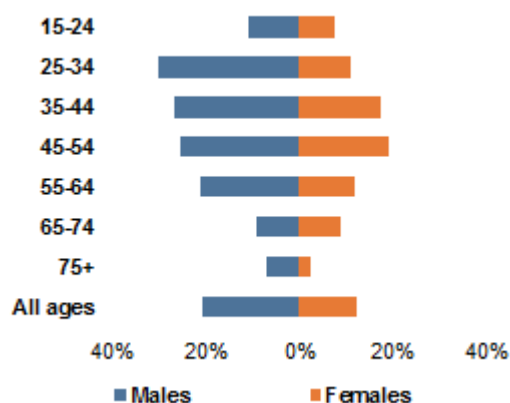
Data source: SA Health 2018

#### 3-12-2. Smoking prevalence in South Australia – by age and sex

- In 2017, the proportion of the state's population aged 15 years and over that reported smoking daily, weekly or less often than weekly was higher among males (20.7%) than females (12.4%)<sup>1</sup>.
- Smoking prevalence varied greatly with age, peaking in the 25-34 years age cohort for males (30.2%) and 45-54 years age cohort for females (19.4%)<sup>1</sup>.

**All smoking prevalence (ages 15+ years), 2017**

Age (years)	Males	Females
15-24	10.9%	7.7%
25-34	30.2%	11.0%
35-44	26.8%	17.7%
45-54	25.6%	19.4%
55-64	21.0%	11.9%
65-74	8.9%	8.9%
75+	7.1%	2.7%
<b>All ages</b>	<b>20.7%</b>	<b>12.4%</b>



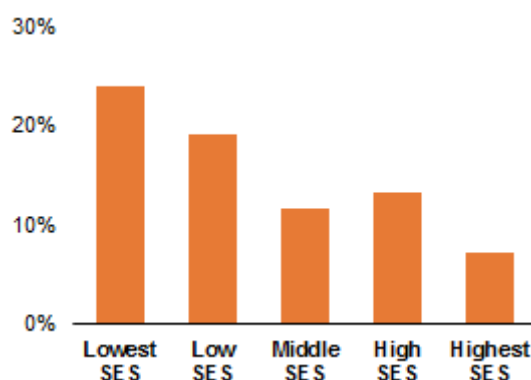
Data source: SA Health 2018

**3-12-3. Smoking prevalence in South Australia – by socio-economic status**

- There is a statistically significant inverse correlation between the proportion of people aged 15 years and over who report smoking daily, weekly or less often than weekly and the socio-economic status of the area in which they live<sup>1</sup>.
- Smoking prevalence recorded during 2017 in areas constituting South Australia's highest socio-economic (SES) quintile (7.1%) was around a third of that recorded for the lowest SES quintile (24.0%)<sup>1</sup>.

**All smoking prevalence (ages 15+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	24.0%
Low SES	19.1%
Middle SES	11.6%
High SES	13.2%
Highest SES	7.1%



Data source: SA Health 2018

**3-12-4. Smoking prevalence in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people aged 18 years and over reporting being current daily smokers and is age-standardised. It is not directly comparable to the Health Omnibus Survey information in sections 3-12-1 to 3-12-3 above which is for people aged 15 years and over who report smoking daily, weekly or less often than weekly.
- However, the national survey results are broadly in line with the state-based figures, revealing that 13.5% of the population in South Australia are current daily smokers. This is a reduction from the 16.8% reported in the previous survey (for 2011-12, second-results release)<sup>2</sup>.
- The South Australian proportion of current smokers is estimated to be a little below the Australia-wide rate of 14.7% and is at the bottom of the range of rates reported for the states and territories, with only the Australian Capital Territory having a lower estimated rate<sup>2</sup>.

**Current daily smokers (ages 18+ years), 2014–15 (age-standardised)**

State/Territory	%
Australian Capital Territory	12.2%
<b>South Australia</b>	<b>13.5%</b>
Victoria	13.9%
Western Australia	14.2%
New South Wales	14.4%
Queensland	16.3%
Tasmania	19.3%
Northern Territory	19.9%
<b>Australia</b>	<b>14.7%</b>



Data source: ABS 2015

**3-12-5. Smoking prevalence – Aboriginal people**

- More than a third (35.4%) of Aboriginal people aged 15 years or older in South Australia reported being a current daily smoker in 2014-15, below the national average for Aboriginal people of 38.9%<sup>3</sup>.
- Although the figures are not directly comparable, due to differing sources and methodologies, this rate is significantly higher than the 16.5% of all South Australians aged 15 years or older who reported smoking daily, weekly or less often than weekly (see 3-12-1 above)<sup>3</sup>.
- Compared to Aboriginal people aged 15 years and over in other states and territories, South Australia was ranked the lowest for this indicator<sup>3</sup>.

**Current daily smokers - Aboriginal people (ages 15+ years), 2014-15**

State/Territory	%
<b>South Australia</b>	<b>35.4%</b>
Tasmania	36.5%
Australian Capital Territory	36.9%
Queensland	38.1%
New South Wales	38.3%
Victoria	38.4%
Western Australia	41.5%
Northern Territory	44.5%
<b>Australia</b>	<b>38.9%</b>



Data source: ABS 2016

**Sources**

1. Based on Health Omnibus Survey customised extract 2018, Drug and Alcohol Services South Australia, SA Health, Adelaide, 30 July 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.

3. Based on Australian Bureau of Statistics (ABS 2016), 'Table 2.3 Selected characteristics, by state or territory of usual residence, Aboriginal and Torres Strait Islander persons aged 15 years and over – 2014-15, Proportion of persons', [\*National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014-15\*](#), cat. no. 4714.0, viewed 6 September 2016.



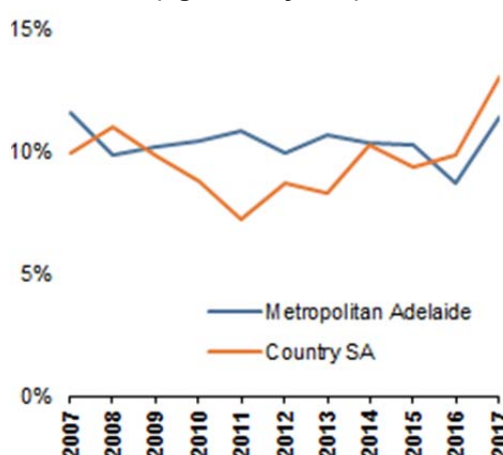
### 3-13. Psychological distress (anxiety and depression)

#### 3-13-1. Psychological distress in South Australia – by Local Health Network

- In 2017, around one in eleven (11.9%) South Australians aged 18 years or more had recently experienced high or very high levels of psychological distress<sup>1</sup>.
- Levels of psychological distress are defined using the [Kessler 10 Item \(K10\) Psychological Distress Questionnaire](#), a checklist to measure whether a person may have been affected by anxiety and depression during the past four weeks.
- The rate varies between local health networks (LHNs) from 6.3% in the Riverland Mallee Coorong LHN to 17.9% in the Barossa Hills Fleurieu Local LHN<sup>1</sup>.
- The proportion of high to very high levels of psychological distress reported amongst residents of metropolitan Adelaide (11.4%) is statistically significantly lower than Country SA (13.0%)
- No statistically significant trend was identified in the metropolitan Adelaide or Country SA time series<sup>1</sup>.

#### High or very high levels of psychological distress (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	14.7%
Central Adelaide	10.8%
Southern Adelaide	9.5%
<b>Metropolitan Adelaide</b>	<b>11.4%</b>
Barossa Hills Fleurieu	17.9%
Eyre and Far North	6.5%*
Flinders and Upper North	10.9%
Riverland Mallee Coorong	6.3%
South East	9.1%
Yorke & Northern	15.1%
<b>Country SA</b>	<b>13.0%</b>
<b>South Australia</b>	<b>11.9%</b>
<b>Australia</b>	<b>n.a.</b>

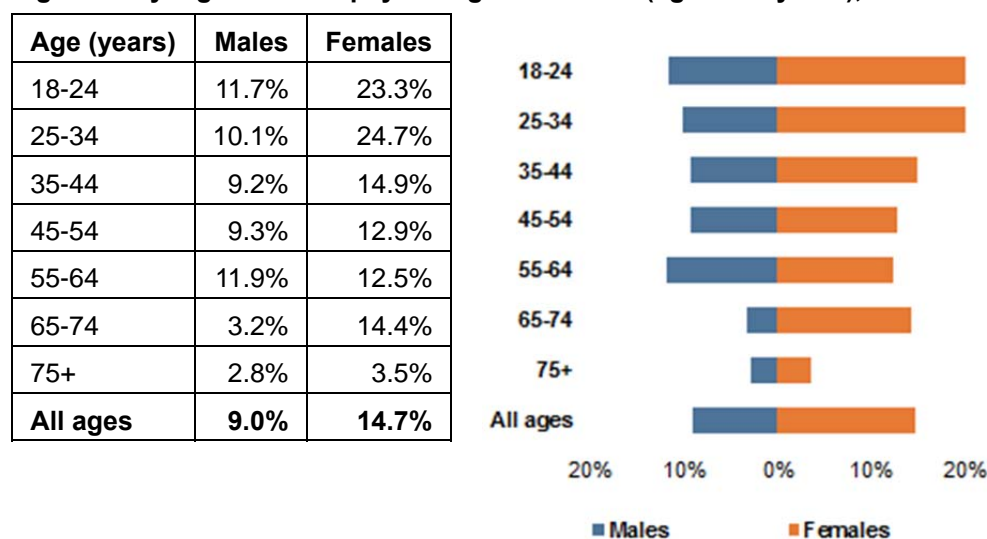


\* Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

Data source: SA Health 2018

#### 3-13-2. Psychological distress in South Australia – by age and sex

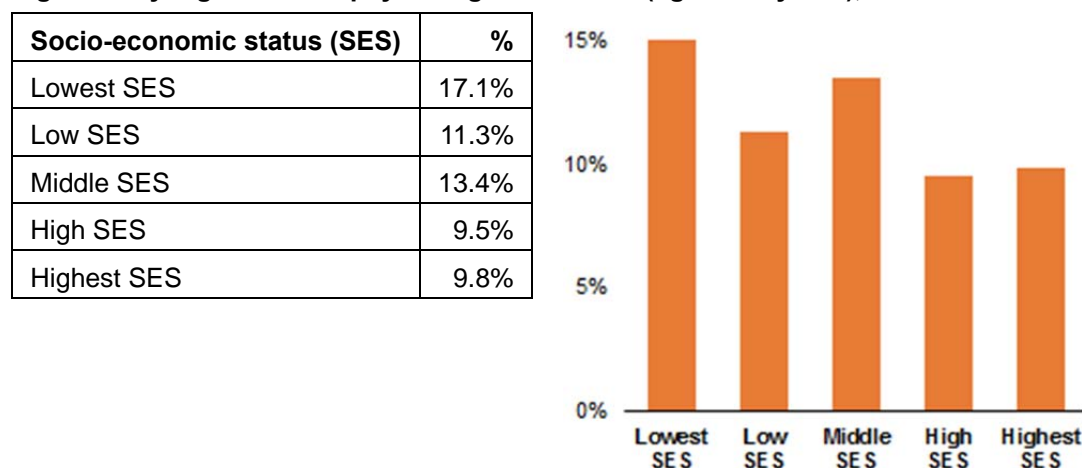
- In 2017, the proportion of the population aged 18 years and over that had recently experienced high or very high levels of psychological distress was higher for females (14.7%) than males (9.0%)<sup>1</sup>.
- Levels of psychological distress are defined using the [Kessler 10 Item \(K10\) Psychological Distress Questionnaire](#), a checklist to measure whether a person may have been affected by anxiety and depression during the past four weeks.
- The extent to which people reported high to very high levels of psychological distress varied with age with prevalence particularly high in the 18-24 and 25-34 years age cohorts for females<sup>1</sup>.

**High or very high levels of psychological distress (aged 18+ years), 2017**

Data source: SA Health 2018

**3-13-3. Psychological distress in South Australia – by socio-economic status**

- In 2017, there was no statistically significant correlation between the proportion of people aged 18 years and over who have recently experienced high or very high levels of psychological distress and the socio-economic status of the geographic area in which they live<sup>1</sup>.
- Levels of psychological distress are defined using the [Kessler 10 Item \(K10\) Psychological Distress Questionnaire](#), a checklist to measure whether a person may have been affected by anxiety and depression during the past four weeks.
- The prevalence of high to very high psychological distress in areas constituting South Australia's lowest socio-economic (SES) quintile (17.1%) is higher than that of the highest SES quintile (9.8%)<sup>1</sup>.

**High or very high levels of psychological distress (aged 18+ years), 2017**

Data source: SA Health 2018

**3-13-4. Psychological distress in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people aged 18 years and over reporting living with high or very high levels of

psychological distress as a long-term condition. It is not directly comparable to the information in 3-13-1 to 3-13-3 above.

- Levels of psychological distress are defined using the [Kessler 10 Item \(K10\) Psychological Distress Questionnaire](#), a checklist to measure whether a person may have been affected by anxiety and depression during the past four weeks.
- The national survey results are broadly in line with the state-based figures, showing that 13.6% of the age-standardised population in South Australia are living with high or very high levels of psychological distress as a condition which has lasted, or is expected to last, for 6 months or more. This is an increase over the 11.4% reported in the previous survey (for 2011-12)<sup>2</sup>.
- The South Australian rate is a little higher than the Australia-wide rate of 11.8% and estimated to be higher than all states and territories except Tasmania<sup>2</sup>.

#### High/very high psychological distress, people (aged 18+ years), 2014–15 (age-standardised)

State/Territory	%
Northern Territory	8.1%
Western Australia	9.9%
Australian Capital Territory	11.0%
New South Wales	11.1%
Queensland	12.0%
Victoria	12.5%
<b>South Australia</b>	<b>13.6%</b>
Tasmania	14.0%
<b>Australia</b>	<b>11.8%</b>



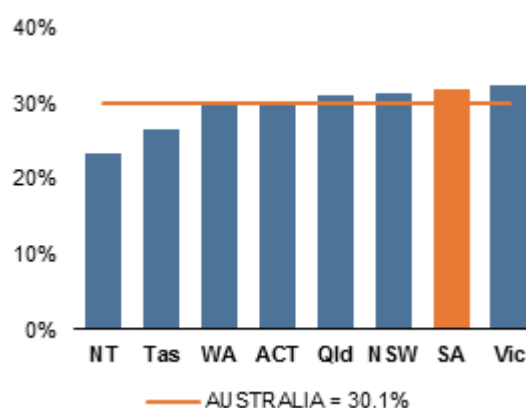
Data source: ABS 2015

#### 3-13-5. Psychological distress – Aboriginal people

- Around a third (31.8%) of Aboriginal people in South Australia aged 15 years or more have recently experienced high or very high levels of psychological distress<sup>3</sup>.
- Levels of psychological distress are defined here using the , a subset of five questions from the [Kessler 10 Item \(K10\) Psychological Distress Questionnaire](#), a checklist to measure whether a person may have been affected by anxiety and depression during the past four weeks.
- As such, and because it is based on data collected for 2012-13 rather than 2011-12, this indicator is not *directly* comparable with the all-person figures in 3-13-4 above<sup>3</sup>.
- South Australia's rate was above the national average for Aboriginal people of 30.1%, ranking this jurisdiction second highest of the states and territories<sup>3</sup>.

**Psychological distress - Aboriginal people (aged 15+ years), 2012-13**

State/Territory	%
Northern Territory	23.3%
Tasmania	26.5%
Western Australia	29.8%
Australian Capital Territory	30.3%
Queensland	31.1%
New South Wales	31.2%
<b>South Australia</b>	<b>31.8%</b>
Victoria	32.3%
<b>Australia</b>	<b>30.1%</b>



Data source: ABS 2014

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2014), 'Table 12.3 Smoker status, by State/Territory by sex, Proportion of persons', [Australian Aboriginal and Torres Strait Islander health survey: Updated results 2012-13](#), cat no 4727.0.55.006, viewed 08 October 2014.

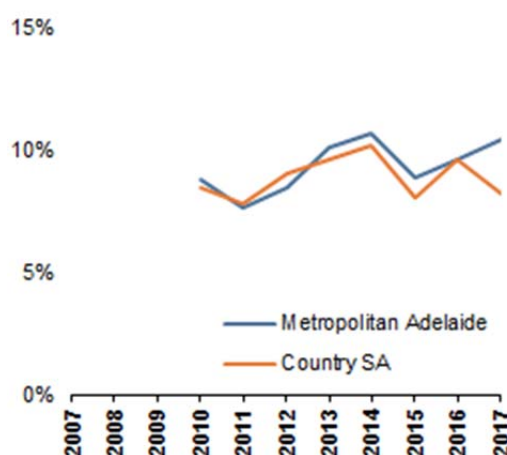
### 3-14. Cancer

#### 3-14-1. Cancer in South Australia – by Local Health Network

- In 2017, around one in ten (9.7%) South Australians aged 18 years or more had ever been told by a doctor that they had cancer<sup>1</sup>.
- The rate varies between local health networks (LHNs) from 6.1%\* in the South East LHN to 10.7% in the Southern Adelaide LHN<sup>1</sup>.
- The proportion of people who reported having or ever had cancer in metropolitan Adelaide (10.4%) is statistically significantly higher than Country SA (8.2%)<sup>1</sup>.
- No statistically significant underlying trend was identified in either the metropolitan Adelaide or Country SA time series<sup>1</sup>.
- Data prior to 2010 is not available.

#### Has or ever had cancer (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	10.4%
Central Adelaide	10.2%
Southern Adelaide	10.7%
<b>Metropolitan Adelaide</b>	<b>10.4%</b>
Barossa Hills Fleurieu	9.0%
Eyre and Far North	8.6%*
Flinders and Upper North	8.0%*
Riverland Mallee Coorong	7.5%
South East	6.1%*
Yorke & Northern	8.4%
<b>Country SA</b>	<b>8.2%</b>
<b>South Australia</b>	<b>9.7%</b>
<b>Australia</b>	<b>n.a.</b>



\* Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

Data prior to 2010 is not available.

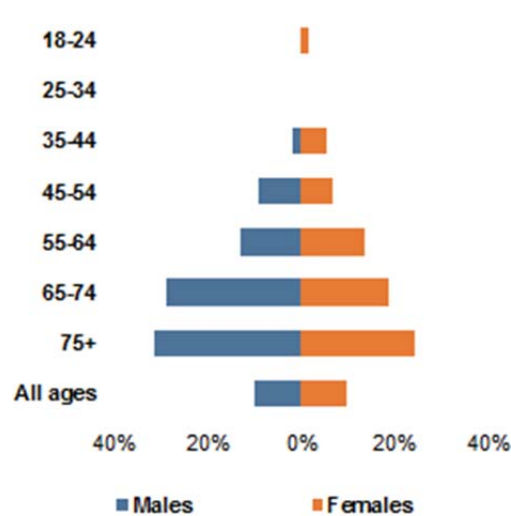
Data source: SA Health 2018

#### 3-14-2. Cancer in South Australia – by age and sex

- In 2017, the proportion of the population aged 18 years and over that had ever been told by a doctor that they had cancer was roughly equivalent between males (9.9%) and females (9.8%)<sup>1</sup>.
- The rate increases with age<sup>1</sup>.

**Has or ever had cancer (aged 18+), 2017**

Age (years)	Males	Females
18-24	0.0%	1.6%
25-34	0.0%	0.0%
35-44	2.0%	5.4%
45-54	9.2%	6.8%
55-64	13.2%	13.6%
65-74	28.7%	19.0%
75+	31.6%	24.6%
<b>All ages</b>	<b>9.9%</b>	<b>9.8%</b>



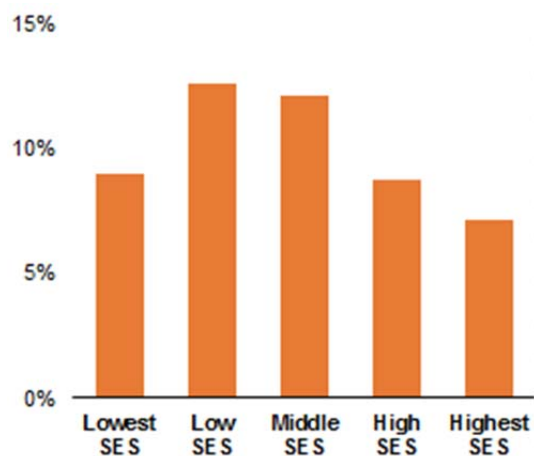
Data source: SA Health 2018

**3-14-3. Cancer in South Australia – by socio-economic status**

- There is no statistically significant correlation evident between the proportion of people aged 18 years and over who have ever been told by a doctor that they have cancer and the socio-economic status of the geographic area in which they live<sup>1</sup>.

**Has or ever had cancer (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	9.0%
Low SES	12.6%
Middle SES	12.1%
High SES	8.8%
Highest SES	7.1%



Data source: SA Health 2018

**3-14-4. Cancer in Australia – by state and territory**

Data not available for this indicator.

**3-14-5. Cancer – Aboriginal people**

Data not available for this indicator.

## Sources

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.

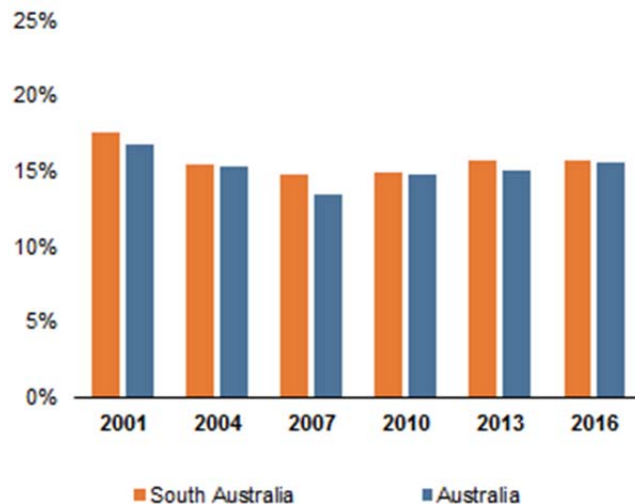
### 3-15. Illicit drug use

#### 3-15-1. Illicit drug use in South Australia

- In 2016, just under one in six (15.7%) South Australians aged 14 years and older reported using drugs illicitly, including the use of pharmaceuticals for non-medical purposes, in the previous 12 months. This is comparable to the national average of 15.6%<sup>1</sup>.
- In the 2001 survey, the reported rate in South Australia was 17.6%, but in the five subsequent three-yearly surveys the state's rate dropped and has hovered around the 15% mark since<sup>1</sup>.
- Illicit drug use in South Australia is higher among males (18.3%) compared to females (13.0%) and peaks in the 20-29 years age cohort (23.9%)<sup>1</sup>.
- Cannabis is the most commonly used illicit drug reported by South Australians aged 14 years and older (10.7%), followed by Misuse of pharmaceuticals (excludes OTC) (5.5%) and pain-killers/analgesics for non-medical purposes (4.3%)<sup>1</sup>.
- In 2016, South Australia ranked fourth-lowest among the states and territories for illicit drug use by people aged 14 years and older, but there is not a great deal of variation between the states and territories – with the exception of the Northern Territory and Australian Capital Territory<sup>1</sup>.
- Readers should note that estimates of drug use by states and territories should be interpreted with caution due to the low prevalence and smaller sample sizes for some states and territories, particularly for low prevalence drugs<sup>1</sup>.

#### Illicit use of any drug\* in previous 12 months (aged 14+ years), 2016

Region	%
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>15.7%</b>
<b>Australia</b>	<b>15.6%</b>



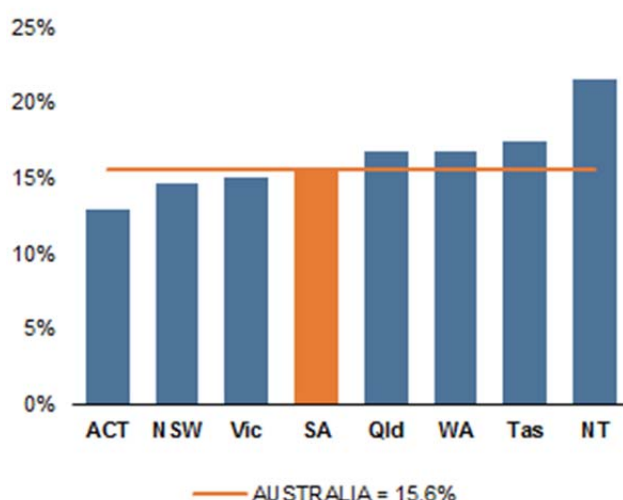
\* including pharmaceuticals

Data source: AIHW 2018a



**Illicit use of any drug\*  
in previous 12 months (aged 14+ years), 2016**

State/Territory	%
Australian Capital Territory	12.9%
New South Wales	14.7%
Victoria	15.0%
<b>South Australia</b>	<b>15.7%</b>
Queensland	16.8%
Western Australia	16.8%
Tasmania	17.4%
Northern Territory	21.6%
<b>Australia</b>	<b>15.6%</b>



\* including pharmaceuticals

N.B. Estimates of drug use by states and territories should be interpreted with caution due to the low prevalence and smaller sample sizes for some states and territories, particularly for low prevalence drugs

Data source: AIHW 2018a

### 3-15-2. Illicit drug use – Aboriginal people

- State-specific data is unavailable. However, in 2016 *nationally*, 27.0% of Aboriginal people aged 14 years and older reported using drugs illicitly, including the use of pharmaceuticals for non-medical purposes<sup>2</sup>.
- This rate represent a rise from the 24.1% reported in the 2013 survey and is substantially higher than the 15.3% national average recorded for non-Aboriginal people.<sup>2</sup>

### Sources

1. Based on Australian Institute of Health and Welfare (AIHW 2018a), 'Table S2.33: Summary of recent drug use, people aged 14 and over, by state/territory, 2010 to 2016 (per cent)', 'Alcohol, tobacco and other drugs', Supplementary data tables, [Alcohol, tobacco & other drugs in Australia](#), Cat. no. PHE 221, viewed 23 August 2018.
2. Based on Australian Institute of Health and Welfare (AIHW 2018b), 'Table S3.1: Drug use by Indigenous status, people aged 14 and over, 2010 to 2016 (per cent)', 'Populations', Supplementary data tables, [Alcohol, tobacco & other drugs in Australia](#), Cat. no. PHE 221, viewed 23 August 2018.

## Living with chronic conditions

### In summary

- Around **one in five** (21.9%) South Australians are living with **two or more** of the following **chronic health conditions**: diabetes, asthma, cardiovascular disease, arthritis, osteoporosis and/or a mental health condition.
- Approximately **one in four** (22.8%) South Australians are living with **arthritis**.
- About **one in five** (20.9%) South Australians are living with a doctor-diagnosed **mental health condition**, defined as *anxiety, depression, stress, or any other mental health problem*.
- Around **one in seven** (14.5%) South Australians are living with **asthma**, defined as *diagnosed with asthma and had experienced symptoms and/or treatment in the last 12-months*.
- Approximately **one in 10** (10.1%) South Australians have been told by a doctor that they have **diabetes** (Type I or II).
- About **one in 12** (7.8%) South Australians are living with **cardiovascular disease**, defined as *ever had doctor-diagnosed heart attack, angina, heart disease and/or stroke*.
- **One in 17** (5.8%) South Australians are living with **osteoporosis**, with the rate for females four times more than that of males.
- **One in 40 (2.5%)** of the South Australian population (adjusted to account for differences in the age structure compared to the Australia generally) are **living with chronic obstructive pulmonary disease (COPD)** including bronchitis and emphysema.
- **One in six (17.0%)** of the South Australian population (adjusted to account for differences in the age structure compared to the Australia generally) are living with a **long-term back condition**, including sciatica, disc disorders, curvature of the spine and other back problems.

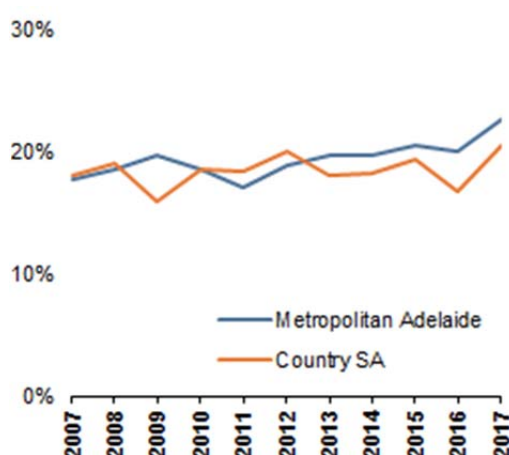
## 4-1. Living with multiple chronic and long-term health conditions

### 4-1-1. Living with multiple chronic conditions in South Australia – by Local Health Network

- In 2017, around one in five (21.9%) South Australians aged 18 years or more were living with two or more of the following chronic health conditions: diabetes, asthma, cardiovascular disease, arthritis, osteoporosis and/or a mental health condition<sup>1</sup>.
- The rate varies between the local health networks (LHNs) from 12.9% in the Riverland Mallee Coorong LHN to 27.0% in the Yorke and Northern LHN<sup>1</sup>.
- The Country SA rate (20.4%) is statistically significantly lower than the metropolitan Adelaide rate of 22.6%<sup>1</sup>.
- A statistically significant increasing trend over the last decade in the proportion of people living with two or more chronic health conditions was identified in the metropolitan Adelaide time series but not Country SA<sup>1</sup>.

#### Living with two or more chronic conditions (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	26.4%
Central Adelaide	20.7%
Southern Adelaide	21.6%
<b>Metropolitan Adelaide</b>	<b>22.6%</b>
Barossa Hills Fleurieu	21.7%
Eyre and Far North	15.8%
Flinders and Upper North	19.0%
Riverland Mallee Coorong	12.9%
South East	20.4%
Yorke & Northern	27.0%
<b>Country SA</b>	<b>20.4%</b>
<b>South Australia</b>	<b>21.9%</b>
<b>Australia</b>	<b>n.a.</b>



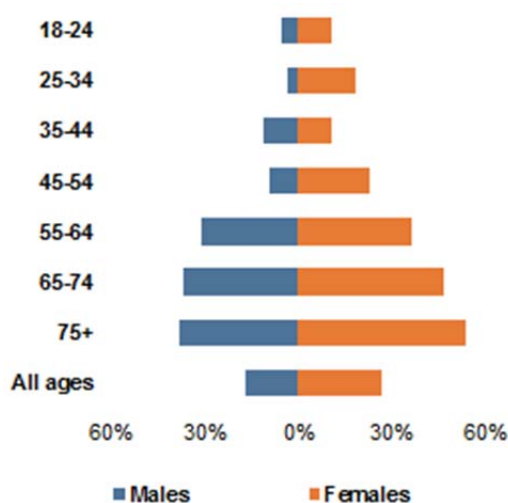
Data source: SA Health 2018

### 4-1-2. Living with multiple chronic conditions in South Australia – by age and sex

- In 2017, the proportion of the population that was living with multiple (two or more) chronic health conditions was higher among females aged 18 years and over (27.0%) than males (17.0%)<sup>1</sup>.
- The chronic health conditions included in this measure are: diabetes, asthma, cardiovascular disease, arthritis, osteoporosis and/or a mental health condition<sup>1</sup>.
- Prevalence is correlated with age<sup>1</sup>.

**Living with two or more chronic conditions (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	5.3%	10.6%
25-34	3.1%	18.7%
35-44	11.3%	11.0%
45-54	9.0%	23.0%
55-64	31.1%	36.3%
65-74	37.1%	47.0%
75+	38.0%	54.3%
<b>All ages</b>	<b>17.0%</b>	<b>27.0%</b>



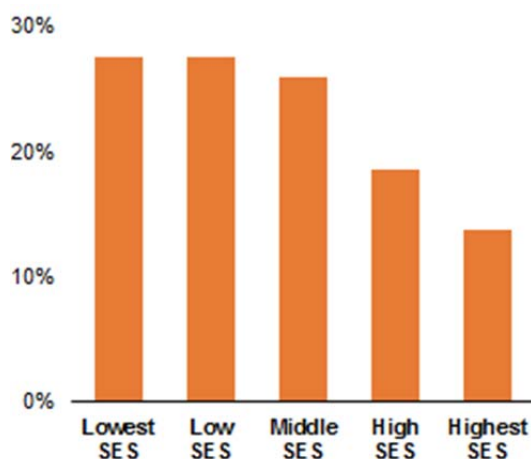
Data source: SA Health 2018

**4-1-3. Living with multiple chronic conditions in South Australia – by socio-economic status**

- In 2017, there was a statistically significant inverse correlation between the proportion of people aged 18 years and over who are living with multiple chronic health conditions and the socio-economic status of the area in which they live<sup>1</sup>.
- "Multiple chronic health conditions" is two or more of the following: diabetes, asthma, cardiovascular disease, arthritis, osteoporosis and/or a mental health condition<sup>1</sup>.

**Living with two or more chronic conditions (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	27.4%
Low SES	27.5%
Middle SES	25.8%
High SES	18.5%
Highest SES	13.7%



Data source: SA Health 2018

**4-1-4. Living with multiple long-term health conditions in Australia – by state and territory**

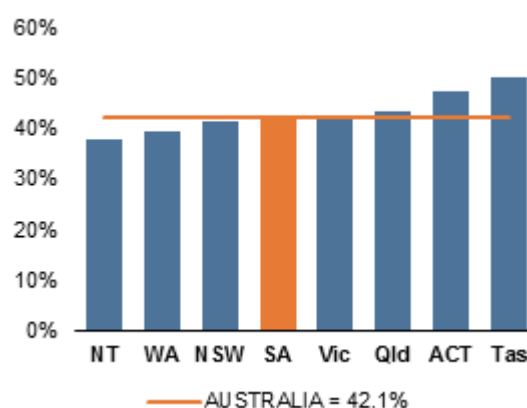
- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people of all ages who report living with three or more long-term medical conditions. This is a more comprehensive measure of multiple long-term health conditions than that used for the state-wide survey results in 4-1-1 to 4-1-3 above. Figures are therefore not comparable.
- Long-term conditions in this measure are medical conditions that have lasted or which the survey respondent expects to last six months or more, such as: arthritis; asthma; back problems; blindness; cancer; chronic obstructive pulmonary disease; deafness; diabetes

mellitus; hayfever and allergic rhinitis; heart, stroke and vascular disease; hypertension; kidney disease; long sightedness; mental and behavioural problems; osteoporosis; and short sightedness<sup>2</sup>.

- According to the national survey, more than two in five (42.0%) of the age-standardised population in South Australia are estimated to be living with three or more long-term health conditions. This is level with the Australia-wide rate (42.1%)<sup>2</sup>.
- The South Australian rate is similar to that for most states and territories, there being for the most part little variation between them, although Tasmania and the Australian Capital Territory do have noticeably higher rates<sup>2</sup>.

#### Living with three or more long-term health conditions (all ages), 2014–15 (age-standardised)

State/Territory	%
Northern Territory	37.9%
Western Australia	39.6%
New South Wales	41.4%
<b>South Australia</b>	<b>42.0%</b>
Victoria	42.5%
Queensland	43.4%
Australian Capital Territory	47.5%
Tasmania	50.3%
<b>Australia</b>	<b>41.1%</b>



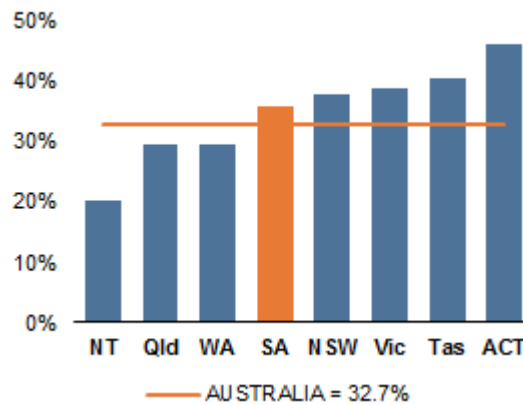
Data source: ABS 2015

#### 4-1-5. Living with multiple long-term health conditions – Aboriginal people

- The 35.7% of Aboriginal people in South Australia who reported living with three or more long-term health conditions was estimated to be above the national rate for Aboriginal people (32.7%)<sup>3</sup>.
- The long-term health conditions considered are: arthritis, asthma, back pain/problems, deafness, diabetes mellitus, hayfever and allergic rhinitis, heart, stroke and vascular diseases, hypertensive disease, long sightedness, malignant neoplasms (cancer), mental and behavioural problems, osteoporosis and/or short sightedness<sup>3</sup>.
- Compared to Aboriginal people in other states and territories, South Australia was ranked fourth lowest for this indicator<sup>3</sup>.
- The 35.7% of Aboriginal people in 2012-13 living with three or more long-term health conditions is *lower* than the 40.5% all-person rate for South Australia recorded in 2011-12 (40.5% - see 4-1-4 above)<sup>3</sup>.

**Living with three or more long-term conditions - Aboriginal people (aged 15+ years), 2012-13**

State/Territory	%
Northern Territory	20.3%
Queensland	29.4%
Western Australia	29.5%
<b>South Australia</b>	<b>35.7%</b>
New South Wales	37.7%
Victoria	38.9%
Tasmania	40.6%
Australian Capital Territory	46.0%
<b>Australia</b>	<b>32.7%</b>



Data source: ABS 2013

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2013), 'Table 3.3 Selected health characteristics by State/Territory', [Australian Aboriginal and Torres Strait Islander health survey: First results 2012-13](#), cat. no. 4727.0.55.001, viewed 4 February 2014.

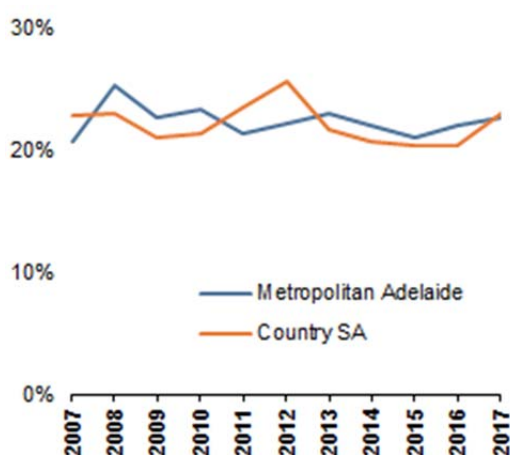
## 4-2. Arthritis prevalence

### 4-2-1. Arthritis prevalence in South Australia – by Local Health Network

- In 2017, around a quarter (22.8%) of South Australians aged 18 years or more were living with arthritis<sup>1</sup>.
- The rate varies between local health networks (LHNs) from 15.4% in the Riverland Mallee Coorong LHN to 28.2% in the Northern Adelaide LHN.
- There is no statistically significant difference between the Country SA rate of 23.0% and the metropolitan Adelaide rate of 22.7%<sup>1</sup>.
- No statistically significant underlying trend over the last decade in the proportion of people reporting living with arthritis was identified in the metropolitan Adelaide or Country SA time series<sup>1</sup>.

#### Arthritis prevalence (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	28.2%
Central Adelaide	19.5%
Southern Adelaide	21.9%
<b>Metropolitan Adelaide</b>	<b>22.7%</b>
Barossa Hills Fleurieu	25.5%
Eyre and Far North	20.9%
Flinders and Upper North	21.9%
Riverland Mallee Coorong	15.4%
South East	21.2%
Yorke & Northern	27.0%
<b>Country SA</b>	<b>23.0%</b>
<b>South Australia</b>	<b>22.8%</b>
<b>Australia</b>	<b>n.a.</b>



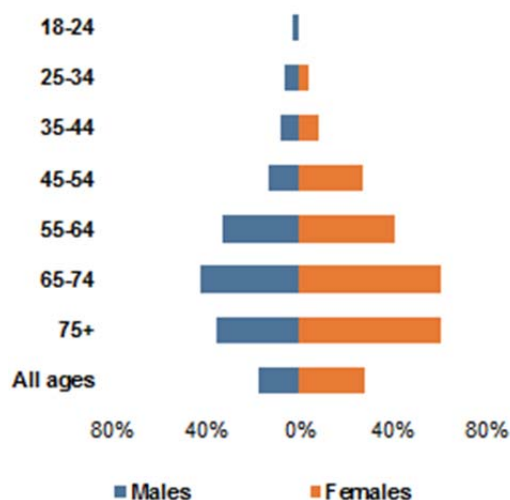
Data source: SA Health 2018

### 4-2-2. Arthritis prevalence in South Australia – by age and sex

- In 2017, the proportion of the population aged 18 years and over that was living with arthritis was higher for females (27.8%) than males (17.6%)<sup>1</sup>.
- Arthritis prevalence is also correlated with age<sup>1</sup>.

**Arthritis prevalence (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	3.1%	0.0%
25-34	6.2%	4.1%
35-44	8.2%	8.4%
45-54	12.7%	27.7%
55-64	32.9%	41.0%
65-74	42.7%	60.7%
75+	35.6%	61.2%
<b>All ages</b>	<b>17.6%</b>	<b>27.8%</b>



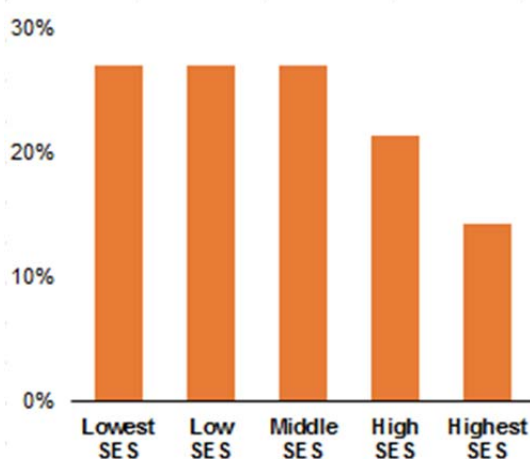
Data source: SA Health 2018

**4-2-3. Arthritis prevalence in South Australia – by socio-economic status**

- In 2017, there was no statistically significant correlation between the proportion of people aged 18 years and over who are living with arthritis and the socio-economic status (SES) of the geographic area in which they live<sup>1</sup>.
- However, the rate in the lowest SES quintile (26.9%) is around double the rate in the highest SES quintile (14.2%)<sup>1</sup>.

**Arthritis prevalence (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	26.9%
Low SES	26.9%
Middle SES	27.0%
High SES	21.4%
Highest SES	14.2%



Data source: SA Health 2018

**4-2-4. Arthritis prevalence in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people of all ages reporting living with arthritis. This is not directly comparable with data presented from the state-wide survey for ages 18 years and over in 4-2-1 to 4-2-3 above.
- The national survey reports figures that broadly corroborate the statewide figures, showing that an estimated 15.2% of the age-standardised population in South Australia are living with arthritis<sup>2</sup>.



- The South Australian rate is a little higher than the Australia-wide estimate (13.9%) and is at the top end of the range of rates for the states and territories, although it is lower than that for Tasmania<sup>2</sup>.

#### Arthritis prevalence (all ages), 2014–15 (age-standardised)

State/Territory	%
Northern Territory	10.2%
Western Australia	12.3%
Queensland	12.4%
Australian Capital Territory	13.6%
Victoria	13.7%
New South Wales	14.7%
<b>South Australia</b>	<b>15.2%</b>
Tasmania	19.3%
<b>Australia</b>	<b>13.9%</b>



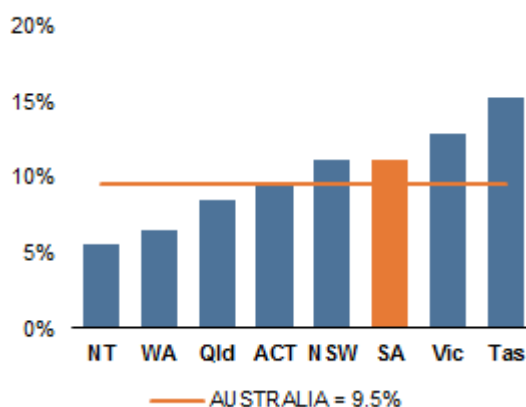
Data source: ABS 2015

#### 4-2-5. Arthritis prevalence – Aboriginal people

- The 11.2% of Aboriginal people in South Australia who reported living with arthritis was above the national average for Aboriginal people of 9.5%<sup>3</sup>.
- Arthritis prevalence for Aboriginal people varied between states and territories, with South Australia ranked equal third highest with New South Wales<sup>3</sup>.
- The rate for Aboriginal people in South Australia during 2012-13 (11.2%) is below the 14.6% for all persons in South Australia recorded in 2011-12 (see 4-2-4 above)<sup>3</sup>.

#### Arthritis prevalence - Aboriginal people (aged 15+ years), 2012-13

State/Territory	%
Northern Territory	5.5%
Western Australia	6.5%
Queensland	8.5%
Australian Capital Territory	9.6%
New South Wales	11.2%
<b>South Australia</b>	<b>11.2%</b>
Victoria	12.8%
Tasmania	15.3%
<b>Australia</b>	<b>9.5%</b>



Data source: ABS 2013

#### Sources

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.

2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [\*National Health Survey: First Results, 2014-15\*](#), cat. no. 4364.0.55.001, viewed 6 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2013), 'Table 3.3 Selected health characteristics by State/Territory,' [\*Australian Aboriginal and Torres Strait Islander health survey: First results 2012-13\*](#), cat. no. 4727.0.55.001, viewed 4 February 2014.

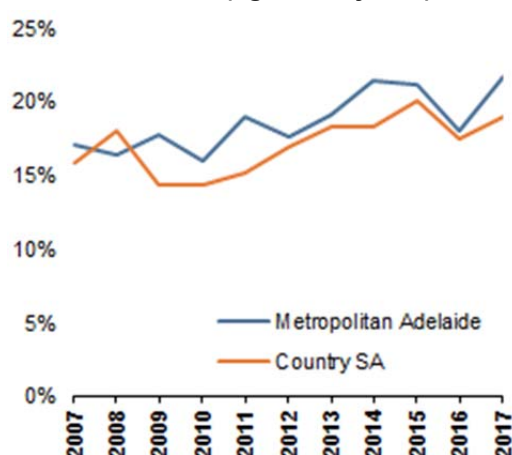
### 4-3. Mental health conditions

#### 4-3-1. Mental health conditions in South Australia – by Local Health Network

- In 2017, around one in five (20.9%) South Australians aged 18 years or more reported living with a doctor-diagnosed mental health condition<sup>1</sup>.
- A mental health condition is defined here as doctor-diagnosed anxiety, depression, stress, or any other mental health problem.
- The rate varies between the local health networks (LHNs) from 10.8% in the Eyre and Far North LHN to 25.6% in the Yorke and Northern LHN<sup>1</sup>.
- The metropolitan Adelaide rate (21.8%) is statistically significantly higher than the Country SA rate of 19.0%<sup>1</sup>.
- A statistically significant increasing trend over the last decade in the proportion of people reporting living with a mental health condition was identified in both the metropolitan Adelaide and Country SA time series<sup>1</sup>.

#### Living with a doctor-diagnosed mental health condition (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	24.6%
Central Adelaide	20.9%
Southern Adelaide	20.4%
<b>Metropolitan Adelaide</b>	<b>21.8%</b>
Barossa Hills Fleurieu	21.2%
Eyre and Far North	10.8%
Flinders and Upper North	21.9%
Riverland Mallee Coorong	15.4%
South East	12.2%
Yorke & Northern	25.6%
<b>Country SA</b>	<b>19.0%</b>
<b>South Australia</b>	<b>20.9%</b>
<b>Australia</b>	<b>n.a.</b>



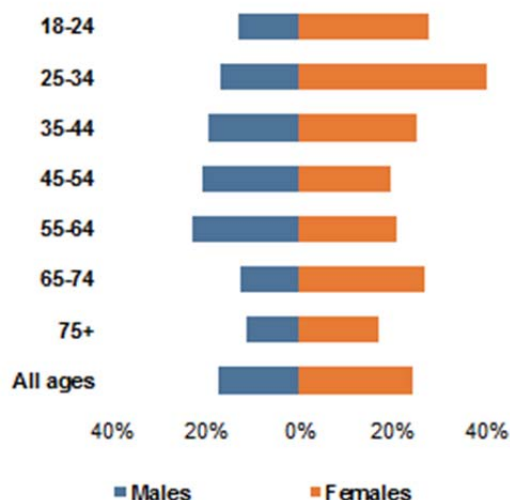
Data source: SA Health 2018

#### 4-3-2. Mental health conditions in South Australia – by age and sex

- In 2017, the proportion of the population aged 18 years and over that reported living with a doctor-diagnosed mental health condition was higher for females (24.5%) than males (17.2%)<sup>1</sup>.
- A mental health condition is defined here as doctor-diagnosed anxiety, depression, stress, or any other mental health problem.

**Living with a doctor-diagnosed mental health condition (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	12.8%	28.0%
25-34	16.7%	42.3%
35-44	19.3%	25.2%
45-54	20.9%	19.5%
55-64	22.8%	20.8%
65-74	12.6%	26.8%
75+	11.2%	17.0%
<b>All ages</b>	<b>17.2%</b>	<b>24.5%</b>



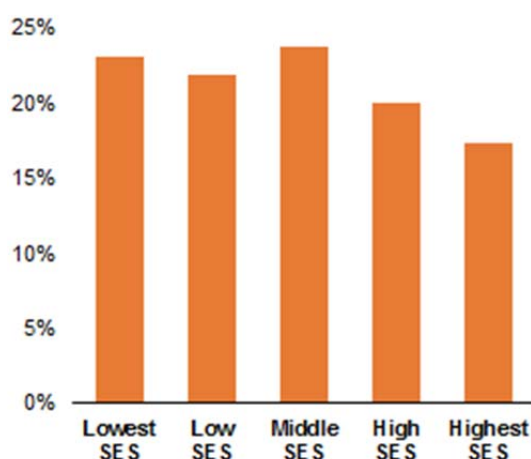
Data source: SA Health 2018

**4-3-3. Mental health conditions in South Australia – by socio-economic status**

- In 2017, there was no statistically significant correlation between the proportion of people aged 18 years reporting living with a doctor-diagnosed mental health condition and the socio-economic status of the geographic area in which they live<sup>1</sup>.
- A mental health condition is defined here as doctor-diagnosed anxiety, depression, stress, or any other mental health problem.

**Living with a doctor-diagnosed mental health condition (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	23.0%
Low SES	21.9%
Middle SES	23.7%
High SES	20.0%
Highest SES	17.3%



Data source: SA Health 2018

**4-3-4. Mental health conditions in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people of all ages and is not directly comparable with data presented from the state-wide survey for ages 18 years and over in 4-3-1 to 4-3-3 above.
- The national survey reports figures that broadly corroborate the statewide figures, showing that an estimated 18.1% of the age-standardised population in South Australia are living with a mental or behavioural problem that has lasted or which the survey respondent expects to last for six months or more<sup>2</sup>.

- The South Australian rate is similar to the Australia-wide rate of 17.4%. There is also not a great deal of variation in rates between the states and territories<sup>2</sup>.

#### Living with a mental or behavioural problem (all ages), 2014–15 (age-standardised)

State/Territory	%
Western Australia	14.5%
Northern Territory	15.3%
Victoria	17.3%
New South Wales	17.7%
Queensland	18.0%
<b>South Australia</b>	<b>18.1%</b>
Australian Capital Territory	18.2%
Tasmania	21.0%
<b>Australia</b>	<b>17.4%</b>



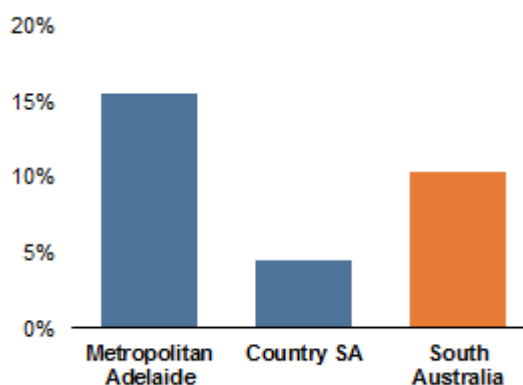
Data source: ABS 2015

#### 4-3-5. Mental health conditions – Aboriginal people

- In 2012, around one in ten (10.3%) Aboriginal people in South Australia reported living with a doctor-diagnosed mental health problem<sup>3</sup>.
- The rate was statistically significantly higher in metropolitan Adelaide (15.5%) than in Country SA (4.5%)<sup>3</sup>.
- The prevalence of mental health conditions in South Australia's Aboriginal population (10.3%) is around a third lower than the state all-person rate (see 4-3-4 above)<sup>3</sup>.

#### Living with a doctor-diagnosed mental health condition - Aboriginal people (aged 15+ years), 2012

Region	%
<b>Metropolitan Adelaide</b>	<b>15.5%</b>
Rural SA	4.4%
Remote SA	4.5%*
<b>Country SA</b>	<b>4.5%</b>
<b>South Australia</b>	<b>10.3%</b>
<b>Australia</b>	<b>n.a.</b>



\* Survey did not include APY Lands

Data source: University of Adelaide 2012

#### Sources

- Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.

2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.
3. Based on Taylor, A, Marin, T, Avery, J & Dal Grande, E 2012, 'Appendix A: Table A5.4 Mental Health', *South Australian Aboriginal health survey*, Population research and outcome studies, University of Adelaide, Adelaide.

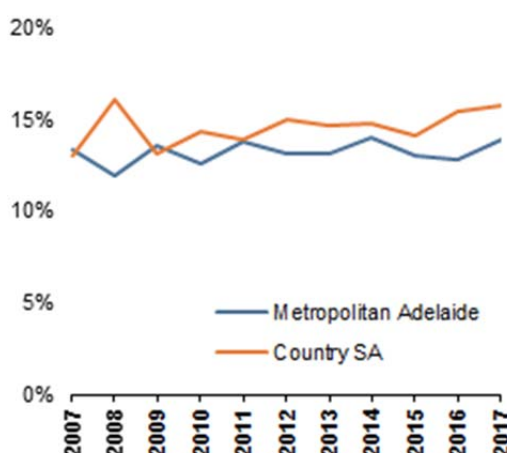
## 4-4. Asthma prevalence

### 4-4-1. Asthma prevalence in South Australia – by Local Health Network

- In 2017, around one in seven (14.5%) South Australians aged 18 years or more were living with asthma<sup>1</sup>.
- Asthma is defined here based on the Australian Centre for Asthma Monitoring: the respondent had been diagnosed with asthma and had experienced symptoms and/or treatment in the last 12-months.
- The rate varies between the local health networks (LHNs) from 10.9% in the Flinders and Upper North LHN to 21.8% in the Yorke and Northern LHN<sup>1</sup>.
- The Country SA rate (15.7%) is statistically significantly higher than the metropolitan Adelaide rate of 13.9%<sup>1</sup>.
- No statistically significant underlying trend over the last decade in the proportion of people reporting living with asthma was identified, either for the metropolitan Adelaide or Country SA time series<sup>1</sup>.

#### Asthma prevalence (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	16.9%
Central Adelaide	11.4%
Southern Adelaide	14.5%
<b>Metropolitan Adelaide</b>	<b>13.9%</b>
Barossa Hills Fleurieu	14.7%
Eyre and Far North	20.1%
Flinders and Upper North	10.9%
Riverland Mallee Coorong	11.6%
South East	15.9%
Yorke & Northern	21.8%
<b>Country SA LHN</b>	<b>15.7%</b>
<b>South Australia</b>	<b>14.5%</b>
<b>Australia</b>	<b>n.a.</b>



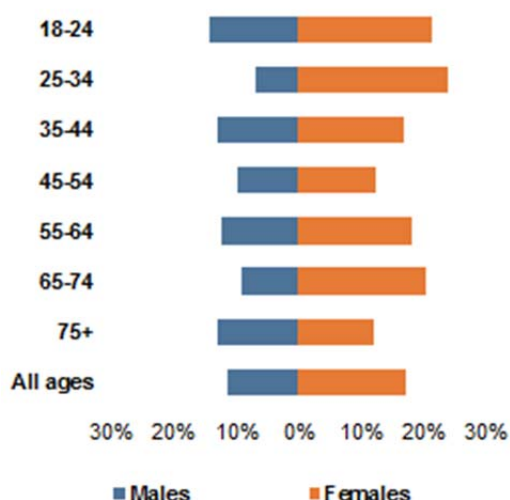
Data source: SA Health 2018

### 4-4-2. Asthma prevalence in South Australia – by age and sex

- In 2017, the proportion of the population aged 18 years and over that was living with asthma was higher for females (17.5%) than males (11.5%)<sup>1</sup>.
- Asthma is defined here based on the Australian Centre for Asthma Monitoring: the respondent had been diagnosed with asthma and had experienced symptoms and/or treatment in the last 12-months.

**Asthma prevalence (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	14.2%	21.5%
25-34	7.0%	24.1%
35-44	12.9%	16.9%
45-54	9.8%	12.5%
55-64	12.4%	18.3%
65-74	9.1%	20.6%
75+	12.8%	12.3%
<b>All ages</b>	<b>11.5%</b>	<b>17.5%</b>



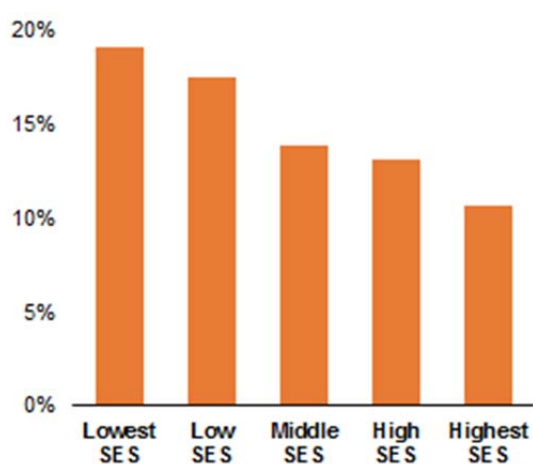
Data source: SA Health 2018

**4-4-3. Asthma prevalence in South Australia – by socio-economic status**

- In 2017, there was a statistically significant inverse correlation between the proportion of people aged 18 years and over who are living with asthma and the socio-economic status of the area in which they live<sup>1</sup>.
- Asthma is defined here based on the Australian Centre for Asthma Monitoring: the respondent had been diagnosed with asthma and had experienced symptoms and/or treatment in the last 12-months.

**Asthma prevalence (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	19.1%
Low SES	17.5%
Middle SES	13.8%
High SES	13.0%
Highest SES	10.6%



Data source: SA Health 2018

**4-4-4. Asthma prevalence in Australia – by state and territory**

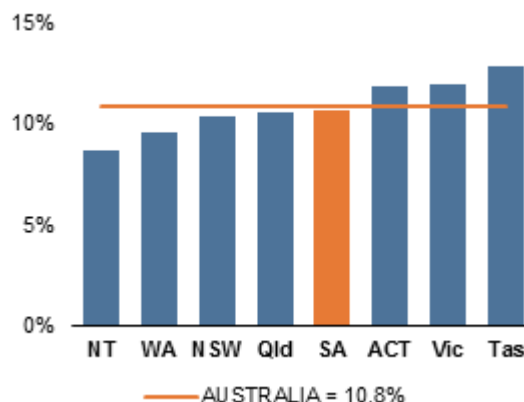
- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people of all ages and is not directly comparable with data presented from the state-wide survey for ages 18 years and over in 4-4-1 to 4-4-3 above.
- The national survey reports figures that broadly corroborate the state-wide survey a little over one in ten (10.6%) of the age-standardised population in South Australia estimated to be living with asthma<sup>2</sup>.



- The South Australian rate is level with the estimated Australia-wide rate (10.8%) and there is little variation identifiable between the rates reported for the various states and territories<sup>2</sup>.

#### Living with asthma (all ages), 2014–15 (age-standardised)

State/Territory	%
Northern Territory	8.7%
Western Australia	9.6%
New South Wales	10.3%
Queensland	10.5%
<b>South Australia</b>	<b>10.6%</b>
Australian Capital Territory	11.8%
Victoria	11.9%
Tasmania	12.8%
<b>Australia</b>	<b>10.8%</b>



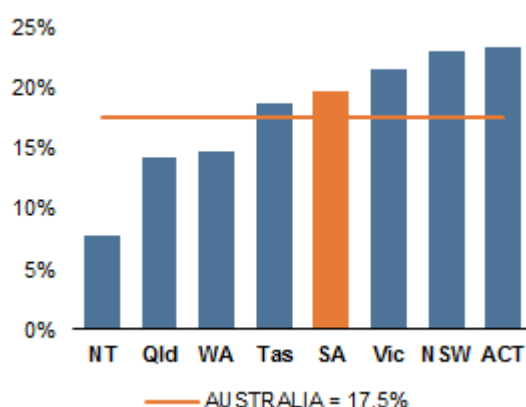
Data source: ABS 2015

#### 4-4-5. Asthma prevalence – Aboriginal people

- The 19.7% of Aboriginal people in South Australia who reported living with asthma was slightly above the national average for Aboriginal people of 17.5%<sup>3</sup>.
- Compared to Aboriginal people in other states and territories, South Australia was ranked fourth highest for this indicator<sup>3</sup>.
- However, the South Australian rate was 11.9 percentage points above the lowest ranked jurisdiction (Northern Territory)<sup>3</sup>.
- The rate for Aboriginal people in South Australia during 2012-13 (19.7%) is around double the 10.8% for all persons in SA recorded in 2011-12 (see 4-4-4 above)<sup>3</sup>.

#### Asthma prevalence - Aboriginal people (aged 15+ years), 2012-13

State/Territory	%
Northern Territory	7.8%
Queensland	14.3%
Western Australia	14.7%
Tasmania	18.8%
<b>South Australia</b>	<b>19.7%</b>
Victoria	21.5%
New South Wales	23.1%
Australian Capital Territory	23.4%
<b>Australia</b>	<b>17.5%</b>



Data source: ABS 2013

#### Sources

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.

2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [\*National Health Survey: First Results, 2014-15\*](#), cat. no. 4364.0.55.001, viewed 6 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2013), 'Table 3.3 Selected health characteristics by State/Territory,' [\*Australian Aboriginal and Torres Strait Islander health survey: First results 2012-13\*](#), cat. no. 4727.0.55.001, viewed 4 February 2014.

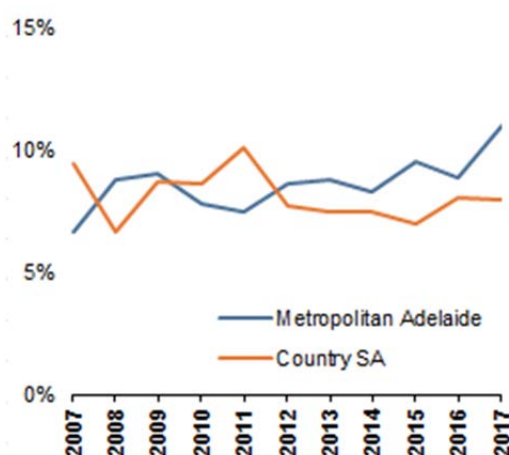
## 4-5. Diabetes prevalence

### 4-5-1. Diabetes prevalence in South Australia – by Local Health Network

- In 2017, around one in ten (10.1%) South Australians aged 18 years or more had ever been told by a doctor that they had diabetes<sup>1</sup>.
- The rate varies between local health networks (LHNs) from 5.4% in the Yorke and Northern LHN to 13.8% in the Flinders and Upper North LHN<sup>1</sup>.
- The increasing trend over the last decade in the proportion of people in metropolitan Adelaide reporting living with diabetes is statistically significant, however not so for the Country SA time series<sup>1</sup>.
- The metropolitan Adelaide rate (10.3%) is not statistically significantly lower than the Country SA rate (11.1%)<sup>1</sup>.

#### Diabetes prevalence (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	11.9%
Central Adelaide	10.8%
Southern Adelaide	10.3%
<b>Metropolitan Adelaide</b>	<b>11.0%</b>
Barossa Hills Fleurieu	7.3%*
Eyre and Far North	8.3%
Flinders and Upper North	13.8%
Riverland Mallee Coorong	11.1%
South East	7.2%
Yorke & Northern	5.4%
<b>Country SA</b>	<b>8.0%</b>
<b>South Australia</b>	<b>10.1%</b>
<b>Australia</b>	<b>n.a.</b>



\*Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

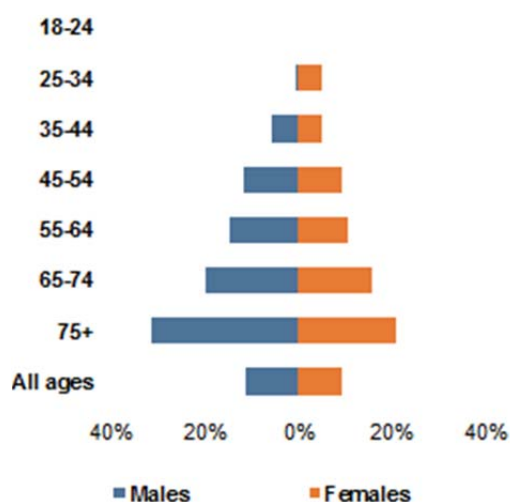
Data source: SA Health 2018

### 4-5-2. Diabetes prevalence in South Australia – by age and sex

- In 2017, the proportion of the population aged 18 years and over that had ever been told by a doctor that they have diabetes was higher for males (11.2%) than females (10.0%)<sup>1</sup>.
- The prevalence of diabetes is correlated with age<sup>1</sup>.

**Diabetes prevalence (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	0.0%	0.0%
25-34	0.3%	5.1%
35-44	5.5%	4.9%
45-54	11.5%	9.4%
55-64	14.5%	10.6%
65-74	19.9%	16.0%
75+	31.4%	20.8%
<b>All ages</b>	<b>11.2%</b>	<b>9.2%</b>



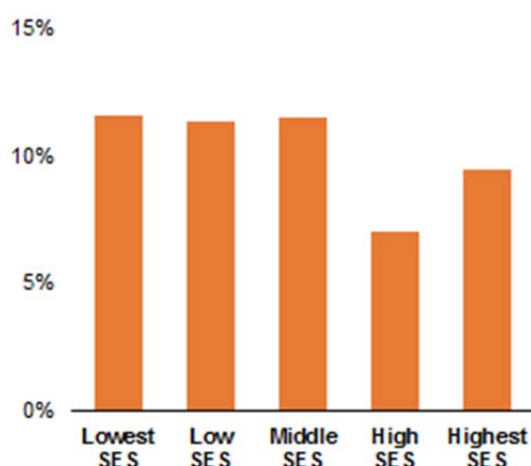
Data source: SA Health 2018

**4-5-3. Diabetes prevalence in South Australia – by socio-economic status**

- In 2017, there was a no statistically significant correlation between the proportion of people aged 18 years and over who have ever been told by a doctor that they have diabetes and the socio-economic status of the area in which they live (SES)<sup>1</sup>.

**Diabetes prevalence (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	11.6%
Low SES	11.4%
Middle SES	11.5%
High SES	7.0%
Highest SES	9.4%



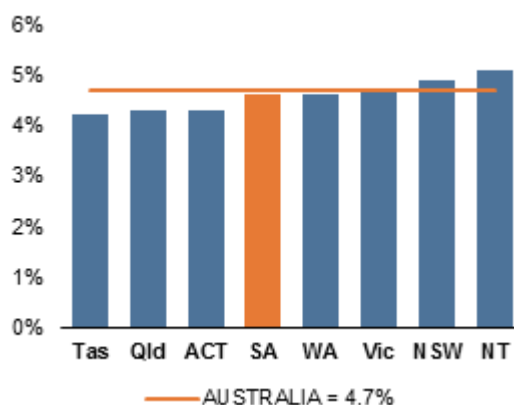
Data source: SA Health 2018

**4-5-4. Diabetes prevalence in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people of all ages who are or had been living with diabetes mellitus and is not directly comparable with data presented from the state-wide survey for ages 18 years and over in 4-5-1 to 4-5-3 above.
- The national survey estimates that 4.6% of the age-standardised South Australian population self-reports having diabetes (whether or not the disease was current at the time of interview)<sup>2</sup>.
- The South Australian rate is level with the estimated Australia-wide rate (4.7%) and there is very little variation between the rates reported for the various states and territories<sup>2</sup>.

**Living with diabetes mellitus (all ages), 2014–15 (age-standardised)**

State/Territory	%
Tasmania	4.2%
Queensland	4.3%
Australian Capital Territory	4.3%
<b>South Australia</b>	<b>4.6%</b>
Western Australia	4.6%
Victoria	4.7%
New South Wales	4.9%
Northern Territory	5.1%
<b>Australia</b>	<b>4.7%</b>



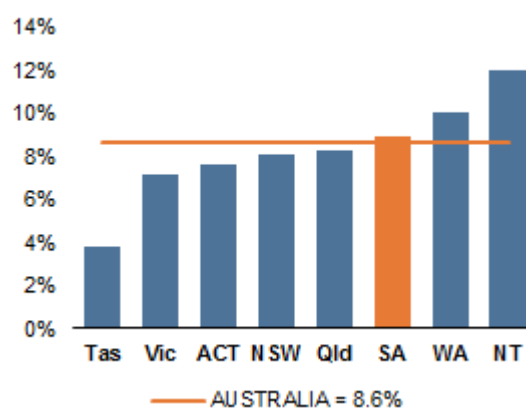
Data source: ABS 2015

**4-5-5. Diabetes prevalence – Aboriginal people**

- The prevalence of diabetes in the South Australian Aboriginal population was 8.9% in 2012-13, around twice that of the all-population prevalence for this state in 2011-12 (see 4-5-4 above). However, readers should note that figures are not directly comparable because of different time periods and definitions<sup>3</sup>.
- Compared to Aboriginal people in other states and territories, South Australia was ranked third highest for this indicator<sup>3</sup>.
- However, the South Australian rate was 3.1 percentage points below the highest ranked jurisdiction (Northern Territory)<sup>3</sup>.

**Diabetes/high sugar levels prevalence – Aboriginal people (aged 2+ years), 2012-13**

State/Territory	%
Tasmania	3.8%
Victoria	7.1%
Australian Capital Territory	7.6%
New South Wales	8.1%
Queensland	8.3%
<b>South Australia</b>	<b>8.9%</b>
Western Australia	10.0%
Northern Territory	12.0%
<b>Australia</b>	<b>8.6%</b>



Data source: ABS 2014

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.

3. Based on Australian Bureau of Statistics (ABS 2014), 'Table 3.3 Selected health characteristics, by State/Territory – 2012-13, Proportion of Aboriginal and Torres Strait Islander persons,' [\*Australian Aboriginal and Torres Strait Islander health survey: Updated results 2012-13\*](#), cat. no. 4727.0.55.006, viewed 18 August 2014.

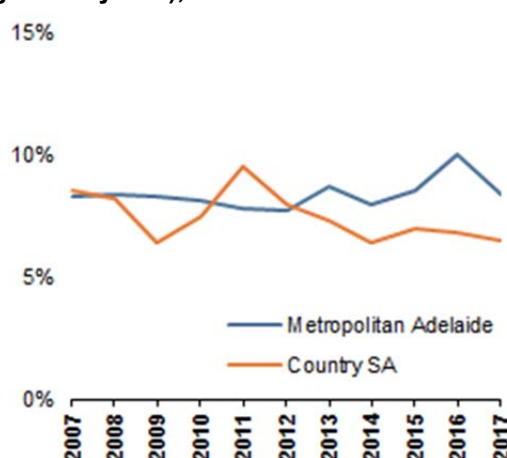
## 4-6. Cardiovascular disease prevalence

### 4-6-1. Cardiovascular disease prevalence in South Australia – by Local Health Network

- In 2017, around one in 12 (7.8%) South Australians aged 18 years or more were living with cardiovascular disease, defined here as *ever had doctor-diagnosed heart attack, angina, heart disease and/or stroke*<sup>1</sup>.
- The rate varies between local health networks (LHNs) from 3.8% in the Barossa Hills Fleurieu LHN to 10.4% in both the Central Adelaide and Riverland Mallee Coorong LHNs.
- The prevalence of cardiovascular disease in metropolitan Adelaide (8.3%) is statistically significantly higher than the Country SA rate of 6.5%<sup>1</sup>.
- No statistically significant underlying trend over the last decade in the proportion of people reporting living with cardiovascular disease was identified, either for the metropolitan Adelaide or Country SA time series<sup>1</sup>.

#### Cardiovascular disease prevalence (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	7.5%
Central Adelaide	10.4%
Southern Adelaide	6.7%
<b>Metropolitan Adelaide</b>	<b>8.3%</b>
Barossa Hills Fleurieu	3.8%
Eyre and Far North	7.2%*
Flinders and Upper North	7.3%*
Riverland Mallee Coorong	10.4%
South East	7.8%
Yorke & Northern	7.4%
<b>Country SA</b>	<b>6.5%</b>
<b>South Australia</b>	<b>7.8%</b>
<b>Australia</b>	<b>n.a.</b>



\* Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

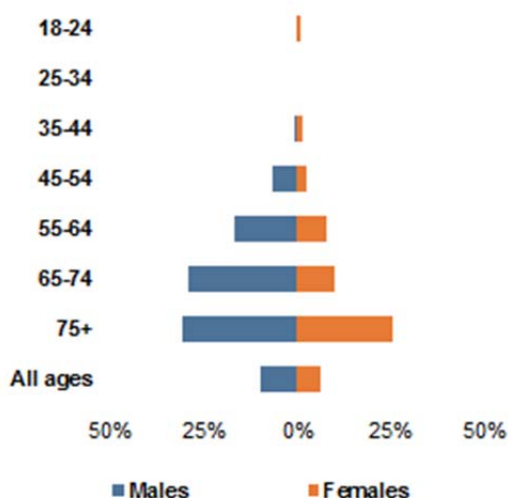
Data source: SA Health 2018

### 4-6-2. Cardiovascular disease prevalence in South Australia – by age and sex

- In 2017, the proportion of the population aged 18 years and over living with cardiovascular disease - defined here as *ever had doctor-diagnosed heart attack, angina, heart disease and/or stroke* - was higher for males (9.6%) than females (6.3%)<sup>1</sup>.
- The prevalence of cardiovascular disease is also correlated with age<sup>1</sup>.

**Cardiovascular disease prevalence (aged 18+ years), 2017**

Age (years)	Males	Females
18-24	0.0%	1.0%
25-34	0.0%	0.0%
35-44	0.2%	1.5%
45-54	6.4%	2.7%
55-64	16.7%	8.2%
65-74	29.4%	10.0%
75+	30.8%	25.9%
<b>All ages</b>	<b>9.6%</b>	<b>6.3%</b>



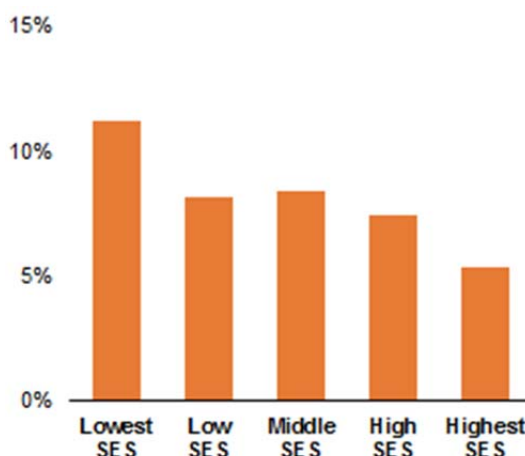
Data source: SA Health 2018

**4-6-3. Cardiovascular disease prevalence in South Australia – by socio-economic status**

- In 2017, there was a statistically significant inverse correlation between the proportion of people aged 18 years and over living with cardiovascular disease - defined here as *ever had doctor-diagnosed heart attack, angina, heart disease and/or stroke* - and the socio-economic status of the area in which they live<sup>1</sup>.

**Cardiovascular disease prevalence (aged 18+ years), 2017**

Socio-economic status (SES)	%
Lowest SES	11.2%
Low SES	8.2%
Middle SES	8.3%
High SES	7.5%
Highest SES	5.3%



Data source: SA Health 2018

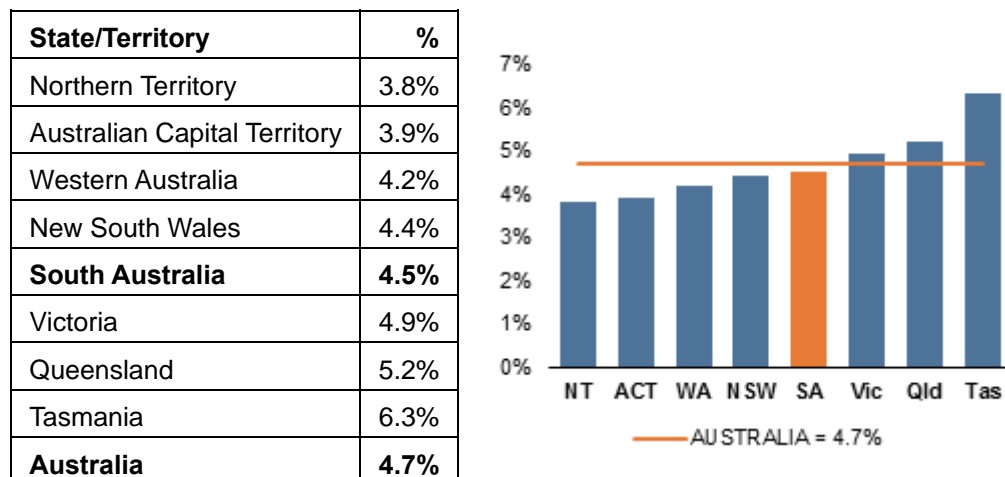
**4-6-4. Cardiovascular disease prevalence in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people of all ages who have been told by a doctor or nurse that they have a cardiovascular condition. It is not directly comparable with data presented in 4-6-1 to 4-6-3 above from the state-wide survey.
- This measure includes the following *current and long-term conditions*: oedema; heart failure; diseases of the arteries, arterioles and capillaries; and the following *conditions whether or not current and long-term*: ischaemic heart diseases (angina, heart attack and other ischaemic heart diseases); cerebrovascular diseases (stroke and other cerebrovascular diseases)<sup>2</sup>.



- The national survey estimates that 4.5% of the age-standardised South Australian population self-reported having a cardiovascular disease<sup>2</sup>.
- The South Australian rate is level with the estimated Australia-wide rate (4.7%) and sits in the middle of a similar band of rates reported for most of the states and territories<sup>2</sup>.

#### Prevalence of heart, stroke and vascular disease (all ages), 2014–15 (age-standardised)



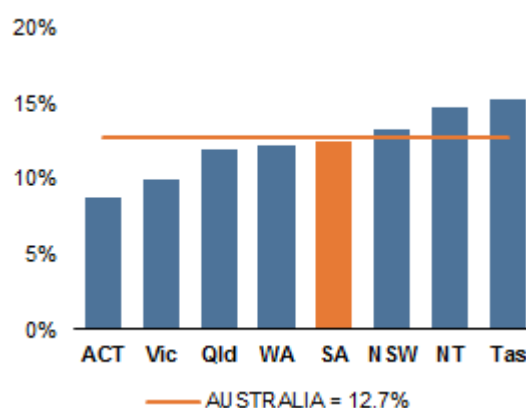
Data source: ABS 2015

#### 4-6-5. Cardiovascular disease prevalence – Aboriginal people

- The prevalence of heart and circulatory problems/diseases in the South Australian Aboriginal population (aged two years and over) was 12.5% in 2012-13, only very slightly below the national average for Aboriginal people of 12.7%<sup>3</sup>.
- *Heart and circulatory problems/diseases* are defined here as hypertensive disease; ischaemic heart diseases; other heart diseases; tachycardia; cerebrovascular diseases; oedema; diseases of the arteries, arterioles and capillaries; diseases of the veins, lymphatic vessels, other diseases of the circulatory system; and symptoms and signs involving the circulatory system<sup>3</sup>.
- The 12.5% of Aboriginal people in South Australia living with cardiovascular disease is substantially higher than the all-person prevalence for this state (see 4-6-4 above). However, readers should note that figures are not directly comparable as the figures in 4-6-4 are age-standardised<sup>3</sup>.
- Compared to Aboriginal people in other states and territories, South Australia was ranked fourth highest for this indicator<sup>3</sup>.

**Cardiovascular disease prevalence --Aboriginal people (aged 2+ years), 2012-13**

State/Territory	%
Australian Capital Territory	8.8%
Victoria	10.0%
Queensland	11.9%
Western Australia	12.2%
<b>South Australia</b>	<b>12.5%</b>
New South Wales	13.3%
Northern Territory	14.7%
Tasmania	15.2%
<b>Australia</b>	<b>12.7%</b>



Data source: ABS 2014

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2014), 'Table 3.3 Selected health characteristics, by State/Territory, Proportion of Aboriginal and Torres Strait Islander persons,' [Australian Aboriginal and Torres Strait Islander health survey: Updated results 2012-13](#), cat. no. 4727.0.55.006, viewed 19 August 2014.

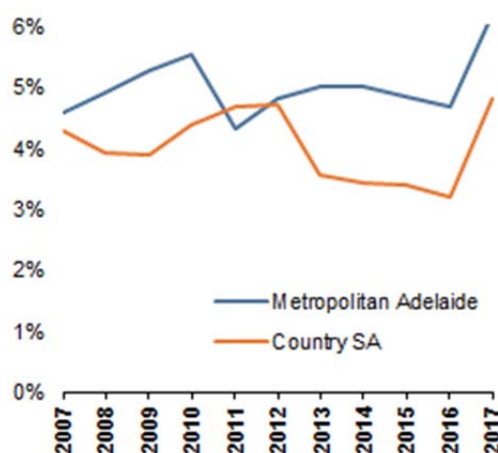
## 4-7. Osteoporosis prevalence

### 4-7-1. Osteoporosis prevalence in South Australia – by Local Health Network

- In 2017, around one in twenty (5.8%) of South Australians aged 18 years or more were living with osteoporosis<sup>1</sup>.
- The rate varies between local health networks (LHNs) from 2.0%\* in the South East LHN to 7.3%\* in the Flinders and Upper North LHN.
- The prevalence of osteoporosis in metropolitan Adelaide (6.2%) is statistically significantly higher than Country SA (4.8%)<sup>1</sup>.
- No statistically significant underlying trend over the last decade in the proportion of people reporting living with osteoporosis was identified, either for the metropolitan Adelaide or Country SA time series<sup>1</sup>.

#### Osteoporosis prevalence (aged 18+ years), 2017

Local Health Network	%
Northern Adelaide	6.1%
Central Adelaide	5.7%
Southern Adelaide	6.8%
<b>Metropolitan Adelaide</b>	<b>6.2%</b>
Barossa Hills Fleurieu	6.0%
Eyre and Far North	2.2%**
Flinders and Upper North	7.3%*
Riverland Mallee Coorong	2.9%*
South East	2.0%*
Yorke & Northern	6.3%
<b>Country SA</b>	<b>4.8%</b>
<b>South Australia</b>	<b>5.8%</b>
<b>Australia</b>	<b>n.a.</b>



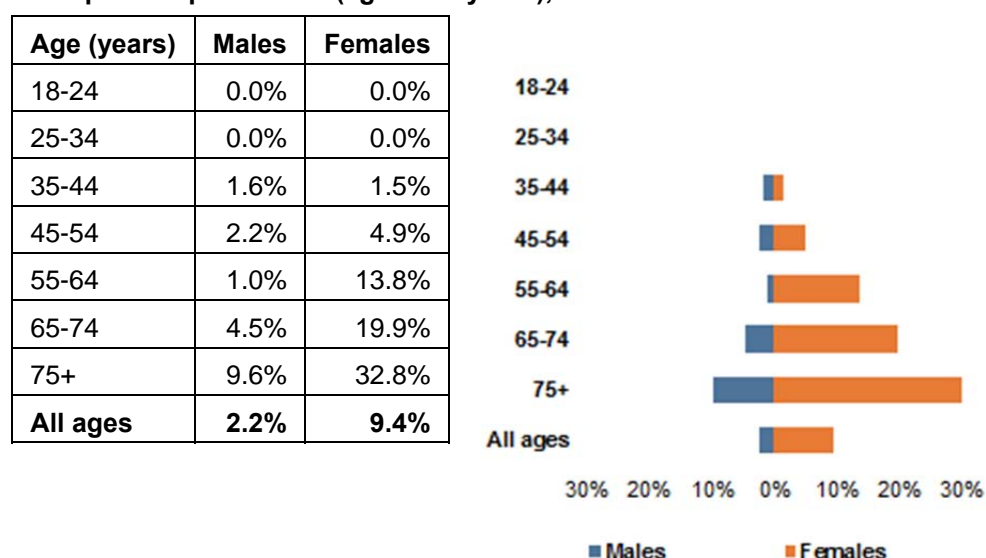
\*\* Relative Standard Error is greater than 50%. Please treat the estimate with extreme caution.

\* Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

Data source: SA Health 2018

### 4-7-2. Osteoporosis prevalence in South Australia – by age and sex

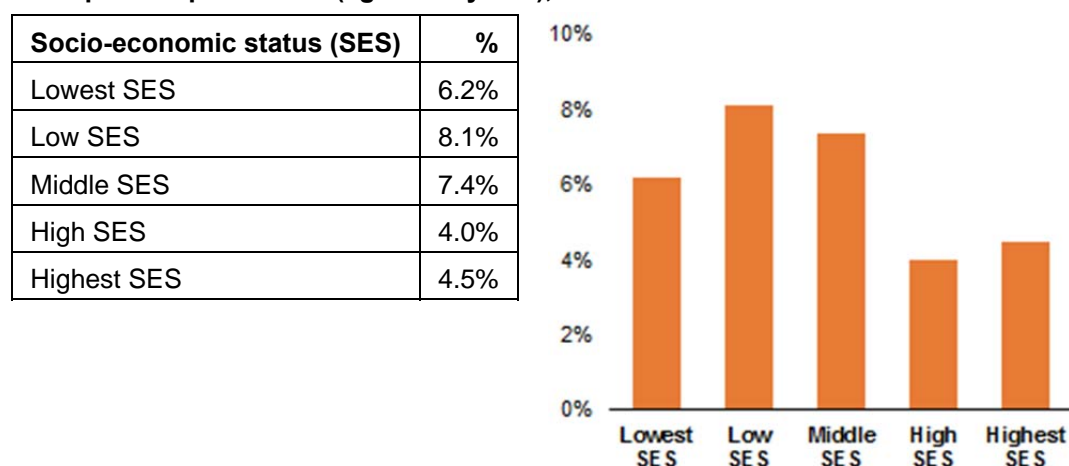
- In 2017, the proportion of the population aged 18 years and over living with osteoporosis was more than four times for females (9.4%) than males (2.2%)<sup>1</sup>.
- The prevalence of osteoporosis is also correlated with age<sup>1</sup>.

**Osteoporosis prevalence (aged 18+ years), 2017**

Data source: SA Health 2018

**4-7-3. Osteoporosis prevalence in South Australia – by socio-economic status**

- In 2017, there was no statistically significant correlation between the proportion of people aged 18 years and over living with osteoporosis and the socio-economic status of the geographic area in which they live<sup>1</sup>.

**Osteoporosis prevalence (aged 18+ years), 2017**

Data source: SA Health 2018

**4-7-4. Osteoporosis prevalence in Australia – by state and territory**

- Data presented here is from the Australian Bureau of Statistics' 2014-15 National Health Survey for people of all ages reporting living with osteoporosis. This is not directly comparable with data presented from the state-wide survey for ages 18 years and over in 4-7-1 to 4-7-3 above.
- The national survey estimates that 3.1% of the age-standardised population in South Australia are living with osteoporosis<sup>2</sup>.
- The South Australian rate is level with the Australia-wide estimate (3.1%) and within a band in which most of the states and territories have their estimated rates, although there is some variation apparent between the jurisdictions<sup>2</sup>.

**Osteoporosis prevalence (all ages), 2014–15 (age-standardised)**

State/Territory	%
Northern Territory	1.6%
Western Australia	2.7%
Queensland	2.8%
Victoria	3.0%
Tasmania	3.0%
<b>South Australia</b>	<b>3.1%</b>
New South Wales	3.6%
Australian Capital Territory	4.0%
<b>Australia</b>	<b>3.1%</b>



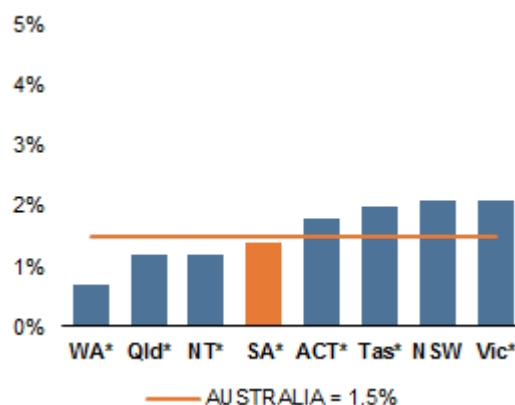
Data source: ABS 2015

**4-7-5. Osteoporosis prevalence – Aboriginal people**

- The prevalence of osteoporosis in the South Australian Aboriginal population was 1.4% in 2012-13, similar to the national average for Aboriginal people of 1.5%<sup>3</sup>.
- Readers are advised that the South Australian estimate has a relative standard error between 25% and 50% and should be used with caution<sup>3</sup>.

**Osteoporosis prevalence - Aboriginal people (aged 2+ years), 2012-13**

State/Territory	%
Western Australia	0.7%*
Queensland	1.2%*
Northern Territory	1.2%*
<b>South Australia</b>	<b>1.4%*</b>
Australian Capital Territory	1.8%*
Tasmania	2.0%*
New South Wales	2.1%
Victoria	2.1%*
<b>Australia</b>	<b>1.5%</b>



\* Relative Standard Error is between 25% and 50%. Please treat the estimate with caution.

Data source: ABS 2013

**Sources**

1. Based on South Australian Monitoring and Surveillance System customised extract 2018, Prevention and Population Health, SA Health, Adelaide, 16 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.
3. Based on Australian Bureau of Statistics (ABS 2013), 'Table 3.3 Selected health characteristics, by State/Territory – 2012-13, Proportion of Aboriginal and Torres Strait Islander

persons,' [\*Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13 – Australia\*](#), cat. no. 4727.0.55.001, viewed 19 August 2014.

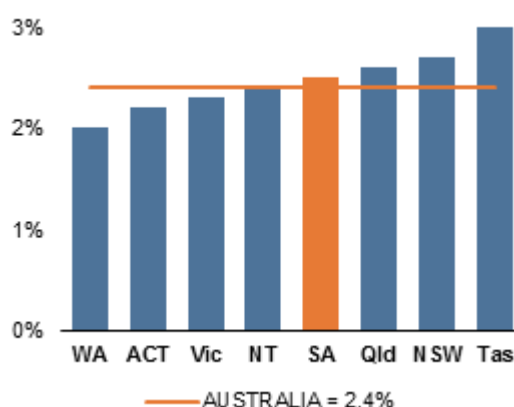
## 4-8. Chronic bronchitis or emphysema prevalence

### 4-8-1. Chronic bronchitis or emphysema prevalence in Australia – by state and territory

- An estimated one in 40 (2.5%) of the age-standardised population in South Australia are living with chronic obstructive pulmonary disease (including bronchitis and emphysema) which has lasted or is expected to last six months or longer<sup>1</sup>.
- The estimate is a little higher than the 2.1% estimated by the previous survey (for 2011-12)<sup>1</sup>.
- The South Australian rate is level with the Australia-wide estimate (2.4%) and around the middle of a narrow band from 2.0% to 3.0% within which the rates for each of the states and territories are estimated to fall<sup>1</sup>.

#### Prevalence of chronic obstructive pulmonary disease, 2014–15 (age-standardised)

State/Territory	%
Western Australia	2.0%
Australian Capital Territory	2.2%
Victoria	2.3%
Northern Territory	2.4%
<b>South Australia</b>	<b>2.5%</b>
Queensland	2.6%
New South Wales	2.7%
Tasmania	3.0%
<b>Australia</b>	<b>2.4%</b>



Data source: ABS 2015

### 4-8-2. Chronic bronchitis or emphysema prevalence – Aboriginal people

Data not available for this indicator.

## Sources

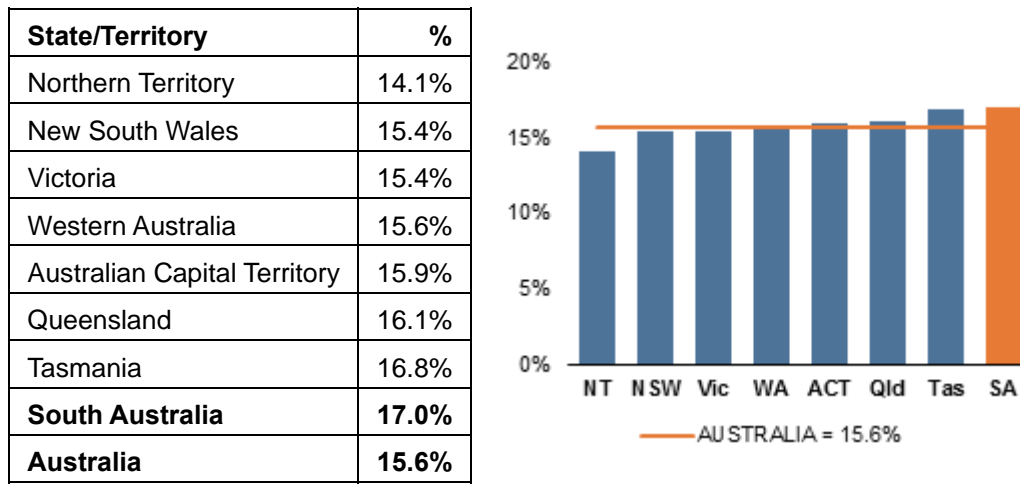
1. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.

## 4-9. Back pain prevalence

### 4-9-1. Back pain prevalence in Australia – by state and territory

- An estimated one in six (17.0%) of the age-standardised population in South Australia are living with a back problem which has lasted or is expected to last six months or longer<sup>1</sup>.
- This measure includes sciatica, disc disorders, curvature of the spine and other back pain/problems<sup>1</sup>.
- The estimate for South Australian rate is higher than for any other state or territory, although margins for error in the estimation mean that there is little to distinguish between the estimates for the various jurisdictions<sup>1</sup>.

#### Prevalence of long-term back conditions, 2014–15 (age-standardised)



Data source: ABS 2015

### 4-9-2. Back pain prevalence – Aboriginal people

Data not available for this indicator.

## Sources

1. Based on Australian Bureau of Statistics (ABS 2015), 'Table 2.3 Summary health characteristics — States and territories, Proportion of persons', [National Health Survey: First Results, 2014-15](#), cat. no. 4364.0.55.001, viewed 6 June 2016.



## End of life

### In summary

- South Australia records **more than 13,000 deaths every year**, converting to a standardised death rate of **5.6 deaths per 1,000 population**.
- The **median age of death for males** in South Australia is **80.2 years**.
- The **median age of death for females** in South Australia is **86.0 years**.
- The **perinatal death rate** in South Australia has been declining over the last decade and is now at **5.5 perinatal deaths per 1,000 all births**. Perinatal deaths are all fetal deaths (at least 20 weeks' gestation or at least 400 grams birth weight) plus all neonatal deaths. South Australia has the lowest rate of perinatal deaths in Australia compared to the other states and territories.
- South Australia's **infant mortality rate** is **3.1 infant deaths per 1,000 live births**. Infant mortality is defined as deaths of persons aged under one year of age.
- Due to the extremely small numbers involved, child mortality (deaths of persons aged 1-4 years) is not reported in *State of Our Health*.
- Overall, the **top three leading causes of death** in South Australia are: **cancer, circulatory diseases** and **respiratory diseases**.
- Leading causes of death vary with age group, but for the younger population, between the **ages of 15 and 44 years**, the leading cause of death is **intentional self-harm**.

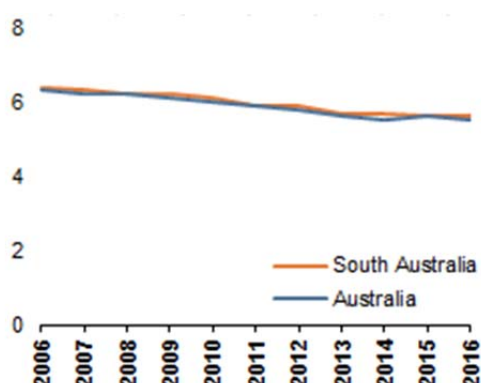
## 5-1. Death rate

### 5-1-1. Death rate

- In 2016, South Australia reported 13,337 deaths, converting to a standardised death rate of 5.6 deaths per 1,000 population.<sup>1</sup>
- The standardised death rate was slightly higher in Country SA (5.8 per 1,000 people) than Greater Adelaide (5.5).<sup>1</sup>
- The South Australian standardised death rate has declined over the last decade, down from 6.4 per 1,000 population recorded in 2006.<sup>1</sup>
- South Australia standardised death rate is only very slightly above the national average of 5.5 per 1,000 population.<sup>1</sup>

#### Standardised death rate, 2016

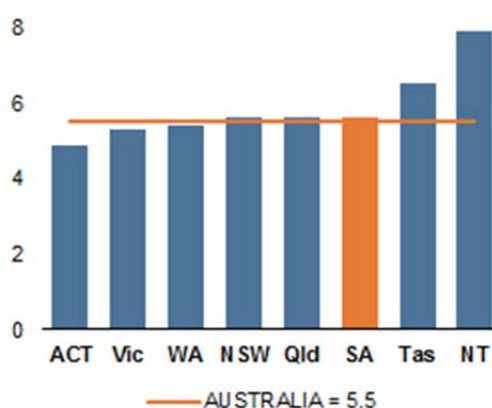
Region	Per 1000 popn.
Greater Adelaide	5.5
Country SA	5.8
<b>South Australia</b>	<b>5.6</b>
Australia	5.5



Data source: ABS 2017

#### Standardised death rate, 2016

State/Territory	Per 1000 popn.
Aust. Capital Territory	4.9
Victoria	5.3
Western Australia	5.4
New South Wales	5.6
Queensland	5.6
<b>South Australia</b>	<b>5.6</b>
Tasmania	6.5
Northern Territory	7.9
<b>Australia</b>	<b>5.5</b>



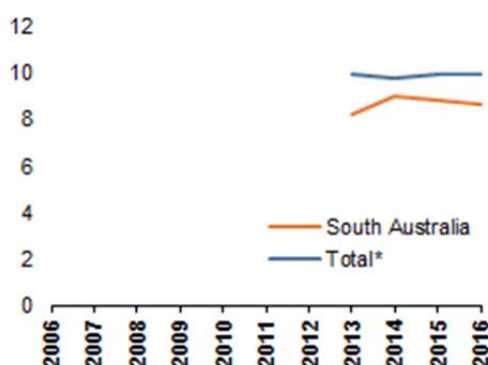
Data source: ABS 2017

### 5-1-2. Aboriginal death rate

- This section reports the age standardised all-cause mortality rate for Aboriginal people (per 1,000 Aboriginal people).
- Only New South Wales, Queensland, Western Australia, South Australia and the Northern Territory are included as these jurisdictions have sufficient data to support mortality analysis.<sup>2</sup>
- In 2016, the Aboriginal death rate in South Australia was 8.7 deaths per 1,000 Aboriginal population (age standardised).<sup>2</sup>
- Of the five states and territories that reported data, South Australia ranks second-lowest for Aboriginal mortality rate.<sup>2</sup>

**Aboriginal standardised death rate, 2016**

Region	Per 1000 popn.
Greater Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>8.7</b>
<b>Total</b>	<b>10.0*</b>

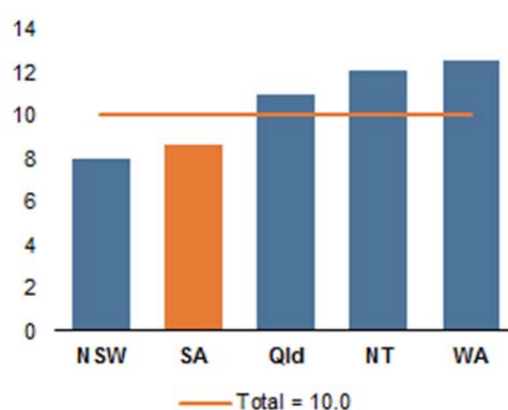


\*Total includes data for NSW, Qld, WA, SA and the NT only

Data source: Report On Government Services 2018

**Aboriginal standardised death rate, 2016**

State/Territory	Per 1000 popn.
New South Wales	8.0
<b>South Australia</b>	<b>8.7</b>
Queensland	11.0
Northern Territory	12.1
Western Australia	12.5
Aust. Capital Territory	n.a.
Tasmania	n.a.
Victoria	n.a.
<b>Total</b>	<b>10.0*</b>



\* Total includes data for NSW, Qld, WA, SA and the NT only. These five states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis. Data were not published for the period starting from 2006 until 2012.

Data source: Report On Government Services 2018

**Sources**

1. Based on Australian Bureau of Statistics (ABS 2017), 'Table 3.1 Deaths, Summary, Statistical Area Level 4-2006 to 2016', [Deaths, Australia, 2016](#), cat. no. 3302.0, viewed 8 August 2018.
2. Based on Health Attachment tables, Table EA.32 Age standardised all-cause mortality rate and rate ratios, by Indigenous status, NSW, Qld, WA, SA, NT (per 100 000 people) ', Part E, [Report on Government Services 2018](#), Government of Australia, viewed 15 August 2018.

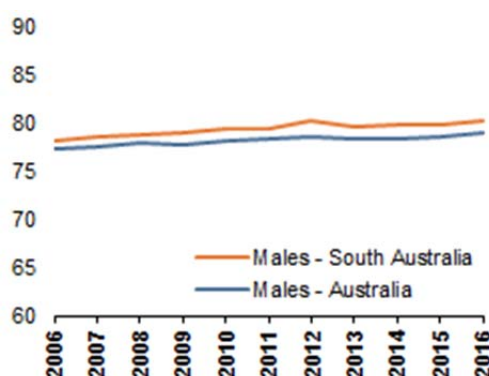
## 5-2. Median age at death

### 5-2-1. Male median age at death

- The median age of death for males in South Australia was 80.2 years in 2016, higher than the 79.1 years recorded for males nationally, but well below the 86.0 years for females in South Australia.<sup>1</sup>
- Over the last decade there has been a gradual increase in the median age at death for males in South Australia up from 78.2 years in 2006.<sup>1</sup>
- In 2016 South Australia had the second highest median age at death for males of the states and territories. However, outside of the Northern Territory there isn't a large amount of variation between the jurisdictions.<sup>1</sup>
- The graphs below do not start at the origin to show detail.

#### Median age at death, Males, 2016

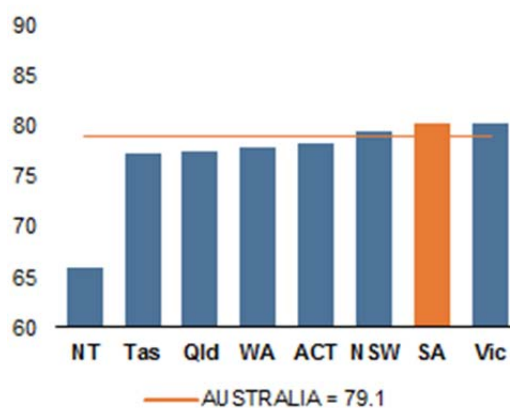
Region	years
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>80.2</b>
Australia	79.1



Data Source: ABS 2017

#### Median age at death, Males, 2016

State/Territory	years
Northern Territory	65.9
Tasmania	77.3
Queensland	77.6
Western Australia	78.0
Australian Capital Territory	78.3
New South Wales	79.4
<b>South Australia</b>	<b>80.2</b>
Victoria	80.3
<b>Australia</b>	<b>79.1</b>



Data Source: ABS 2017

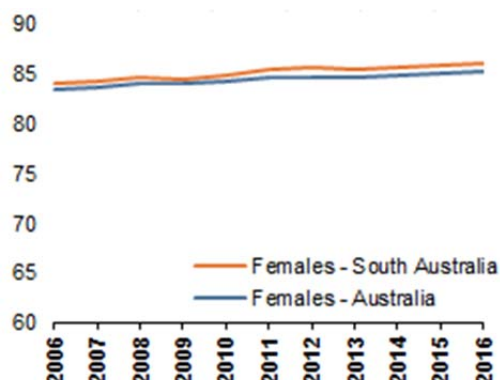
### 5-2-2. Female median age at death

- The median age of death for females in South Australia was 86.0 years in 2016, higher than the 85.1 years recorded for females nationally, and well above the 80.2 years for males in South Australia.<sup>1</sup>
- Over the last decade there has been a gradual increase in the median age at death for females in South Australia, up from 84.0 years in 2006.<sup>1</sup>

- In 2016 South Australia had the highest median age at death for females of the states and territories. However, outside of the Northern Territory there isn't a large amount of variation between the jurisdictions.<sup>1</sup>
- The graphs below do not start at the origin to show detail.

#### Median age at death, Females, 2016

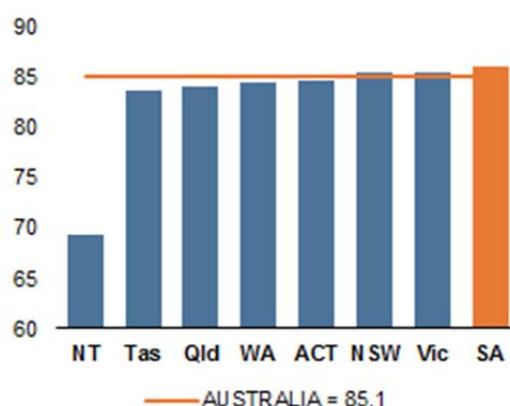
Region	years
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>86.0</b>
Australia	85.1



Data Source: ABS 2017

#### Median age at death, Females, 2016

State/Territory	years
Northern Territory	69.3
Tasmania	83.7
Queensland	84.1
Western Australia	84.5
Australian Capital Territory	84.6
New South Wales	85.4
Victoria	85.5
<b>South Australia</b>	<b>86.0</b>
<b>Australia</b>	<b>85.1</b>



Data Source: ABS 2017

### 5-2-3. Aboriginal median age at death

Due to serious data quality concerns raised by several sources, the *State of Our Health* does not report Aboriginal median age at death as a useful population health status indicator at this time.

#### Sources

1. Based on Australian Bureau of Statistics (ABS 2017), 'Table 2.1 Median age at death, Year of occurrence, States and territories-2006 to 2016', [Deaths, Australia, 2016](#), cat. no. 3302.0, viewed 8 August 2018.

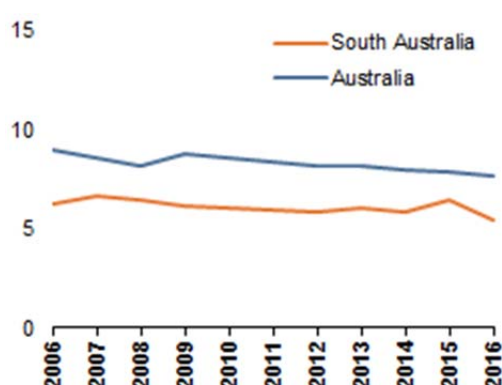
### 5-3. Perinatal deaths

#### 5-3-1. Perinatal deaths

- Perinatal deaths are all fetal deaths (at least 20 weeks' gestation or at least 400 grams birth weight) plus all neonatal deaths.
- In 2016, there were 5.5 perinatal deaths in South Australia per 1,000 all births, a rate that has declined over the last decade, down from 6.3 in 2006.<sup>1</sup>
- South Australia has the lowest rate of perinatal deaths in Australia compared to the other states and territories, and below the national average rate of 7.7 perinatal deaths per 1,000 all births.<sup>2</sup>
- *All births* comprise live births and stillbirths.

#### Perinatal deaths, 2016

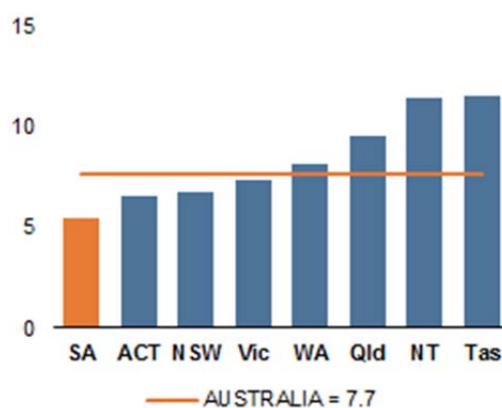
Region	per 1000 all births
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>5.5</b>
<b>Australia</b>	<b>7.7</b>



Data source: ABS 2017a and ABS 2017b

#### Perinatal deaths, 2016

State/Territory	per 1000 all births
<b>South Australia</b>	<b>5.5</b>
Australian Capital Territory	6.6
New South Wales	6.8
Victoria	7.4
Western Australia	8.2
Queensland	9.5
Northern Territory	11.4
Tasmania	11.5
<b>Australia</b>	<b>7.7</b>



Data source: ABS 2017a and ABS 2017b

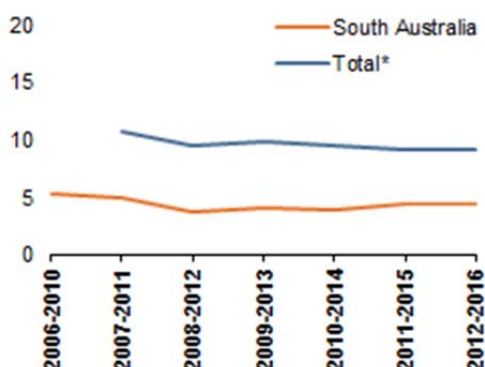
#### 5-3-2. Aboriginal perinatal deaths

- Perinatal deaths are all fetal deaths (at least 20 weeks' gestation or at least 400 grams birth weight) plus all neonatal deaths.
- In the five-year period 2012-2016, there were 4.5 Aboriginal perinatal deaths in South Australia per 1,000 relevant births, down from 5.3 recorded in the 2006-2010 period.<sup>3</sup>
- South Australia has the lowest rate of Aboriginal perinatal deaths in Australia compared to the selected states and territories that reported data, and below the combined total rate of 9.2 Aboriginal perinatal deaths per 1,000 relevant births.<sup>3</sup>

- Total *relevant* births comprise live births and fetal deaths (where gestation is at least 20 weeks' or birthweight of at least 400 grams).

### Aboriginal perinatal deaths, 2012-2016

Region	per 1000 relevant births
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>4.5</b>
<b>Total</b>	<b>9.2*</b>



Data source: ABS 2017c

### Aboriginal perinatal deaths, 2012-2016

State/Territory	per 1000 relevant births
<b>South Australia</b>	<b>4.5</b>
New South Wales	6.1
Western Australia	9.7
Queensland	10.1
Northern Territory	19.6
Aust. Capital Territory	n.p.
Tasmania	n.p.
Victoria	n.p.
<b>Total</b>	<b>9.2*</b>



\* Total includes data reported by jurisdiction of usual residence for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory only.

Data source: ABS 2017c

### Sources

1. Based on Australian Bureau of Statistics (ABS 2017a), 'Table 14.4 Perinatal deaths by state or territory of usual residence of mother, 2007-2016', [Causes of death, Australia, 2016](#), cat. no. 3303.0, viewed 8 August 2018.
2. Based on Australian Bureau of Statistics (ABS 2017b), 'Table 14.1 Fetal, neonatal and perinatal deaths, Australia, 2007-2016', [Causes of death, Australia, 2016](#), cat. no. 3303.0, viewed 8 August 2018.
3. Based on Australian Bureau of Statistics (ABS 2017c), 'Table 14.20 Perinatal deaths, by Aboriginal and Torres Strait Islander status, Selected states and territories, 2012-2016', [Causes of death, Australia, 2016](#), cat. no. 3303.0, viewed 8 August 2018.

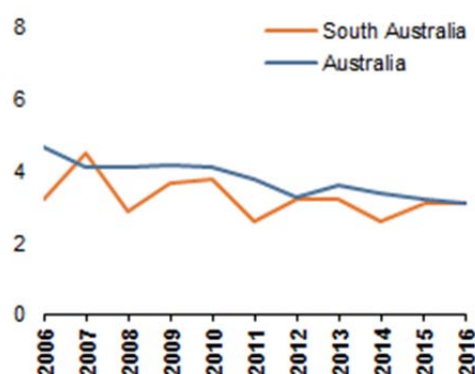
## 5-4. Infant mortality

### 5-4-1. Infant mortality

- Infant mortality is defined as deaths of persons aged under one year of age, expressed here as a rate per 1,000 live births.
- Over the last decade, Australia's infant mortality rate has been trending statistically significantly downwards. No statistically significant underlying trend over the last decade was identified in the South Australian time series.<sup>1</sup>
- The state rate is equal to the national average of 3.1 infant deaths per 1,000 live births.<sup>1</sup>
- South Australia ranks fourth-highest for infant mortality rate of the states and territories (same as Western Australia and Australian Capital Territory).<sup>1</sup>

#### Infant mortality rate, 2016

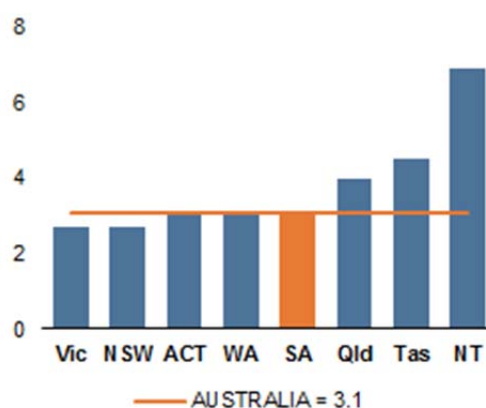
Region	per 1000 live births
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>3.1</b>
<b>Australia</b>	<b>3.1</b>



Data source: ABS 2018a

#### Infant mortality rate, 2016

State/Territory	per 1000 live births
Victoria	2.7
New South Wales	2.7
Australian Capital Territory	3.1
Western Australia	3.1
<b>South Australia</b>	<b>3.1</b>
Tasmania	4.5
Northern Territory	6.9
<b>Australia</b>	<b>3.1</b>



Data source: ABS 2018a

### 5-4-2. Aboriginal infant mortality

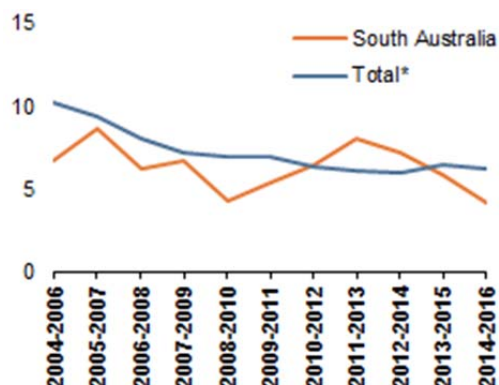
- Aboriginal infant mortality is defined as deaths of Aboriginal persons aged under one year of age, expressed here as a rate per 1,000 live Aboriginal births, and then averaged over a three year period due to the small numbers involved.
- Over the last decade, South Australia's Aboriginal infant mortality rate has been, overall, trending down, from 6.7 Aboriginal infant deaths per 1,000 live Aboriginal births in the period 2004-2006 to 4.2 in the period 2014-2016.<sup>2</sup>
- The South Australian figure is below the average of the total of the states and territories that reported data (6.2 Aboriginal infant deaths per 1,000 live Aboriginal births).<sup>2</sup>



- Of the five states and territories that published data, South Australia ranks lowest for Aboriginal infant mortality rate.<sup>2</sup>

### Aboriginal infant mortality, 2014-2016

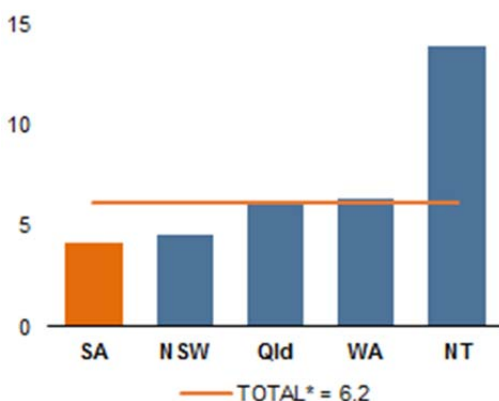
Region	per 1000 live births
Metropolitan Adelaide	n.a.
Country SA	n.a.
<b>South Australia</b>	<b>4.2</b>
<b>Total</b>	<b>6.2*</b>



Data source: ABS 2018b

### Aboriginal infant mortality, 2014-2016

State/Territory	per 1000 live births
<b>South Australia</b>	<b>4.2</b>
New South Wales	4.6
Queensland	6.3
Western Australia	6.4
Northern Territory	13.9
Aust. Capital Territory	n.a.
Tasmania	n.a.
Victoria	n.a.
<b>Total</b>	<b>6.2*</b>



\* Total includes data reported by jurisdiction of usual residence for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory only

Data source: ABS 2018b

### Sources

- Based on Australian Bureau of Statistics (ABS 2018a), 'Infant deaths and Infant mortality rates, Year of registration, Age at death, Sex, States, Territories and Australia', [ABS.Stat \(beta\)](#), viewed 10 August 2018.
- Based on Australian Bureau of Statistics (ABS 2018b), 'Deaths, Year of registration, Indigenous status, Summary data, Sex, States, Territories and Australia', [ABS.Stat \(beta\)](#), viewed 10 August 2018.

## 5-5. Leading causes of death by age group in South Australia

### Summary – Top 3 causes of death

The top three leading causes of death in South Australia in 2016 were **neoplasms** (ie. cancer), **circulatory system** diseases and **respiratory system** diseases.<sup>1</sup>

#### All-ages standardised death rate per 100,000 population, 2016

	Males	Females	Persons
<b>ALL AGES, ALL CAUSES</b>	<b>641.6</b>	<b>446.3</b>	<b>536.3</b>
<i>1. Neoplasms</i>	<i>195.8</i>	<i>127.8</i>	<i>157.8</i>
<i>2. Diseases of the circulatory system</i>	<i>164.3</i>	<i>110.3</i>	<i>135.6</i>
<i>3. Diseases of the respiratory system</i>	<i>60.1</i>	<i>39.2</i>	<i>48.2</i>

Additional detail by age cohort and sex is provided in the tables below.

Data source: ABS 2017

### 5-5-1. Ages under one year – Top 3 causes of death

#### Age specific death rate per 1,000 live births, 2016

	Males	Females	Persons
<b>Ages under 1 year, all causes</b>	<b>3.5</b>	<b>2.7</b>	<b>3.1</b>
<i>1. Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery</i>	<i>0.9</i>	<i>n.p.</i>	<i>0.6</i>
<i>2. Disorders related to length of gestation and fetal growth</i>	<i>0.5</i>	<i>n.p.</i>	<i>0.5</i>
<i>3. Ill-defined and unknown causes of mortality</i>	<i>n.p.</i>	<i>n.p.</i>	<i>0.3</i>

n.p. not available for publication but included in totals where applicable, unless otherwise indicated.

Data source: ABS 2017

**5-5-2. Ages one year and over by cohort – Top 3 causes of death****Age specific death rate per 100,000 population, 2016**

	<b>Males</b>	<b>Females</b>	<b>Persons</b>
<b>Ages 1-14 years, all causes</b>	<b>13.1</b>	<b>9.4</b>	<b>11.3</b>
1. <i>Malignant neoplasms of lymphoid, haematopoietic and related tissue</i>	<i>n.p.</i>	<i>n.p.</i>	1.8
2. <i>Accidental drowning and submersion</i>	<i>n.p.</i>	<i>n.p.</i>	1.8
3. <i>[Not published]</i>	<i>n.p.</i>	<i>n.p.</i>	<i>n.p.</i>
<b>Ages 15-24 years, all causes</b>	<b>39.1</b>	<b>15.9</b>	<b>27.7</b>
1. <i>Intentional self-harm</i>	15.1	5.6	10.5
2. <i>Car occupant injured in transport accident</i>	5.3	<i>n.p.</i>	4.1
3. <i>[Not published]</i>	<i>n.p.</i>	<i>n.p.</i>	<i>n.p.</i>
<b>Ages 25-34 years, all causes</b>	<b>86.5</b>	<b>39.0</b>	<b>62.8</b>
1. <i>Intentional self-harm</i>	28.6	10.4	19.5
2. <i>Accidental poisoning by and exposure to noxious substances</i>	7.8	5.2	6.5
3. <i>Car occupant injured in transport accident</i>	6.9	<i>n.p.</i>	4.3
<b>Ages 35-44 years, all causes</b>	<b>133.1</b>	<b>95.0</b>	<b>114.1</b>
1. <i>Intentional self-harm</i>	34.7	12.2	23.5
2. <i>Accidental poisoning by and exposure to noxious substances</i>	14.1	12.2	13.1
3. <i>Ischaemic heart diseases</i>	13.1	<i>n.p.</i>	7.0
<b>Ages 45-54 years, all causes</b>	<b>301.5</b>	<b>194.0</b>	<b>247.1</b>
1. <i>Malignant neoplasms of digestive organs</i>	46.1	18.2	32.0
2. <i>Intentional self-harm</i>	26.6	14.7	20.6
3. <i>Ischaemic heart diseases</i>	30.2	6.9	18.4
<b>Ages 55-64 years, all causes</b>	<b>679.6</b>	<b>379.1</b>	<b>525.9</b>
1. <i>Malignant neoplasms of digestive organs</i>	120.8	46.7	82.9
2. <i>Ischaemic heart diseases</i>	92.0	16.5	53.4
3. <i>Malignant neoplasms of respiratory and intrathoracic organs</i>	56.6	40.3	48.2
<b>Ages 65-74 years, all causes</b>	<b>1,512.4</b>	<b>833.6</b>	<b>1,163.5</b>
1. <i>Malignant neoplasms of digestive organs</i>	194.3	93.0	142.2
2. <i>Ischaemic heart diseases</i>	221.3	41.9	129.1
3. <i>Malignant neoplasms of respiratory and intrathoracic organs</i>	129.1	95.3	111.8

	<b>Males</b>	<b>Females</b>	<b>Persons</b>
<b>Ages 75-84 years, all causes</b>	<b>4,270.5</b>	<b>2,978.7</b>	<b>3,568.2</b>
1. <i>Ischaemic heart diseases</i>	534.1	282.3	397.2
2. <i>Malignant neoplasms of digestive organs</i>	448.3	220.2	324.3
3. <i>Malignant neoplasms of respiratory and intrathoracic organs</i>	269.4	194.2	228.5
<b>Ages 85-94 years, all causes</b>	<b>13,770.6</b>	<b>10,865.5</b>	<b>11,958.5</b>
1. <i>Ischaemic heart diseases</i>	2,065.9	1,396.9	1,648.6
2. <i>Organic, including symptomatic, mental disorders</i>	1,138.2	1,452.4	1,334.2
3. <i>Cerebrovascular diseases</i>	894.8	1,023.9	975.3
<b>Ages 95 years and over, all causes</b>	<b>30,198.5</b>	<b>29,784.7</b>	<b>29,897.5</b>
1. <i>Ischaemic heart diseases</i>	5,224.7	5,127.2	5,153.8
2. <i>Organic, including symptomatic, mental disorders</i>	3,657.3	4,540.1	4,299.5
3. <i>Cerebrovascular diseases</i>	2,403.3	3,326.8	3,075.2

n.p. not available for publication but included in totals where applicable, unless otherwise indicated.

Data source: ABS 2017

## Sources

1. Based on Australian Bureau of Statistics (ABS 2017), 'Table 5.1 Underlying cause of death, All causes, South Australia, 2016' and 'Table 5.3 Underlying cause of death, Selected causes by age at death, numbers and rates, South Australia, 2016', [Causes of Death, Australia, 2016](#), cat. no. 3303.0, viewed 9 August 2018.

# **SA HEALTH 2016 HEALTH PERFORMANCE COUNCIL SA**

## **ANNUAL REPORT**

**WHAT'S WORKING, WHAT'S NOT  
REVIEW OF THE SOUTH AUSTRALIAN  
HEALTH SYSTEM PERFORMANCE FOR  
2011-2014**

## BUILDING HEALTHY COMMUNITIES

### RECOMMENDATION 1

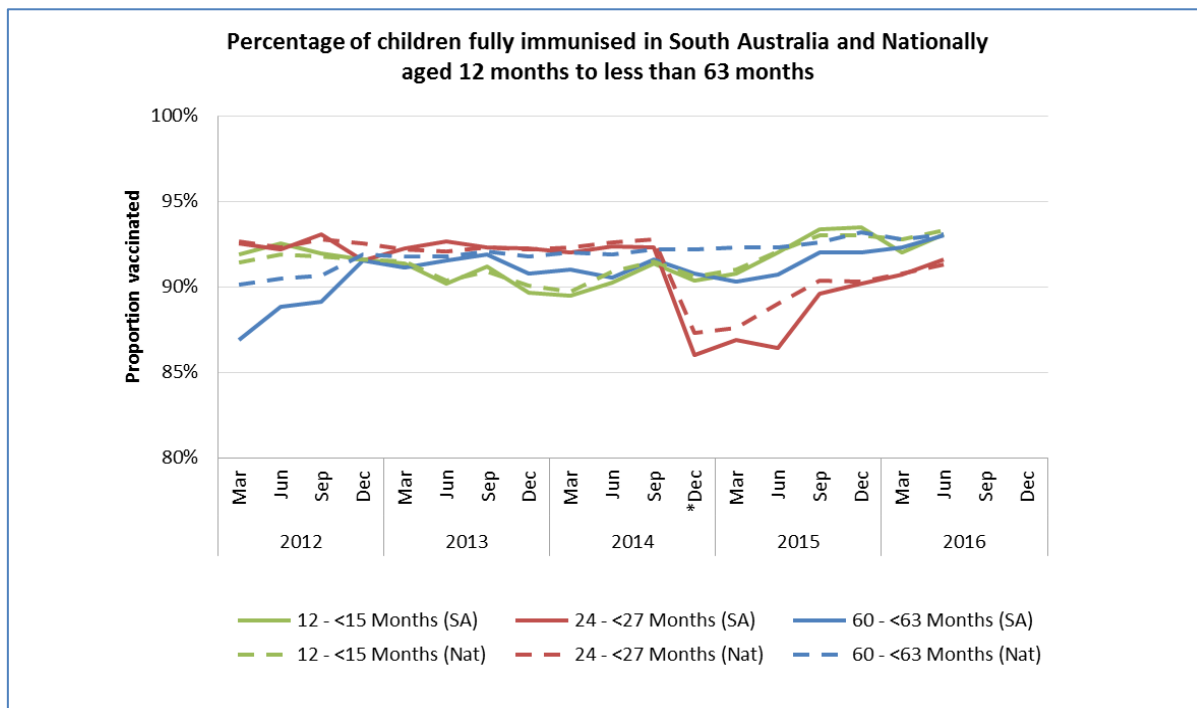
Require SA Health to set a performance outcome that all Local Health Networks increase childhood immunisation rates to 92 per cent or greater by 2018, with a priority focus on Aboriginal rates.

### SA Health Performance Indicator

All Local Health Networks increase childhood immunisation rates to 92 per cent or greater by 2018, with a priority focus on Aboriginal rates.

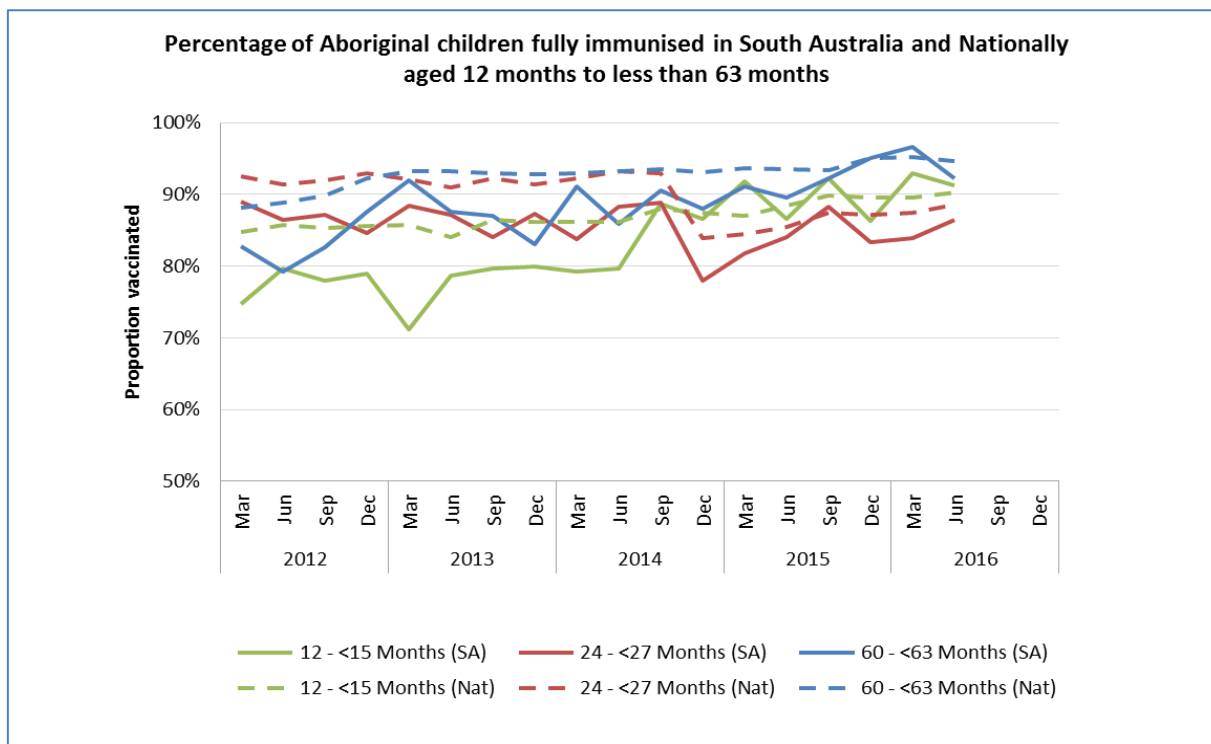
2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
<p><b>SA annual coverage data for 2015*</b></p> <p><b>12-15 mths 92.4%</b></p> <p><b>24-27 mths 88.3%</b></p> <p><b>60-63 mths 91.2%</b></p> <p><b>SA annual coverage data for Aboriginal children in 2015*</b></p> <p><b>12-15 mths 89.2%</b></p> <p><b>24-27 mths 84.5%</b></p> <p><b>60-63 mths 92.0%</b></p> <p>*The data provided are annualised for age groups 12 to less than 15 months, 24 to less than 27 months, and 60 to less than 63 months using the ACIR March, June, September and December 2015 assessment quarters. Where there are less than 10 children in a Local Government Area (LGA) the data are not given. As a result not all LGAs are listed.</p>	<p><b>In 2015-16 the childhood immunisation rates increased compared to 2014-15</b></p> <p><b>12-15 mths 93.4%</b></p> <p><b>24-27 mths 91.8%</b></p> <p><b>60-63 mths 93.1%</b></p> <p>SA coverage data for Aboriginal children in 2015-16</p> <p><b>12-15 mths 90.5%</b></p> <p><b>24-27 mths 85.5%</b></p> <p><b>60-63 mths 94.0%</b></p>	<p>As at <b>December 2015</b> the <b>national average</b> for Aboriginal children</p> <p>12-15 mths <b>87.2%</b></p> <p>24-27 mths <b>95.1%</b></p> <p>60-63 mths <b>92%</b></p> <p>As at <b>June 2016</b> compared to the <b>national average</b> coverage for Aboriginal children</p> <p>12-15 mths <b>93.3%</b></p> <p>24-27 mths <b>91.3%</b></p> <p>60-63 mths <b>93.1%</b></p> <p><b>See Attachment 1</b></p>	<p><b>Note:</b> Approximately 70% of immunisation service delivery occurs through General Practice, 18% via local councils and the residual by government agencies such as Aboriginal Health Services, child and maternal health services and dedicated migrant and refugee services. LHN impact on SA coverage rates is minimal.</p> <p>Through the Closing the Gap strategy funding was received to implement projects focussed on improving coverage rates in Aboriginal children. These projects were extremely successful with significant increases in coverage rates across all cohorts (see table 2).</p> <p>The campaign Help Me Stay Strong continues to target new parents of Aboriginal children. SA Health continues to target the general public through health promotions, and health professionals through education programs.</p> <p>As the 18 month cohort has the lowest coverage in both Aboriginal and non-Aboriginal populations, SA Health is focusing on this age group with data cleaning and stakeholder engagement to continue improving this cohort's coverage.</p> <p>The introduction of the <i>No Jab No Pay</i> policy on 1 January 2016 has appeared to have lifted all immunisation coverage Nationally in all cohorts.</p>

Table 1:



From quarter ending 31 December 2014, meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella (MMR) and dose 1 varicella (given as MMRV at 18 months) was included in the definition of fully immunised for the 24-27 month cohort.

Table 2:



**Note:**

From quarter ending 31 December 2014, meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella (MMR) and dose 1 varicella (given as MMRV at 18 months) was included in the definition of fully immunised for the 24-27 month cohort. Source: Australian Childhood Immunisation Register.

Further information is published at:

<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/immunisation+for+health+professionals/immunisation+provider+information/south+australian+immunisation+coverage+rates>

## RECOMMENDATION 2

Take action with the Minister for Ageing to develop a joint plan with the aged care and primary care sector that will increase protection of the older population from vaccine preventable conditions.

### SA Health Performance Indicator

Reduce rates of hospitalisation for vaccine preventable conditions such as influenza and pneumonia by 2018.

2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
In the absence of an adult vaccination register the coverage of influenza vaccination is loosely based on distribution doses. The last National Adult Vaccination Survey was conducted in 2009 and estimated that, for the population aged ≥65 years, 74.6% were vaccinated against seasonal influenza and 54.4% against pneumococcal disease.	<p>Influenza vaccine coverage of residents in aged care facilities is not collected at a state level. The number of influenza vaccines distributed in SA for the National Immunisation Program in 2016 was approximately 385,000 as at August 2016.</p> <p>The total number of influenza vaccine doses distributed during 2015 was 396,363 which is slightly more than in 2016.</p> <p>In 2015-16, the hospital separation rate for vaccine preventable conditions was 9.1 per 1,000 separations. This was an improvement from the rate of 9.5 per 1,000 separations reported 2014-15.</p>	Previous CATI surveys used to measure the uptake of influenza vaccination in the elderly routinely showed SA to have the highest uptake nationally with the last survey demonstrating SA with uptake in excess of 83% compared to the national average of 74.6%. Adults with chronic conditions such as diabetes, chronic lung disease and renal failure, and those taking immuno-suppressive medications are also under-immunised.	<p>The Commonwealth has responsibility for the aged care and primary care sectors. Implementation of and promotion of vaccines for adults including Influenza, Pneumococcal and Zoster vaccines.</p> <p>Expansion of Australian Childhood Immunisation Register (ACIR) to become a whole of life register in September 2016 (Australian Immunisation Register (AIR) will include adult vaccination records and capture more accurate data.</p> <p>Implementation of a Zoster vaccination program commencing November 2016 will provide free vaccine to those aged 70 years up to 79 years and provide a degree of protection from shingles. The department will promote the use of the vaccines through GPs and aged care facilities.</p> <p>Education programs and the promotion of an annual influenza vaccination program for residents and health care workers in aged care facilities are ongoing. In 2016, a new influenza vaccination educational program for health care workers will be released, and an initiative to allow pharmacists to directly administer the influenza vaccine. It is also noted that engagement with the primary care sector requires some input from the Commonwealth.</p>

## GETTING INTO THE SYSTEM

## RECOMMENDATION 5

Require SA Health to manage a reduction to 15 per cent or less by 2018 of people living in country South Australia reporting delaying or not seeing a dental professional.

### SA Health Performance Indicator

SA Health to reduce the number of people living in country South Australia reporting delaying or not seeing a dental professional due to cost by up to 15% by 2018.



2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
<p>Whilst the number of people waiting for care increased in the 12 months to 30 June 2015, the gap between the country and metropolitan waiting times reduced from 5.7 months to 3.30 months by 30 June 2015.</p>	<p>In the 12 months to 30 June 2016 the country waiting list improved from 13,046 people waiting 15.5 months as at 30 June 2015) to 11,082 people waiting 13.7 months by 30 June 2016. Importantly in the same timeframe the gap between metropolitan and country areas further reduced from 3.3 months to just 0.6 months.</p> <p>Due to a change in data source, waiting time data are not comparable with survey data published previously. Public dentistry waiting times is defined as the median time waited between being placed on a public dentistry waiting list and receiving an offer of a course of public dental care from a waitlist.</p> <p>In 2015-16, the median waiting time for an offer of public general dental care for people living in country SA was an average of 358 days, an increase from 338 days in 2014-15. The median waiting time for people living in the Metro area was also 358 days, an increase from 268 days in 2014-15.</p> <p>In 2015-16, the median waiting time for an offer of public denture care for people living in country SA was an average of 502 days, an increase from 411 days in 2014-15. The median waiting time for people</p>		<p>The new national Oral Health Plan was signed off by COAG Health Council in late 2015 and includes people living in regional and remote areas as a priority group and calls for specific actions for this population group including access to care.</p> <p>SA Dental Service and SA Health continue to focus on improving access to affordable timely oral health for people in rural and remote locations.</p> <p>The use of overseas qualified dental practitioners via the National Public Sector Dental Workforce Scheme (PSDWS) has been a major source of the dentist workforce in SA public dental clinics in country locations over the past several years. Recent changes to the scheme indicate a ccess to the use of the PSDWS dentists is likely to decrease in future and lead to a reduction in the availability of dentists in country areas and increasing waiting lists. SA Dental Service is currently exploring strategies to assist meet the workforce requirements.</p> <p>As outlined in last year's report, in SA, including country SA, the majority of dental services are provided in the private dental sector, which is largely outside the scope of the Minister for Health, SA Health and/or Local Health Networks to manage.</p> <p>Modest patient co-payment fees are applied within the SA public dental system. However, strategies implemented in the public dental system to reduce cost barriers include:</p> <ul style="list-style-type: none"> <li>Financial hardship arrangement for patients who are assessed by an accredited Financial Counsellor as being unable to pay the usual fees have care provided free of charge;</li> <li>Patients requiring urgent care are not refused care if they are unable to pay the emergency patient fee on the day;</li> <li>Targeted programs for specific client cohorts are fee free, for example clients who are Aboriginal, homeless or live in Supported Residential Facilities;</li> <li>Continuing to work with private dental</li> </ul>

	living in the Metro area was 408 days, an increase from the 301 days in 2014-15. (RoGS 2017)		providers to maintain the viability of private dental practice in some small country areas. In the past four years, this has included initiatives in Peterborough, Kingscote and Kingston SE.
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Improving access to affordable basic public dental care for people living in country areas has been a major focus for SA Dental Service in recent years.

State public dental waiting lists have fluctuated over the past four years in line with the availability of additional Commonwealth funding provided under the NPA on Treating More Public Dental Patients and the NPA on Adult Public Dental Services.

#### RECOMMENDATION 9

Require SA Health to set a performance outcome that all Local Health Networks increase the rate that Aboriginal people attending hospital emergency departments are seen on time (treated within national benchmarks) to 75 per cent or above by 2018.

#### SA Health Performance Indicator

SA Health to undertake analysis of Aboriginal people rate seen on time in emergency department – targeted at metro EDs to establish baseline.

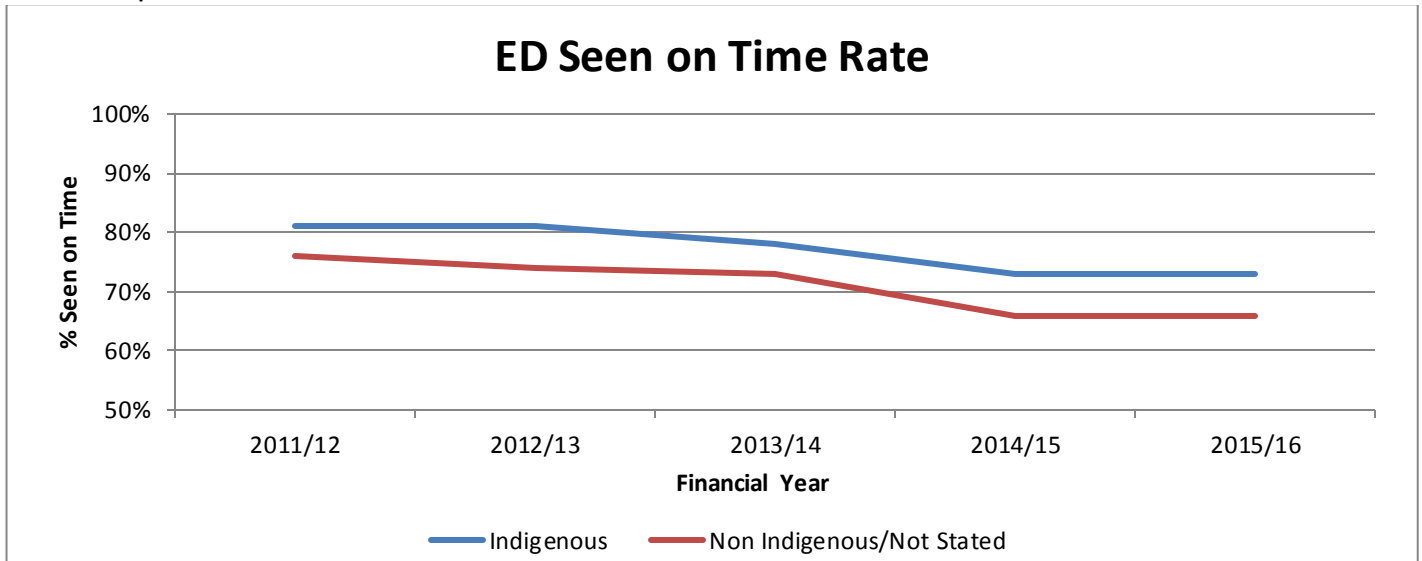
2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
<p>Prioritisation of patients seen is based on clinical needs, regardless of cultural background or gender.</p> <p>In 2014-15, 73 percent of Aboriginal patients presenting at a South Australian ED were seen on time.</p>	<p>In 2015-16, 73 percent of Aboriginal patients presenting at a South Australian ED were seen on time, compared to 66 percent of Other Australians. These figures have remained stable compared to 2014-15.</p>	<p>In 2014-15 SA performance was 73 percent compared to the national rate of 75 percent for indigenous presentations to an ED. For other Australians 66 percent in SA were seen on time as compared with the national average of 74 percent.</p> <p>The percentage of patients with ED visits completed within 4 hours improved for South Australia between 2011-12 and 2015-16 by 1.4 percentage points (from 64.6 percent to 66.0 percent). Nationally there was an 8.9 percentage point improvement (from</p>	<p>Through the state investment in Closing the Gap, an Aboriginal Cultural Learning Framework was developed to provide Aboriginal Cultural awareness training for all staff within SA Health in preparation for the new Aboriginal specific Quality and Safety health standards in 2017.</p> <p>AHMAC Hospital Principal Committee has commenced the "Take Own Leave" project to address rates of Aboriginal people discharging from Emergency Departments (ED's) against medical advice and increase the rates of Aboriginal people being seen on time.</p> <p>Key component of Transforming Health (TH) is to ensure the design and structure of metropolitan hospitals, including Emergency Departments improve care and waiting times and Aboriginal Hospital Liaison Officers continue to support Aboriginal patients.</p> <p>In addition a new Aboriginal Expert Advisory Group (AEAG) is being established under the governance of the TH Ministerial Clinical Advisory Group to identify:</p> <ul style="list-style-type: none"> <li>• How to ensure the needs of Aboriginal</li> </ul>

		<p>64.4 percent to 73.3 percent) for the same period. South Australia improved by 2.2 percentage points (from 63.8 percent to 66.0 percent) between 2014-15 and 2015-16 whilst nationally performance remained stable.</p> <p>For South Australia the median ED visit time increased by 5 minutes between 2011-12 and 2015-16 (from 2 hours and 55 minutes to 3 hours) but performance improved by 2 minutes compared to the 2014-15 results. Nationally the reverse occurred with an improvement in median ED visit time of 14 minutes to 2 hours and 44 minutes in 2015-16) compared with 2011-12 but increased by 3 minutes compared to 2014-15.</p> <p>Note: Unable to present metro specific data due to data limitations and quality issues related to new data recording practices and systems across three LHN's.</p>	<p>and Torres Strait Islanders peoples (including those who are SA Health staff) are addressed under TH</p> <ul style="list-style-type: none"> <li>• Opportunities to strengthen TH programs to focus on Aboriginal health and achieving improved health outcomes as well as assessing potential impact on staff</li> <li>• Approaches to existing evaluations of TH programs to ensure their effect on Aboriginal people and Aboriginal SA Health staff is measured</li> <li>• Work with MCAG and the TH decision-making bodies to disseminate and help translate information about TH programs improve the way they connect with South Australian Aboriginal communities.</li> </ul>
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**Table 3**  
**ED Seen On Time Rate (Excludes Did Not Wait)**

Indigenous Status	2011/12	2012/13	2013/14	2014/15	2015/16
Indigenous	81%	81%	78%	73%	73%
Non Indigenous/Not Stated	76%	74%	73%	66%	66%
<b>Sum:</b>	<b>76%</b>	<b>75%</b>	<b>73%</b>	<b>66%</b>	<b>66%</b>

Graph 4



## BEING TREATED WELL

### RECOMMENDATION 12

Require SA Health to direct local health networks to investigate, in collaboration with Aboriginal leaders, the causes of each hospital's discharge against medical advice rates and develop appropriate implementation and monitoring strategies to achieve the SA Health target by July 2016.

### SA Health Performance Indicator

N/A

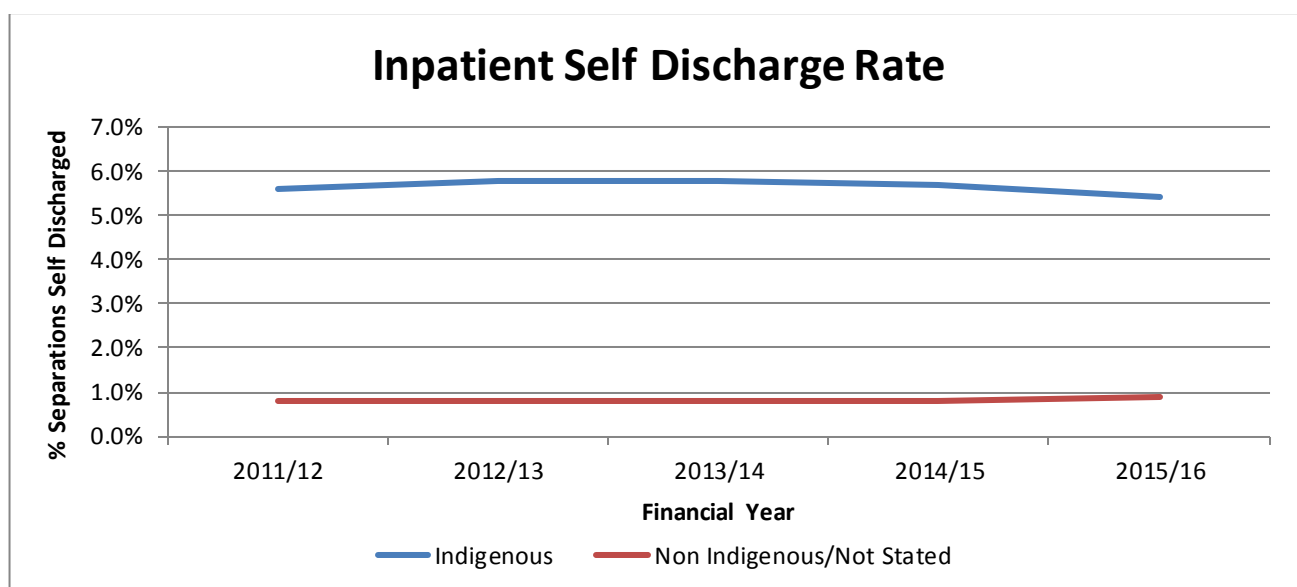
2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
ED and inpatient measure included in tables 3,4,5 and 6. SA generated figures include dialysis and mental health and are therefore slightly higher than national rates.		<a href="http://www.aihw.gov.au/indigenous-data/health-performance-framework">http://www.aihw.gov.au/indigenous-data/health-performance-framework</a>  Refer to table 5 - after excluding dialysis and mental health for 2011-12 to 2012-13 in SA 6.2 per cent of indigenous person treated as inpatient left against medical advice. Compared with the national average of 4.5. Age-adjusted these rates were 4.5 and 3.6 respectively.	Refer to Recommendation 9. LHNs continue to monitor discharge rates.  The Aboriginal Health Care plan implementation committees also monitor discharge rates and support the development and of strategies that support decreasing discharge rates for example: <ul style="list-style-type: none"> <li>• Cancer Care Coordinators and Aboriginal Liaison Officers provide support, cultural brokerage with linkages to interpreter services, social work services including referrals to Step Down Units and other services provided external to the Hospital.</li> <li>• Self-discharge mechanisms implemented under the new Aboriginal Consumer Engagement Strategy support making hospitals culturally safe and inclusive</li> <li>• Each of the LHN Health Advisory Councils have an Aboriginal community representative to ensure the health needs of Aboriginal people are considered including clear discharge strategies and patient feedback</li> </ul>

Table 5

**Inpatient Self Discharge Rate (Overnight Stay Only)**

Indigenous Status	2011/12	2012/13	2013/14	2014/15	2015/16
Indigenous	5.6%	5.8%	5.8%	5.7%	5.4%
Non Indigenous/Not Stated	0.8%	0.8%	0.8%	0.8%	0.9%
<b>Total:</b>	<b>1.0%</b>	<b>1.0%</b>	<b>1.0%</b>	<b>1.0%</b>	<b>1.1%</b>

Table 6

**GETTING GOOD OUTCOMES****RECOMMENDATION 16**

The Department to assess rates of patient incidents, and develop strategies to reduce the rate to less than 10 per 100 overnight separations by 2018.

**SA HEALTH PERFORMANCE INDICATOR**

10% reduction on actual harm (number not proportion, actual SAC 1 and 2 incidents) from 2015-16 to 2017-18.

2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
The total number of SAC 1&2 incidents was 536.	<p>The total number of SAC 1&amp;2 incidents was 567.</p> <p>There has been a 3% increase in the number of incidents reported for 2016.</p> <p>The percentage of actual harm has reduced from 2.9% in 2011 to 1% in 2016.</p> <p>Refer table 7</p>		<p>Per last year's response SA Health continues to implement and modify:</p> <ul style="list-style-type: none"> <li>a focused patient safety program targeting areas of patient harm which may result in an adverse consumer outcome aligned to the National Safety and Quality Priorities and National Safety and Quality Health Service Standards</li> <li>a suite of safety and quality metrics in LARS (LHN Analytics and Reporting Service) to support continuous monitoring and improvement which include volume of incidents and near misses</li> </ul>

			reported and the actual level of harm.
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**Table 7**  
**SAC 1&2 Incidents**

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
<b>Total Incidents</b>	27862	32696	37683	44103	53754	55043
<b>SAC 1&amp;2</b>	818	905	607	594	536	567
<b>Harm (SAC 1&amp;2) as % of total</b>	2.9%	2.8%	1.6%	1.3%	1.0%	1.0%

#### **RECOMMENDATION 17**

SA Health through its Infection Control Service (ICS) continues implementation of quality programs aimed at improving infection control in hospitals, and monitoring the effectiveness of new interventions.

#### **SA Health Performance Indicator**

Monitoring of key infection control indicators:

- Rate of healthcare associated Staphylococcus aureus bacteraemia per 10,000 patient days (as April 2016 YTD 0.9 – National target: 2.0)
- Hospital VRE infections per 10,000 bed days (as April 2016 YTD 0.8 – no national target)
- Healthcare associated MRSA infections per 10,000 bed days (as April 2016 YTD 1.2 – no national target)

2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
2014/15 Rate of Staphylococcus aureus bacteraemia (SAB) for public hospitals 0.89 per 10,000 bed-days  2014/15 Hospital VRE infections 0.50 per 10,000 bed days  2014/15 MRSA infections 1.33 per 10,000 bed days	2015/16 Rate of Staphylococcus aureus bacteraemia (SAB) for public hospitals 0.78 per 10,000 bed-days  2015/16 Hospital VRE infections 0.68 per 10,000 bed days  2015/16 MRSA infections 1.24 per 10,000 bed days	The national SAB rate for 2014/15 was 0.77 per 10,000 patient bed-days. National SAB target rate is 2.0 per 10,000. SA compares favourably to other states.  There is no national VRE target or comparator rates available.  There is no national MRSA target or comparator rates available.	ICS monitors and reports on the incidence of key healthcare associated infections for public acute hospitals.  Surveillance data are reported to the Department and Hospital Executives on a monthly basis.  ICS develops and maintains policies, guidelines and resources on the prevention of infection. Documents are renewed as required, including at the request of LHN CEOs.  New on-line educational tools developed in 2015 / 2016 include: <ul style="list-style-type: none"> <li>• Aseptic technique</li> <li>• Safe use of personal protective equipment</li> <li>• Basic principles of infection control (for all health care staff)</li> </ul>

**RECOMMENDATION 18**

SA Health to develop strategies that will close the gap in the rates of potentially avoidable deaths between Aboriginal and non-Aboriginal people in South Australia by 2018.

**SA Health Performance Indicator**

Close the gap in the rates of potentially avoidable deaths between Aboriginal and non-Aboriginal people in South Australia by 2018

2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
There has been a reduction in potentially avoidable deaths from 1.6 per 1,000 persons in 2008 to 1.5 in 2011. However, the 5-year average for Aboriginal people from 2007-2011 was almost four times as high at 5.4 per 1,000 population.	There has been a 16% decline in mortality rates between 1998 and 2013, and a 39% decline in deaths due to circulatory disease. A narrowing of the gap in low birth weight babies from 10.4% in 2001 to 8.5% in 2011. (per Aboriginal and Torres Strait Islander Health Performance Framework Report 2014)	Data not available	Since 2009 the State investment into Closing the Gap programs has seen some 29 programs and initiatives implemented to contribute to Close the Gap in life expectancy in a generation by 2031 & halve the gap in mortality rates for children under 5 by 2018.

## WORKING EFFICIENTLY AND REMAINING STABLE

### RECOMMENDATION 23

Develop strategies and implement efficiencies that will reduce growth in cost per case mix to a nominated target (eg. Consumer Price Index) to bring down the South Australian average to the national average over a five year period.

#### SA Health Performance Indicator

Reduce growth in cost per case mix to bring down the South Australian average to the national average over a five year period.

2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
		<p>The recurrent cost per case mix-adjusted separation in 2013-14 was \$5,402, higher than the national average of \$4,836 and higher than the 2012-13 average cost of \$5,113.</p> <p>(RoGS 2017)</p> <p>Costing Report for 2015-16 is not available.</p> <p>Note: It is anticipated that costing's and trend data against national costing's will be available in 2017.</p>	<p>Per last year's response, spending on health care will always increase, however, SA Health continues to identify, implement and monitor strategies so we spend our money wisely including efficient ward configurations, product standardization, the negotiation of improved procurement terms, optimized pathology and pharmacy costs, and voluntary redundancies. Many of these programs will continue to deliver benefits across the forward estimates.</p> <p>Recommendations 21, 22 and 23 fall under the state governments commitment to TH and the six principles underpinning TH which include: a health system that is:</p> <p>Patient centred</p> <ol style="list-style-type: none"> <li>1. Safe</li> <li>2. Effective</li> <li>3. Accessible</li> <li>4. Efficient, and</li> <li>5. Equitable.</li> </ol> <p>TH health aims to provide the right care, minimises waste and optimises value and productivity.</p> <p>The Transforming Health Ministerial Clinical Advisory Group (MCAG) continues to provide clinical leadership and guides the way Transforming Health is implemented.</p> <p>The MCAG provides input into and leadership of:</p> <ul style="list-style-type: none"> <li>• Service delivery changes required for the new metropolitan wide configuration of services</li> <li>• New models of care and new hospital models</li> <li>• Capital re-design to deliver quality</li> </ul>



			<ul style="list-style-type: none"> <li>Quality principles, standards of care and productivity improvements identified in TH.</li> </ul>
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## ENGAGING WITH THE COMMUNITY

### RECOMMENDATION 24

24. Build on its Framework for Active Participation by establishing a single point of contact to support units across SA Health to conduct quality engagement by:

- providing engagement tools and advice
- contributing to continuous improvement in engagement practices and delivery of health care by monitoring and making public engagement processes and their outcomes
- implementing a strategic approach to relationships with community organisations, businesses, universities, consumers and the community
- linking in with whole of government efforts to improve engagement practice through the Better Together Principles.

### SA Health Performance Indicator

N/A

2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
<p>The SA Health Consumer and Community Advisory Committee Policy Guideline and Toolkit were released in October 2015, as a practical tool to assist health care services to implement the Framework.</p> <p>The SA Health Sitting Fees and Reimbursement for External Individuals Policy Directive was released in October 2015.</p> <p>The SA Health Partnering with Consumers and Community Advisory Group was set up in March 2013. The group is established under the governance structure of the SA Health Safety and Quality Strategic Governance Committee.</p>	See Strategies	N/A	<p>Safety and Quality Branch coordinates the state's 'Partnering with Consumers and the Community' program and provides advice and assists health services in planning for assessment against the National Safety and Quality Health Standard 2 – Partnering with Consumers.</p> <p>The SA Health Partnering with Consumers and the Community Strategic Action Plan is the strategic framework which underpins the National Safety and Quality Health Service Standards 1 and 2.</p> <p>Standard 1 includes consumer feedback and complaints management, open disclosure, patient rights and engagement, informed consent, and measuring consumer experience.</p> <p>National Standard 2 includes consumer partnerships in service planning, designing care and service measurement and evaluation.</p> <p>The SA Health Framework for Active Partnership with Consumers and the Community and Guide for Engaging with Consumers and the Community were released in 2013 are due to review in December 2016. The Better Together Principles and best practice are embedded within the Framework.</p> <p>SA Health continues to fund the Health</p>

<p>The SA Health Culturally and Linguistically Diverse (CALD) Consumer Experience Group was established in December 2012. The group works collaboratively with Safety and Quality Branch to understand the CALD communities' needs in health care. Representatives include Multicultural Communities Council SA (MCCSA).</p>			<p>Consumers' Alliance (HCA) as the peak agency in South Australia for consumer engagement. SA Health is collaborating with the HCA to co-create consumer and community engagement strategies.</p> <p>The Safety and Quality Branch works collaboratively with HCA, Health and Community Services Complaints Commissioner (HCSCC), Aboriginal Health Council SA, Carers SA, Council on the Ageing (COTA), and Multicultural Communities Council SA (MCCSA) to provide quality community engagement.</p> <p>Safety and Quality Branch works collaboratively with Carers SA.</p> <p>The Partnering with Carers Strategic Action Plan was developed in 2016, includes the SA Health Partnering with Carers Policy Directive, which was released in October 2015, during National Carers Week.</p> <p>The SA Health Culturally and Linguistically Diverse (CALD) Consumer Experience Group was established in December 2012. The group works collaboratively with Safety and Quality Branch to understand the CALD communities' needs in health care. Representatives include Multicultural Communities Council SA (MCCSA).</p>
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#### RECOMMENDATION 25

Commission a Consumer Experience Survey of Aboriginal and culturally and linguistically diverse South Australians to complement its existing mainstream survey.

#### SA Health Performance Indicator

N/A

2015 Result for SA	2016 Result for SA	Progress against other Jurisdictions	Strategies
<p>The SA Consumer Experience Surveillance System (SACESS) is a telephone survey where consumers are interviewed soon after an overnight stay in a metropolitan or country hospital using a set of internationally validated questions. In 2015, 2340 South Australians were interviewed, and</p>	<p>See Strategies</p>		<p>SA Health continues to identify where gaps exist for Aboriginal people to share their experience with SA Health.</p> <p>In February 2016, a MCE CAPI Aboriginal and Torres Strait Islander Work Group was convened with members from NALHN, DASSA, SALHN, Aboriginal Health Branch, Wardliparingga Aboriginal Research Unit at SAHMRI, Safety and Quality, and is working in collaboration with Northern Territory Department of Health. Discussions included review of the national core patient experience questions and top ATSI languages to translate surveys. A background image has been developed specifically targeted to Aboriginal and Torres Strait Islander people, and a statewide ATSI survey is planned for</p>

since 2010, over 13,000 patients have participated in SACCESS.			<p>early 2017.</p> <p>In mid-2016, Watto Purrinna Aboriginal Private Health Care Service commenced surveying consumers. Consumers from Lyell McEwin Hospital and Wonggangga Turtpandi, were asked about being treated with respect and dignity, their involvement in decision making, information, pain and follow up care.</p> <p>In 2015/16 the Measuring Consumer Experience Computer-Assisted Personal Interview (MCE CAPI) pilot commenced. The pilot enables SA Health to better understand the consumer and community needs in health care for all consumers including Aboriginal and Torres Strait Islander (ATSI), Culturally and Linguistically Diverse (CALD), patients aged 16 years and under, maternity, mental health / lived experience, substance abuse, chemotherapy or renal dialysis episodes of care. The MCE CAPI will enable all consumers the opportunity to share their experiences and provide us with their perspective on health care services, which is currently excluded from the SA Consumer Experience Surveillance System (SACCESS).</p>
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# **SA HEALTH 2017 HEALTH PERFORMANCE COUNCIL SA**

## **ANNUAL REPORT**

**WHAT'S WORKING, WHAT'S NOT  
REVIEW OF THE SOUTH AUSTRALIAN  
HEALTH SYSTEM PERFORMANCE FOR  
2011-2014**

## BUILDING HEALTHY COMMUNITIES

### RECOMMENDATION 1

Require SA Health to set a performance outcome that all Local Health Networks increase childhood immunisation rates to 92 per cent or greater by 2018, with a priority focus on Aboriginal rates.

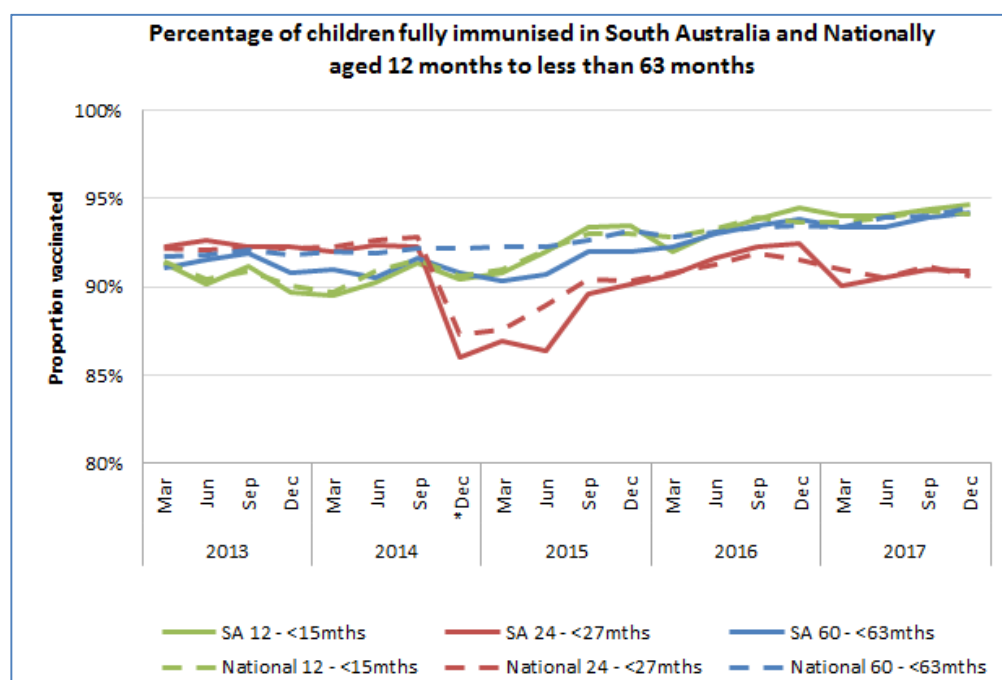
### SA Health Performance Indicator

All Local Health Networks increase childhood immunisation rates to 92 per cent or greater by 2018, with a priority focus on Aboriginal rates.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
<b>SA annual coverage data for 2015*</b> <b>12-15 mths 92.4%</b> <b>24-27 mths 88.3%</b> <b>60-63 mths 91.2%</b> <b>SA annual coverage data for Aboriginal children in 2015*</b> <b>12-15 mths 89.2%</b> <b>24-27 mths 84.5%</b> <b>60-63 mths 92.0%</b> *The data provided are annualised for age groups 12 to less than 15 months, 24 to less than 27 months, and 60 to less than 63 months using the ACIR March, June, September and December 2015 assessment quarters. Where there are less than 10 children in a Local Government Area (LGA) the data are not given. As a result not all LGAs are listed.	<b>SA annual coverage for 2016*</b> <b>12-15 mths 93.4%</b> <b>24-27 mths 91.4%</b> <b>60-63 mths 93.1%</b> <b>SA annual coverage data for Aboriginal children in 2016*</b> <b>12-15 mths 89.2%</b> <b>24-27 mths 84.5%</b> <b>60-63 mths 92.0%</b>	SA annual coverage data for 2017*. 12-15 mths 94.3% 24-27 mths 90.6% 60-63 mths 93.8% SA annual Aboriginal children coverage data for 2017*. 12-15 mths 90.3% 24-27 mths 88.3% 60-63 mths 94.2%	As at December 2017 the national coverage rates for children: 12-15 mths 94.1 % 24-27 mths 90.6% 60-63 mths 94.5% <b>See Table 1</b> As at <b>December 2017</b> the <b>national coverage rate</b> for Aboriginal children: 12-15 mths <b>92.3%</b> 24-27 mths <b>89.4%</b> 60-63 mths <b>96.6%</b>	<b>Note:</b> Approximately 70% of immunisation service delivery occurs through General Practice, 18% via local councils and the residual by government agencies such as Aboriginal Health Services, child and maternal health services and dedicated migrant and refugee services. <b>LHN impact on SA coverage rates is minimal.</b> Through the Closing the Gap strategy funding was received to implement projects focussed on improving coverage rates in Aboriginal children. These projects were extremely successful with significant increases in coverage rates across all cohorts (see figure 2). The campaign Help Me Stay Strong continues to target new parents of Aboriginal children. SA Health continues to target the general public through health promotions, and health professionals through education programs. As the 18 month cohort has the lowest coverage in both Aboriginal and non-Aboriginal populations, SA Health is focusing on this age group with data cleaning and stakeholder engagement to continue improving this cohort's coverage. The introduction of the <i>No Jab No Pay</i> policy on 1 January 2016 has appeared to have lifted all immunisation coverage Nationally in all cohorts.

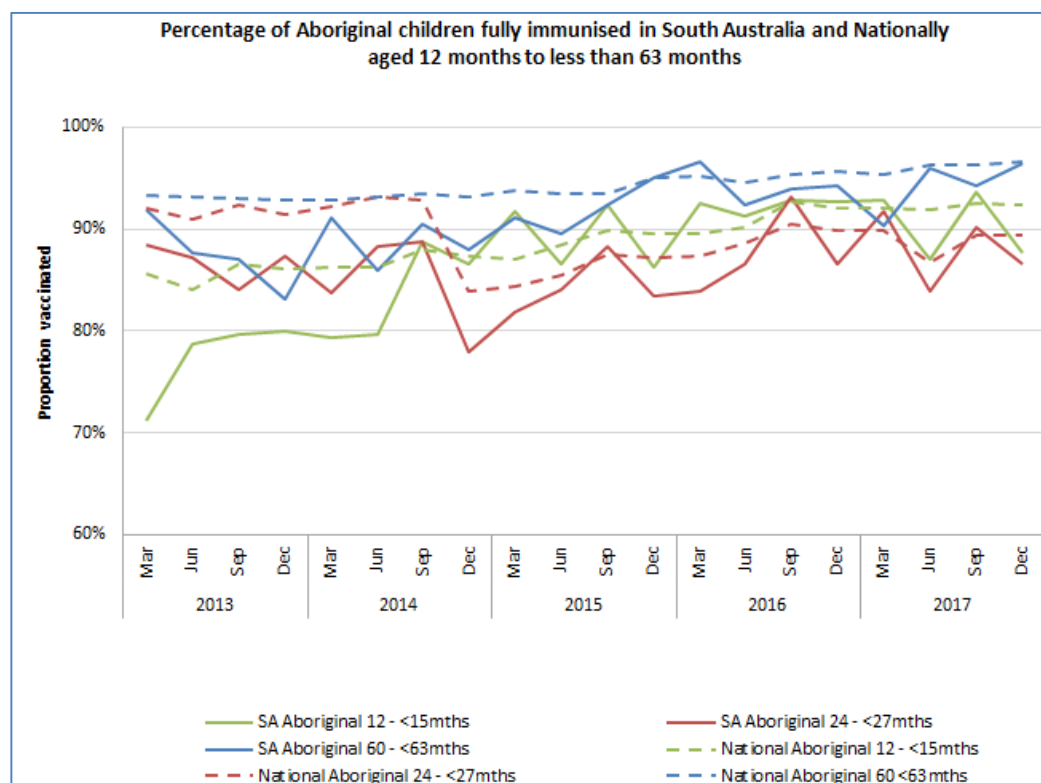
\*The data provided are annualised for age groups 12 to less than 15 months, 24 to less than 27 months, and 60 to less than 63 months using the Australian Immunisation Register (AIR) March, June, September and December assessment quarters.

Figure 1:



\* From quarter ending 31 December 2014, meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella (MMR) and dose 1 varicella (given as MMRV at 18 months) was included in the definition of fully immunised for the 24-27 month cohort.

Figure 2:



**Note:**  
\* From quarter ending 31 December 2014, meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella (MMR) and dose 1 varicella (given as MMRV at 18 months) was included in the definition of fully immunised for the 24-27 month cohort. Source: Australian Immunisation Register.

Further information is published at:  
<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/immunisation+for+health+professionals/immunisation+provider+information/south+australian+immunisation+coverage+rates>

## RECOMMENDATION 2

Take action with the Minister for Ageing to develop a joint plan with the aged care and primary care sector that will increase protection of the older population from vaccine preventable conditions.

### SA Health Performance Indicator

Reduce rates of hospitalisation for vaccine preventable conditions such as influenza and pneumonia by 2018.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
In the absence of an adult vaccination register the coverage of influenza vaccination is loosely based on distribution doses. The last National Adult Vaccination Survey was conducted in 2009 and estimated that, for the population aged ≥65 years, 74.6% were vaccinated against seasonal influenza and 54.4% against pneumococcal disease.	<p>Influenza vaccine coverage of residents in aged care facilities is not collected at a state level. The number of influenza vaccines distributed in SA for the National Immunisation Program in 2016 was approximately 385,000 as at August 2016.</p> <p>The total number of influenza vaccine doses distributed during 2015 was 396,363 which is slightly more than in 2016.</p> <p>In 2015-16, the age-standardised hospital separation rate for vaccine preventable conditions was 2.3 per 1,000 people.</p>	<p>The total number of influenza vaccine doses distributed during 2017 was 418,743.</p> <p>In 2016-17, the age-standardised hospital separation rate for vaccine preventable conditions was 2.2 per 1,000 people. This was a slight improvement from the rate of 2.3 percent reported in 2015-16.</p>	Previous CATI surveys used to measure the uptake of influenza vaccination in the elderly routinely showed SA to have the highest uptake nationally with the last survey demonstrating SA with uptake in excess of 83% compared to the national average of 74.6%. Adults with chronic conditions such as diabetes, chronic lung disease and renal failure, and those taking immuno-suppressive medications are also under-immunised.	<p>The Commonwealth has responsibility for the aged care and primary care sectors. Implementation of and promotion of vaccines for adults including Influenza, Pneumococcal and Zoster vaccines.</p> <p>Expansion of Australian Childhood Immunisation Register (ACIR) to become a whole of life register in September 2016 (Australian Immunisation Register (AIR) will include adult vaccination records and capture more accurate data.</p> <p>Implementation of a Zoster vaccination program commencing November 2016 will provide free vaccine to those aged 70 years up to 79 years and provide a degree of protection from shingles. The department will promote the use of the vaccines through GPs and aged care facilities.</p> <p>Education programs and the promotion of an annual influenza vaccination program for residents and health care workers in aged care facilities are ongoing. In 2016, a new influenza vaccination educational program for health care workers will be released, and an initiative to allow pharmacists to directly administer the influenza vaccine. It is also noted that engagement with the primary care sector requires some input from the Commonwealth.</p>

## GETTING INTO THE SYSTEM

### RECOMMENDATION 5

Require SA Health to manage a reduction to 15 per cent or less by 2018 of people living in country South Australia reporting delaying or not seeing a dental professional.

### SA Health Performance Indicator

SA Health to reduce the number of people living in country South Australia reporting delaying or not seeing a dental professional due to cost by up to 15% by 2018.



2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
<p>Whilst the number of people waiting for care increased in the 12 months to 30 June 2015, the gap between the country and metropolitan waiting times reduced from 5.7 months to 3.30 months by 30 June 2015.</p>	<p>In the 12 months to 30 June 2016 the country waiting list improved from 13,046 people waiting 15.5 months as at 30 June 2015) to 11,082 people waiting 13.7 months by 30 June 2016. Importantly in the same timeframe the gap between metropolitan and country areas further reduced from 3.3 months to just 0.6 months.</p> <p>Due to a change in data source, waiting time data are not comparable with survey data published previously. Public dentistry waiting times is defined as the median time waited between being placed on a public dentistry waiting list and receiving an offer of a course of public dental care from a waitlist.</p> <p>In 2015-16, the median waiting time for an offer of public general dental care for people living in country SA was an average of 358 days, an increase from 338 days in 2014-15. The median waiting time for people living in the Metro area was also 358 days, an increase from 268 days in 2014-15.</p> <p>In 2015-16, the median waiting time for an offer of public denture care for people living in country SA was an average of 502 days, an increase from 411 days in 2014-15. The median waiting time for people</p>	<p>In the 12 months to 30 June 2017 country public dental waiting lists deteriorated slightly from 11,082 people waiting 13.7 months (as at 30 June 2016) to 14,101 people waiting 15.3 months by 30 June 2017.</p> <p>The gap between metropolitan and country waiting times remained relatively stable, improving slightly from 0.6 months longer in country areas to 0.2 months longer in the same timeframe.</p> <p>In 2016-17, the median waiting time for an offer of public general dental care for people living in country SA was an average of 492 days (outer regional) and 405 days (remote), an increase from 399 days (outer regional) and 340 days (remote in 2015-16. The median waiting time for people living in the Metro area was 406 days, an increase from 358 days in 2015-16. People in remote areas waited a similar time to metro area.</p> <p>In 2016-17, the median waiting time for an offer of public denture care for people living in country SA was an average of 588 days (outer regional) and</p>		<p>The National Oral Health Plan (2015-2024 Healthy Mouths – Healthy Lives) includes people living in regional and remote areas as a priority group and calls for specific actions for this population group including access to care.</p> <p>SA Dental Service and SA Health continue to focus on improving access to affordable timely oral health for people in rural and remote locations.</p> <p>The use of overseas qualified dental practitioners via the National Public Sector Dental Workforce Scheme (PSDWS) has been a major source of the dentist workforce in SA public dental clinics in country locations over the past several years. Recent changes to the scheme indicate access to the use of the PSDWS dentists is likely to decrease in future and lead to a reduction in the availability of dentists in country areas and increasing waiting lists. SA Dental Service will continue to explore strategies to assist meeting the workforce requirements for public dental clinics in country areas.</p> <p>In South Australia the majority (around 85%) of dental services are provided in the private dental sector. The level of any out of pocket costs charged by the private sector are largely outside the scope of the Minister for Health, SA Health and/or Local Health Networks to manage.</p> <p>Modest patient co-payment fees are applied within the SA public dental system. However, strategies implemented in the public dental system to reduce cost barriers include:</p> <ul style="list-style-type: none"> <li>Financial hardship arrangement for patients who are assessed by an accredited Financial Counsellor as being unable to pay the usual fees have care provided free of charge;</li> <li>Patients requiring urgent care are not refused care if they are unable to pay the emergency patient fee on the day;</li> <li>Targeted programs for specific client cohorts are fee free, for example clients who are Aboriginal, homeless or live in Supported Residential Facilities;</li> <li>Continuing to work with private dental providers to maintain the viability of private dental practice in some small country areas.</li> </ul>

	living in the Metro area was 408 days, an increase from the 301 days in 2014-15. (RoGS 2017)	610 days (remote), an increase from 498 days and 516 days in 2015-16. The median waiting time for people living in the Metro area was 566 days, an increase from the 408 days in 2015-16. People in outer regional and remote areas waited about three to six weeks longer for dentures than people in the metro area. (RoGS 2018)		In recent years, this has included initiatives in Peterborough, Kingscote and Kingston SE.
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Improving access to affordable basic public dental care for people living in country areas continues to be a major focus for SA Dental Service.

State public dental waiting lists have fluctuated over the past four-six years in line with the availability of additional Commonwealth National Partnership Agreement funding.

#### RECOMMENDATION 9

Require SA Health to set a performance outcome that all Local Health Networks increase the rate that Aboriginal people attending hospital emergency departments are seen on time (treated within national benchmarks) to 75 per cent or above by 2018.

#### SA Health Performance Indicator

SA Health to undertake analysis of Aboriginal people rate seen on time in emergency department – targeted at metro EDs to establish baseline.

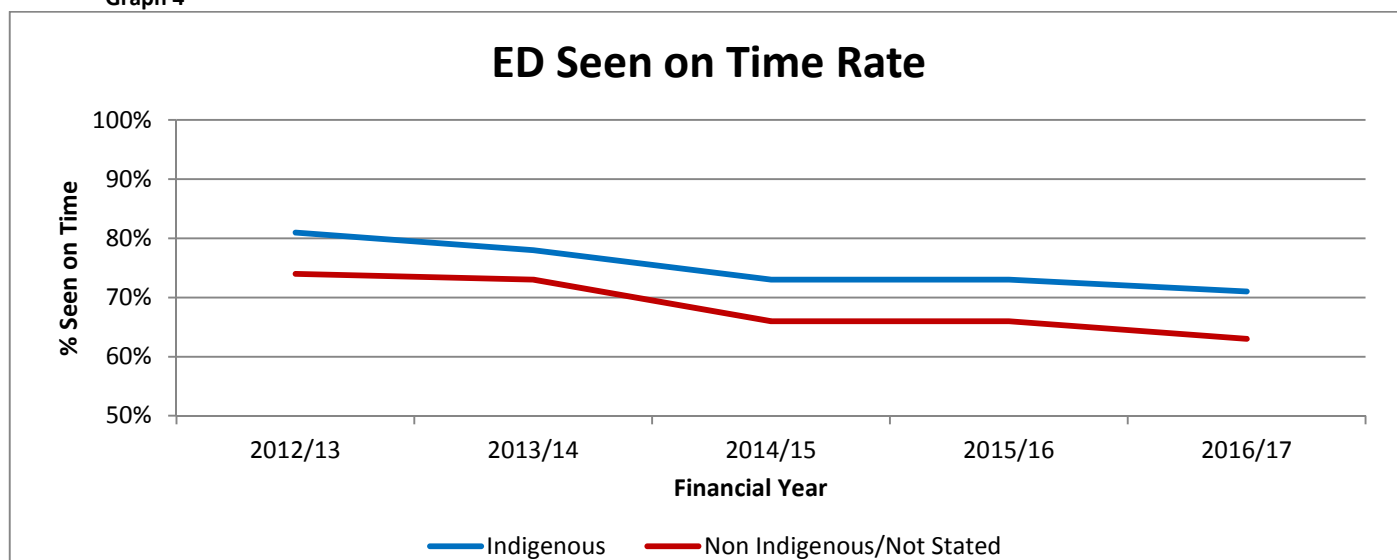
2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
<p>Prioritisation of patients seen is based on clinical needs, regardless of cultural background or gender.</p> <p>In 2014-15, 73 percent of Aboriginal patients presenting at a South Australian ED were seen on time.</p>	<p>In 2015-16, 73 percent of Aboriginal patients presenting at a South Australian ED were seen on time, compared to 66 percent of Other Australians. These figures have remained stable compared to 2014-15.</p>	<p>In 2016-17, 71 percent of Aboriginal patients presenting at a South Australian ED were seen on time, a decline when compared to 73 percent in 2015-16.</p> <p>In comparison, 63 percent of Other Australians presenting at a South Australian ED were seen on time. This is a decline of 3 percent when compared to 2015-16 figures.</p>	<p>In 2016-17 SA performance was 71 percent compared to the national rate of 74 percent for indigenous presentations to an ED. For other Australians 63 percent in SA were seen on time as compared with the national average of 73 percent.</p> <p>The percentage of patients with ED visits completed within 4 hours declined for South Australia between</p>	<p>Through the state investment in Closing the Gap, an Aboriginal Cultural Learning Framework was developed to provide Aboriginal Cultural awareness training for all staff within SA Health in preparation for the new Aboriginal specific Quality and Safety health standards in 2017.</p> <p>AHMAC Hospital Principal Committee has commenced the "Take Own Leave" project to address rates of Aboriginal people discharging from Emergency Departments (ED's) against medical advice and increase the rates of Aboriginal people being seen on time.</p> <p>Key component of Transforming Health (TH) is to ensure the design and structure of metropolitan hospitals, including Emergency Departments improve care and waiting times</p>

			<p>2012-13 and 2016-17 by 2.2 percentage points (from 65.9 percent to 63.7 percent). Nationally there was an 5.1 percentage point improvement (from 67.3 percent to 72.4 percent) for the same period.</p> <p>South Australia declined by 2.3 percentage points (from 66.0 percent to 63.7 percent) between 2015-16 and 2016-17 whilst nationally performance declined by 0.9 percentage points (73.3 percent to 72.4 percent).</p> <p>For South Australia the median ED visit time increased by 16 minutes between 2012-13 and 2016-17 (from 2 hours and 52 minutes to 3 hours and 8 minutes) and this was an increase by 8 minutes compared to the 2015-16 results. Nationally the reverse occurred with an improvement in median ED visit time of 11 minutes to 2 hours and 48 minutes in 2016-17) compared with 2012-13 but increased by 4 minutes compared to 2015-16.</p>	<p>and Aboriginal Hospital Liaison Officers continue to support Aboriginal patients.</p> <p>In addition a new Aboriginal Expert Advisory Group (AEAG) is being established under the governance of the TH Ministerial Clinical Advisory Group to identify:</p> <ul style="list-style-type: none"> <li>• How to ensure the needs of Aboriginal and Torres Strait Islanders peoples (including those who are SA Health staff) are addressed under TH</li> <li>• Opportunities to strengthen TH programs to focus on Aboriginal health and achieving improved health outcomes as well as assessing potential impact on staff</li> <li>• Approaches to existing evaluations of TH programs to ensure their effect on Aboriginal people and Aboriginal SA Health staff is measured</li> <li>• Work with MCAG and the TH decision-making bodies to disseminate and help translate information about TH programs improve the way they connect with South Australian Aboriginal communities.</li> </ul>
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**Table 3**  
**ED Seen On Time Rate (Excludes Did Not Wait)**

Indigenous Status	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Indigenous	81%	81%	78%	73%	73%	71%
Non Indigenous/Not Stated	76%	74%	73%	66%	66%	63%
Sum:	76%	75%	73%	66%	66%	64%

**Graph 4**



## BEING TREATED WELL

### RECOMMENDATION 12

Require SA Health to direct local health networks to investigate, in collaboration with Aboriginal leaders, the causes of each hospital's discharge against medical advice rates and develop appropriate implementation and monitoring strategies to achieve the SA Health target by July 2016.

### SA Health Performance Indicator

N/A

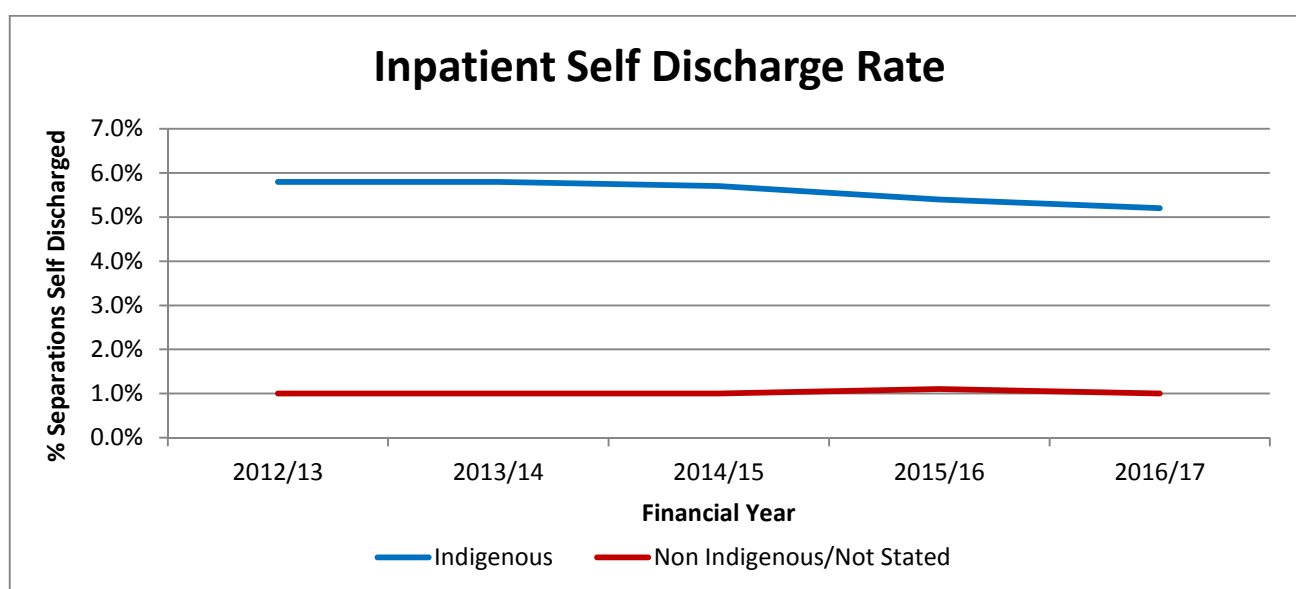
2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
ED and inpatient measure included in tables 3,4,5 and 6. SA generated figures include dialysis and mental health and are therefore slightly higher than national rates.		In South Australia, the percentage of indigenous patients who discharged against medical advice was 5.2% in 2016-17. This is an improvement from the 2015-16 rate of 5.4% and 5.7% for 2014-15.  NOTE: this is Public	<a href="http://www.aihw.gov.au/indigenous-data/health-performance-framework">http://www.aihw.gov.au/indigenous-data/health-performance-framework</a>  Refer to table 5 - after excluding dialysis, mental and behavioural disorders for 2013-14 and 2014-15 in SA 5.7 percent of indigenous person treated as inpatient	Refer to Recommendation 9. LHNs continue to monitor discharge rates.  The Aboriginal Health Care plan implementation committees also monitor discharge rates and support the development and of strategies that support decreasing discharge rates for example: <ul style="list-style-type: none"><li>Cancer Care Coordinators and Aboriginal Liaison Officers provide support, cultural brokerage with linkages to interpreter services, social work services including referrals to Step Down Units and other services provided external to the Hospital.</li></ul>

		and private hospitals.	left against medical advice. Compared with the national average of 4.3 percent. Age-adjusted these rates were 4.2 and 3.4 respectively.	<ul style="list-style-type: none"> <li>• Self-discharge mechanisms implemented under the new Aboriginal Consumer Engagement Strategy support making hospitals culturally safe and inclusive</li> <li>• Each of the LHN Health Advisory Councils have an Aboriginal community representative to ensure the health needs of Aboriginal people are considered including clear discharge strategies and patient feedback</li> </ul>
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**Table 5**  
**Inpatient Self Discharge Rate (Overnight Stay Only)**

Indigenous Status	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Indigenous	5.6%	5.8%	5.8%	5.7%	5.4%	5.2%
Non Indigenous/Not Stated	0.8%	0.8%	0.8%	0.8%	0.9%	0.9%
<b>Total:</b>	<b>1.0%</b>	<b>1.0%</b>	<b>1.0%</b>	<b>1.0%</b>	<b>1.1%</b>	<b>1.0%</b>

**Graph 5**



## GETTING GOOD OUTCOMES

### RECOMMENDATION 16

The Department to assess rates of patient incidents, and develop strategies to reduce the rate to less than 10 per 100 overnight separations by 2018.

## SA HEALTH PERFORMANCE INDICATOR

10% reduction on actual harm (number not proportion, actual SAC 1 and 2 incidents) from 2015-16 to 2017-18.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
The total number of SAC 1&2 incidents was 536.	<p>The total number of SAC 1&amp;2 incidents was 567.</p> <p>There has been a 3% increase in the number of incidents reported for 2016.</p> <p>The percentage of actual harm has reduced from 2.9% in 2011 to 1% in 2016.</p> <p>Refer table 7</p>	<p>The total number of SAC 1&amp;2 incidents was 506.</p> <p>There has been a 9.5% increase in the number of incidents reported for 2017.</p> <p>There has been a 11% reduction in harm reported for 2017.</p> <p>The percentage of actual harm has reduced from 2.9% in 2011 to 0.84% in 2017.</p> <p>Refer table 7</p>		<p>Per last year's response SA Health continues to implement and modify:</p> <ul style="list-style-type: none"> <li>a focused patient safety program targeting areas of patient harm which may result in an adverse consumer outcome aligned to the National Safety and Quality Priorities and National Safety and Quality Health Service Standards</li> <li>a suite of safety and quality metrics in LARS (LHN Analytics and Reporting Service) to support continuous monitoring and improvement which include volume of incidents and near misses reported and the actual level of harm.</li> </ul>

**Table 7**  
**SAC 1&2 Incidents**

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
<b>Total Incidents</b>	27860	32698	37691	44113	53830	55330	60559
<b>SAC 1&amp;2</b>	818	904	606	588	551	568	506
<b>Harm (SAC 1&amp;2) as % of total</b>	2.9%	2.8%	1.6%	1.3%	1.0%	1.0%	0.84%

## RECOMMENDATION 17

SA Health through its Infection Control Service (ICS) continues implementation of quality programs aimed at improving infection control in hospitals, and monitoring the effectiveness of new interventions.

### SA Health Performance Indicator

Monitoring of key infection control indicators:

- Rate of healthcare associated *Staphylococcus aureus* bacteraemia (SAB) per 10,000 patient days (National target: 2.0) – includes all SA public hospitals
- Hospital vancomycin resistant enterococci (VRE) infections per 10,000 bed days (no national target) – includes all public metropolitan hospitals and 6 larger country hospitals
- Healthcare associated methicillin resistant *Staphylococcus aureus* (MRSA) infections per 10,000 bed days (no national target) – includes all public metropolitan hospitals and 6 larger country hospitals

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
<p>2014/15 Rate of SAB for public hospitals: 0.56 per 10,000 bed-days</p> <p>2014/15 Hospital VRE infections 0.50 per 10,000 bed days</p> <p>2014/15 MRSA infections 1.33 per 10,000 bed days</p>	<p>2015/16 Rate of SAB for public hospitals: 0.67 per 10,000 bed-days</p> <p>2015/16 Hospital VRE infections 0.68 per 10,000 bed days</p> <p>2015/16 MRSA infections 1.24 per 10,000 bed days</p>	<p>2016/17 Rate of SAB for public hospitals: 0.77 per 10,000 bed-days</p> <p>2016/17 Hospital VRE infections 0.92 per 10,000 bed days</p> <p>2016/17 MRSA infections 1.08 per 10,000 bed days</p>	<p>The national SAB rate for 2016/17 was 0.76 per 10,000 patient bed-days. SA compares favourably to other states (range 0.72 – 1.04).</p> <p>Hospital VRE infections: there is no comparator rate available.</p> <p>MRSA infections: there is no comparator rate available.</p>	<p>ICS monitors and reports on the incidence of key healthcare associated infections for public acute hospitals.</p> <p>Surveillance data are reported to the Department and Hospital Executives on a monthly basis.</p> <ul style="list-style-type: none"> <li>ICS develops and maintains policies, guidelines and resources on the prevention of infection. Documents are reviewed as required, including at the request of LHN CEOs.</li> </ul>

#### RECOMMENDATION 18

SA Health to develop strategies that will close the gap in the rates of potentially avoidable deaths between Aboriginal and non-Aboriginal people in South Australia by 2018.

#### SA Health Performance Indicator

Close the gap in the rates of potentially avoidable deaths between Aboriginal and non-Aboriginal people in South Australia by 2018

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
<p>There has been a reduction in potentially avoidable deaths from 1.6 per 1,000 persons in 2008 to 1.5 in 2011. However, the 5-year average for Aboriginal people from 2007-2011 was almost four times as high at 5.4 per 1,000 population.</p>	<p>There has been a 16% decline in mortality rates between 1998 and 2013, and a 39% decline in deaths due to circulatory disease.</p> <p>A narrowing of the gap in low birth weight babies from 10.4% in 2001 to 8.5% in 2011. (per Aboriginal and Torres Strait Islander Health Performance Framework Report 2014)</p>	<p>In 2011–2015 in South Australia, there were 403 deaths of Indigenous Australians aged 0-74 from avoidable causes. The age-standardised avoidable death rate for Indigenous Australians was 3.3 times the rate for non-Indigenous Australians (346 compared with 106 per 100,000).</p>	<p>Data not available</p>	<p>Since 2009 the State investment into Closing the Gap programs has seen some 29 programs and initiatives implemented to contribute to Close the Gap in life expectancy in a generation by 2031 &amp; halve the gap in mortality rates for children under 5 by 2018.</p>

## WORKING EFFICIENTLY AND REMAINING STABLE

### RECOMMENDATION 23

Develop strategies and implement efficiencies that will reduce growth in cost per case mix to a nominated target (eg. Consumer Price Index) to bring down the South Australian average to the national average over a five year period.

#### SA Health Performance Indicator

Reduce growth in cost per case mix to bring down the South Australian average to the national average over a five year period.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
			<p>The recurrent cost per casemix-adjusted separation in 2013-14 was \$5,402, higher than the national average of \$4,836 and higher than the 2012-13 average cost of \$5,113.</p> <p>(RoGS 2017)</p> <p>Costing Report for 2015-16 is not available.</p> <p>Note: It is anticipated that costing's and trend data against national costing's will be available in 2017.</p>	<p>Per last year's response, spending on health care will always increase, however, SA Health continues to identify, implement and monitor strategies so we spend our money wisely including efficient ward configurations, product standardization, the negotiation of improved procurement terms, optimized pathology and pharmacy costs, and voluntary redundancies. Many of these programs will continue to deliver benefits across the forward estimates.</p> <p>Recommendations 21, 22 and 23 fall under the state governments commitment to TH and the six principles underpinning TH which include: a health system that is:</p> <p>Patient centred</p> <ol style="list-style-type: none"> <li>1. Safe</li> <li>2. Effective</li> <li>3. Accessible</li> <li>4. Efficient, and</li> <li>5. Equitable.</li> </ol> <p>TH health aims to provide the right care, minimises waste and optimises value and productivity.</p> <p>The Transforming Health Ministerial Clinical Advisory Group (MCAG) continues to provide clinical leadership and guides the way Transforming Health is implemented.</p> <p>The MCAG provides input into and leadership of:</p> <ul style="list-style-type: none"> <li>• Service delivery changes required for the new metropolitan wide configuration of services</li> <li>• New models of care and new hospital models</li> <li>• Capital re-design to deliver quality</li> </ul>



				<ul style="list-style-type: none"> <li>Quality principles, standards of care and productivity improvements identified in TH.</li> </ul>
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## ENGAGING WITH THE COMMUNITY

### RECOMMENDATION 24

Build on its Framework for Active Participation by establishing a single point of contact to support units across SA Health to conduct quality engagement by:

- providing engagement tools and advice
- contributing to continuous improvement in engagement practices and delivery of health care by monitoring and making public engagement processes and their outcomes
- implementing a strategic approach to relationships with community organisations, businesses, universities, consumers and the community
- linking in with whole of government efforts to improve engagement practice through the Better Together Principles.

### SA Health Performance Indicator

N/A

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
<p>The SA Health Consumer and Community Advisory Committee Policy Guideline and Toolkit were released in October 2015, as a practical tool to assist health care services to implement the Framework.</p> <p>The SA Health Sitting Fees and Reimbursement for External Individuals Policy Directive was released in October 2015.</p> <p>The SA Health Partnering with Consumers and Community Advisory Group was set up in March 2013. The group is established under the governance structure of the SA Health Safety and Quality Strategic Governance</p>	See Strategies	<p><b>Partnering with Consumers and the Community</b></p> <p>The SA Health Partnering with Consumers and Community Advisory Group continued to meet in 2017, to progress the Strategic Action Plan.</p> <p>In 2017, the SA Health Consumer and Community Engagement Governance Model – Consumer and Community Advisory Groups was established. The governance model outlines the Consumer and Community Advisory Groups involved in service planning, designing care, measuring and evaluating health care services at a local level.</p> <p>In 2017, SA Health continues to</p>	N/A	<p>Safety and Quality Branch coordinates the state's 'Partnering with Consumers and the Community' program and provides advice and assists health services in planning for assessment against the National Safety and Quality Health Standard 2 – Partnering with Consumers.</p> <p>The SA Health Partnering with Consumers and the Community Strategic Action Plan is the strategic framework which underpins the National Safety and Quality Health Service Standards 1 and 2.</p> <p>Standard 1 includes consumer feedback and complaints management, open disclosure, patient rights and engagement, informed consent, and measuring consumer experience.</p> <p>National Standard 2 includes consumer partnerships in service planning, designing care and service measurement and evaluation.</p> <p>The SA Health Framework for Active Partnership with Consumers and the Community and Guide for Engaging with Consumers and the Community were released in 2013 are due to review in December 2018. The Better Together Principles and best practice are embedded within the Framework.</p>

<p>Committee.</p> <p>The SA Health Culturally and Linguistically Diverse (CALD) Consumer Experience Group was established in December 2012. The group works collaboratively with Safety and Quality Branch to understand the CALD communities' needs in health care. Representatives include Multicultural Communities Council SA (MCCSA).</p>		<p>collaborate with HCA, HCSCC, AHCSA, Carers SA, COTA and MCCSA.</p> <p><b>Partnering with Carers</b></p> <p>The SA Health Partnering with Carers Strategic Action Plan 2017-2020 and key priorities was launched at the International Carers Conference in Adelaide in October 2017.</p> <p>National Carers Week is celebrated every October with care information displayed at health sites and carer stories shared via social media.</p> <p>Lyell McEwin Hospital piloted the first Partnering with Carers Education and Training Forum – a collaboration with SA Health and Carers SA.</p> <p>With positive feedback, the Partnering with Carers Education and Training Forum will be implemented statewide in 2018.</p> <p>Partnering with Carers webpage was established at <a href="http://www.sahealth.sa.gov.au/carers">www.sahealth.sa.gov.au/carers</a></p> <p>In 2017, Safety and Quality continued to work with Culturally and Linguistically Diverse (CALD) Experience Group, and details are provided in recommendation 25.</p>		<p>SA Health continues to fund the Health Consumers' Alliance (HCA) as the peak agency in South Australia for consumer engagement. SA Health is collaborating with the HCA to co-create consumer and community engagement strategies.</p> <p>The Safety and Quality Branch works collaboratively with HCA, Health and Community Services Complaints Commissioner (HCSCC), Aboriginal Health Council SA, Carers SA, Council on the Ageing (COTA), and Multicultural Communities Council SA (MCCSA) to provide quality community engagement.</p> <p>Safety and Quality Branch works collaboratively with Carers SA.</p> <p>The Partnering with Carers Strategic Action Plan 2017 – 2020 and key priorities was launched at the International Carers Conference in Adelaide in October 2017.</p> <p>The SA Health Culturally and Linguistically Diverse (CALD) Consumer Experience Group was established in December 2012. The group works collaboratively with Safety and Quality Branch to understand the CALD communities' needs in health care. Representatives include Multicultural Communities Council SA (MCCSA).</p>
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**RECOMMENDATION 25**

Commission a Consumer Experience Survey of Aboriginal and culturally and linguistically diverse South Australians to complement its existing mainstream survey.

**SA Health Performance Indicator**

N/A

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
<p>The SA Consumer Experience Surveillance System (SACCESS) is a telephone survey where consumers are interviewed soon after an overnight stay in a metropolitan or country hospital using a set of internationally validated questions. In 2015, 2340 South Australians were interviewed, and since 2010, over 13,000 patients have participated in SACCESS.</p>	<p>See Strategies</p>	<p>The <a href="#">Australian Hospital Patient Experience Question Set (AHPEQS)</a> by the Australian Commission on Safety and Quality in Health Care and endorsed by Australian Health Ministers Advisory Council (AHMAC) in late 2017.</p> <p>In early 2018, discussions commenced with the Aboriginal and Torres Strait community and Multicultural Communities Council SA (MCCSA) to review the AHPEQS and consider survey questions to be implemented for community surveys.</p>		<p>SA Health continues to identify where gaps exist for Aboriginal people to share their experience with SA Health.</p> <p>In February 2016, a MCE CAPI Aboriginal and Torres Strait Islander Work Group was convened with members from NALHN, DASSA, SALHN, Aboriginal Health Branch, Wardliparingga Aboriginal Research Unit at SAHMRI, Safety and Quality, and is working in collaboration with Northern Territory Department of Health. Discussions included review of the national core patient experience questions and top ATSI languages to translate surveys. A background image has been developed specifically targeted to Aboriginal and Torres Strait Islander people, and a statewide ATSI survey is planned for early 2017.</p> <p>In mid-2016, Watto Purrinna Aboriginal Private Health Care Service commenced surveying consumers. Consumers from Lyell McEwin Hospital and Wonggangga Turtpandi, were asked about being treated with respect and dignity, their involvement in decision making, information, pain and follow up care.</p> <p>In 2015/16 the Measuring Consumer Experience Computer-Assisted Personal Interview (MCE CAPI) pilot commenced. The pilot enables SA Health to better understand the consumer and community needs in health care for all consumers including Aboriginal and Torres Strait Islander (ATSI), Culturally and Linguistically Diverse (CALD), patients aged 16 years and under, maternity, mental health / lived experience, substance abuse, chemotherapy or renal dialysis episodes of care. The MCE CAPI will enable all consumers the opportunity to share their experiences and provide us with their perspective on health care services, which is currently excluded from the SA Consumer Experience Surveillance System (SACCESS).</p>



SA Health's formal response to the  
Health Performance Council's four-yearly review

# Review of the Public Health System's Performance for 2011-2014

June 2015



Government  
of South Australia

SA Health

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## 1. Introduction

On 24 December 2014, the Health Performance Council (HPC) submitted its report *What's Working, What's Not – Review of the South Australian Health System Performance for 2011-2014* (the Report) to the Minister for Health in accordance with the requirements of the *Health Care Act 2008*.

SA Health acknowledges HPC's four-yearly review of the overall operations of the State's health system, which requires the collection and evaluation of health intelligence information. It is the second such review since the HPC was established in 2008.

This response addresses the latest Report's key findings, and outlines SA Health's current undertakings and/or planned actions.

A focus on transparency in public reporting of information on health system performance began with the introduction of the HPC by the State Government in 2008, the first State to introduce an independent review process.

Since 2011, the introduction of national performance monitoring and reporting has driven continuous improvement of health care services, by offering extensive information for patients and consumers, health care providers and health system managers. Reports issued by the National Health Performance Authority, which operates independently of both the Commonwealth and State and Territory Governments, allows updated comparisons of performance, quality and efficiency of health services across jurisdictions.

The State Government also has an increased focus on open government and transparency in public reporting of information on health system performance. For example, the patient safety reports and the hospital dashboards published on the SA Health website provide easy access to up-to-date information about how the State's metropolitan public health system is performing in a range of areas.

SA Health continues to engage with clinicians, the community and consumers as it endeavours to ensure the best quality healthcare into the future. In October 2014, the Minister for Health sought to engage South Australians on the future of the State's health system with the release of the *Transforming Health* discussion paper. The paper was a response, in part, to funding challenges faced in light of the 2014/15 Federal Budget announcements. Following further community and staff engagement in early 2015, the Minister for Health released *Delivering Transforming Health* which outlines the next steps for Transforming Health, based on extensive input, feedback and ideas provided by the community, our staff and the health care sector.

*Transforming Health* seeks to achieve consistent, effective, efficient and quality outcomes for patients by providing the best service configuration and best practice models of care.

## 2. Summary of advice to the Minister for Health on areas of potential improvement

### Building healthy communities

1. Require SA Health to set a performance outcome that all local health networks increase childhood immunisation rates to 92 per cent or greater by 2018, with a priority focus on Aboriginal rates.
2. Take action with the Minister for Ageing to develop a joint plan with the aged care and primary care sector that will increase protection of the older population from vaccine preventable conditions.
3. Request the Minister for Education and Child Development to set a target of 80 per cent by 2018 for the percentage of vulnerable families with young children accepting sustained home visiting services with a particular focus on Aboriginal families.
4. Require SA Health to work with the primary health care networks to raise the rate of all children receiving fourth year developmental checks to 70 per cent by 2018.

### Getting into the system

5. Require SA Health to manage a reduction to 15 per cent or less by 2018 of people living in country South Australia reporting delaying or not seeing a dental professional.
6. Request the Department for Health and Ageing investigate what actions South Australia can take to reduce household out-of-pocket medical expenditure.
7. Take action with the Minister for Ageing to develop a joint plan with the aged care and primary care sector that will increase the percentage of older people receiving annual health assessments to 35 per cent by 2018.
8. Require the SA Dental Service to reduce the percentage of people who wait one month or more for public dentistry to 70 per cent or less by 2018.
9. Require SA Health to set a performance outcome that all local health networks increase the rate that Aboriginal people attending hospital emergency departments are seen to 75 per cent or above by 2018.

### Being treated well

10. Ask the South Australian Health and Medical Research Institute to investigate, in collaboration with the Aboriginal community, what action can be taken by primary and community health care sectors to reduce the rate of potentially preventable hospitalisations for Aboriginal people.
11. Take action with the Minister for Ageing to develop a joint plan with the aged care sector that will reduce the rate of hospital patient days used by those eligible and waiting for Residential Aged Care to 1.0 per 100 patient days or less by 2018.
12. Require SA Health to direct local health networks to investigate, in collaboration with Aboriginal leaders, the causes of each hospital's discharge against medical advice rates and develop appropriate implementation and monitoring strategies to achieve the SA Health target by July 2016.
13. Require the Department's Mental Health Unit to work with local health networks to assess rates of community follow-up within 7 days of discharge from a psychiatric care admission, and develop strategies to increase this rate to 75 per cent by 2018.
14. Require SA Health to work with the primary care sector to develop strategies to help people feel supported when they seek primary care.

### Getting good outcomes

15. The SA Cancer Registry to include cancer stage at diagnosis as a core item in its database, and SA Health to make private hospital data available to SA-NT DataLink.
16. The Department to assess rates of adverse events, and develop strategies to reduce the rate to less than 10 per 100 overnight separations by 2018.



17. SA Health through its Infection Control Service continues implementation of quality programs aimed at improving infection control in hospitals, and monitoring the effectiveness of new interventions.

18. SA Health to develop strategies that will close the gap in the rates of potentially avoidable deaths between Aboriginal and non-Aboriginal people in South Australia by 2018.

19. SA Health to develop strategies that support the community with the psychosocial and respite supports critical to helping people with a terminal illness remain at home if they wish.

### **Working efficiently and remaining sustainable**

20. Develop strategies and implement efficiencies that will reduce growth in health expenditure per person to bring South Australia's expenditure back to the Australian average within five years.

21. Develop strategies that will improve length of stay by identifying patients that can be better cared for in non-acute hospital settings.

22. Continue with its workforce commitments set out in the Strategic Plan, including identifying new approaches that further develop a competent, flexible, sustainable, responsive, and diverse workforce.

23. Develop strategies and implement efficiencies that will reduce growth in cost per casemix to a nominated target (e.g. Consumer Price Index) to bring down the South Australian average to the national average over a five year period.

### **Engaging with the community**

24. Build on its Framework for Active Participation by establishing a single point of contact to support units across SA Health to conduct quality engagement by:

- providing engagement tools and advice

- contributing to continuous improvement in engagement practices and delivery of health care by monitoring and making public engagement processes and their outcomes

- implementing a strategic approach to relationships with community organisations, businesses, universities, consumers and the community

- linking in with whole of government efforts to improve engagement practice through the Better Together Principles.

25. Commission a Consumer Experience Survey of Aboriginal and culturally and linguistically diverse South Australians to complement its existing mainstream survey.

### **Improving SA population health data collection and analysis**

26. The Minister for Health recommend to Government that it supplements its data collection with purposeful sampling of specific population groups and routinely report on these groups on a cyclic basis.

### 3. Response to the Health Performance Council's 26 recommendations to the Minister for Health

#### Building healthy communities

- 1. Require SA Health to set a performance outcome that all Local Health Networks increase childhood immunisation rates to 92 per cent or greater by 2018, with a priority focus on Aboriginal rates.**

##### Supported

Immunisation is provided across a range of providers, for example local government and General Practitioners, and is not the sole remit of the Local Health Networks. SA Health supports achievement of the national benchmark for immunisation, across a network of providers in government, non-government GP practices, and is pleased by positive improvements to rates for Aboriginal children.

As at June 2014, in SA, 90.3 per cent of children aged 12-15 months were fully immunised, while 92.4 per cent of children aged 24-27 months were fully immunised. For children aged 60-63 months, 90.5 per cent were fully immunised. A state-wide Aboriginal immunisation program funded through *Closing the Gap* until June 2016 has lifted coverage of Aboriginal children, achieving a halving of the gap between Aboriginal and non-Aboriginal five-year-olds over the past four years. The campaign *Help Me Stay Strong* targets new parents of Aboriginal children.

SA Health continues to target the general public through health promotions, and health professionals through education programs. Changes to immunisation programs, such as additional vaccines or assessment rules and a small percentage of parents who refuse to immunise their children, as well as some providers who vaccinate children but fail to submit data to the register, present significant challenges in maintaining high vaccine coverage rates.

- 2. Take action with the Minister for Ageing to develop a joint plan with the aged care and primary care sector that will increase protection of the older population from vaccine preventable conditions.**

##### Agree in principle

The responsibility for this matter falls to the Minister for Health. SA had the highest per cent of people aged 65 years or more fully vaccinated against influenza for 2009 at 81.3 per cent, above the Australian average of 74.6 per cent. Education programs and the promotion of an annual influenza vaccination program for residents and health care workers in aged care facilities are ongoing. In 2015, a new influenza vaccination educational program for health care workers will be released, and an initiative to allow pharmacists to directly administer the influenza vaccine. It is also noted that engagement with the primary care sector requires some input from the Commonwealth.

- 3. Request the Minister for Education and Child Development to set a target of 80 per cent by 2018 for the percentage of vulnerable families with young children accepting sustained home visiting services with a particular focus on Aboriginal families.**

##### Agree in principle

Parents of newborns are offered a Universal Contact Visit with a community child and family health nurse. Family Nurse Visiting is offered to eligible families identified by CaFHS nurses at the Universal Contact Visit. About 10 per cent of families may benefit from the sustained nurse visiting service, having being identified with low to moderate depression, a lack of social connections, having socio-economic disadvantage and lower levels of developmental literacy, which is consistent with the 2014 report, *Five by Five: A Supporting Systems Framework for Child Health and Development*.

This sustained visiting program does not meet the needs of all families identified as vulnerable (an agreed definition needs to be applied). This was highlighted in an external

evaluation in 2013 by Professor Michael Sawyer, *Evaluation of the South Australian Family Home Visiting Program Final Report*. Alternative services are targeted at parents affected by mental health conditions, parents who show psychological distress or report risky levels of substance abuse, including alcohol. The matching of families to the program that they are most likely to benefit from is important, rather than a general perception that 'home visiting' is the overall solution to families who experience challenges that impact on effective parenting.

It is therefore suggested the indicator be amended to "SA Health set a target of 80 per cent of the approximately 10 per cent of families with young children in South Australia accepting sustained nurse visiting services with a particular focus on identified risk factors, inclusive of Aboriginal families".

It is also noted that Royal Commissioner Margaret Nyland will report later in 2015 on a review of the policies, practices and procedures of the State's child protection authorities and other government and non-government organisations charged with the care and protection of children deemed at risk of harm.

#### **4. Require SA Health to work with the primary health care networks to raise the rate of all children receiving fourth year developmental checks to 70 per cent by 2018.**

##### **Agree in principle**

Health/developmental check screening rates have remained relatively stable for many years. For the fourth year check, SA Health targets pre-school and child-care centres in lower socio-economic areas, while many parents organise this check with a GP. The outcome of those checks is that no issues were identified for the majority who present. (It is noted that 2014 Productivity Commission data related to developmental health checks does not include activity conducted outside Medicare, such as preschools and community health centres.)

SA Health notes there is currently no evidence that supports health checks at any particular age. The preferred approach is to increase the awareness of children's development and the types of activities which positively promote effective parenting. SA Health supports parents in many ways, including engagement with families with identified risk factors in the antenatal period, providing ongoing services (including access to child care and then pre-school) and for a health/developmental check at 18-24 months. The Blue Book (the child health record) is being promoted universally, with parents encouraged to seek help if they have concerns.

It is further noted that this target will be difficult to achieve as the Medicare rebate will no longer apply to GPs for this item, under Federal Budget changes announced in May 2015.

### **Getting into the system**

#### **5. Require SA Health to manage a reduction to 15 per cent or less by 2018 of people living in country South Australia reporting delaying or not seeing a dental professional.**

##### **Supported conditionally**

The principle of reducing the proportion of people living in country areas who delay, or do not see, a dental professional is supported conditionally. It is understood this indicator resulted from a COAG Reform Council Report that highlights relatively more people delay or avoid seeing a dental professional due to cost, when compared with any other health professional, including General Practitioners. It is therefore suggested the indicator be amended to incorporate the 'due to cost' component.

In SA, including country SA, the majority of dental services are provided in the private dental sector, which is largely outside the scope of the Minister for Health, SA Health and/or Local Health Networks to manage.

Modest patient co-payment fees are applied within the SA public dental system. However, strategies implemented in the public dental system to reduce cost barriers include:

- Financial hardship arrangement for patients who are assessed by an accredited Financial Counsellor as being unable to pay the usual fees have care provided free of charge;
- Patients requiring urgent care are not refused care if they are unable to pay the emergency patient fee on the day;

- Targeted programs for specific client cohorts are fee free, for example clients who are Aboriginal, homeless or live in Supported Residential Facilities;
- Maintaining required staffing levels in country public dental clinics to ensure public patients can access their care locally and minimise additional travel-related costs;
- Continuing to work with private dental providers to maintain the viability of private dental practice in some small country areas. In the past four years, this has included initiatives in Peterborough, Kingscote and Kingston SE.

Improving access to affordable basic public dental care for people living in country areas has been a major focus for SA Dental Service in recent years. As a result, waiting lists have improved from 12,000 people in country areas waiting an average of 22 months as at 1 January 2011, to 11,000 people waiting 12 months in December 2014. Additional Commonwealth funding under the National Partnership Agreement (NPA) on Treating More Public Dental Patients contributed to this improvement.

#### **6. Request the Department for Health and Ageing investigate what actions South Australia can take to reduce household out-of-pocket medical expenditure.**

##### **Qualified**

Out of pocket medical expenditure generally relates to private health insurance, Medicare, pharmaceuticals and General Practice (GP), all of which are outside the direct responsibility of the State Government. The listing of items on the Medicare Benefits Schedule (MBS) and pharmaceuticals on the Pharmaceutical Benefits Scheme is a Commonwealth Government responsibility. GP services are a Commonwealth responsibility under the National Health Reform Agreement, however, in recognising that primary care is a key component of health care, the State government continues to develop ways to work cooperatively with GPs.

The SA Government believes that health care should be affordable and will continue to advocate to the Commonwealth on behalf of South Australians.

#### **7. Take action with the Minister for Ageing to develop a joint plan with the aged care and primary care sector that will increase the percentage of older people receiving annual health assessments to 35 per cent by 2018.**

##### **Agree in principle**

The responsibility for this matter falls to the Minister for Health. While SA Health has no control over the delivery of annual health assessments to older people, work is underway with the aged care sector, the Commonwealth and the primary care sector to support the health of older people. An Acute and Aged Care Taskforce is being established to ensure clear communication and collaboration exists between these sectors. Similar forums exist to support the work with the primary care sector. The State government continues to develop ways to work more effectively with General Practitioners for improved patient outcomes and pathways.

(It is noted that 2014 Productivity Commission data related to annual health assessments for older people does not cover all health assessments, it does not include services provided in public hospitals and excludes people living in residential aged care facilities.)

#### **8. Require the SA Dental Service to reduce the percentage of people who wait one month or more for public dentistry to 70 per cent or less by 2018.**

##### **Agree in principle**

The target is driven by results of the Australian Bureau of Statistics Patient Experience Survey 2013-14, based on a small sample of patient recollections, rather than actual public dental waiting times. It does not consider the proportion of urgent and non-urgent dental care provided in the SA public dental sector. It is assumed this measure is about public dental waiting times for general (non-urgent) dental care. People in need of urgent dental care (severe pain, bleeding or trauma) are prioritised and offered care within 1-2 days for the clinically most urgent, or 1-2 weeks for the second priority clinical category.

People assessed as requiring general (non-urgent) care are added to a chronological waiting list. Waiting times have reduced from 16 months as at 1 January 2011 to 11 months as at December 2014.

**9. Require SA Health to set a performance outcome that all Local Health Networks increase the rate that Aboriginal people attending hospital emergency departments are seen on time (treated within national benchmarks) to 75 per cent or above by 2018.**

**Not supported**

Prioritisation of patients seen is based on clinical needs, regardless of cultural background or gender, even so, all Local Health Networks (LHNs) are required to meet Emergency Access Targets requiring that 82 per cent of all patients should be seen within four hours of arrival. A further target specifies that 80 per cent of all patients should be seen within the clinically recommended time for their triage category. These performance measures are also consistent across jurisdictions.

Nevertheless there is an agreement amongst all LHNs and the Aboriginal Health Branch, as part of the Aboriginal Health Care Plan Steering Committee, to develop a cultural competency framework across SA Health. The aim is to support an approach, through workforce development, that ensures SA Health employees have the required essential minimal skills and knowledge to be culturally competent and be flexibly responsive to the needs of Aboriginal people in their care. SA Health staff are also encouraged to use the cultural knowledge of Aboriginal Hospital Liaison Officers. SA Health has increased the capacity to manage chronic disease, prevention and follow-up care through investment and collaboration with Aboriginal Community Controlled Health Services.

As at December 2014 Calendar Year to Date, 64 percent of presentations to South Australian Emergency Departments were seen within 4 hours of arrival, an improvement of 2 per cent from December 2011. As at December 2014 Financial Year to Date, South Australia achieved 67 per cent of all patients being seen within the clinically recommended time. All LHNs remain committed to improving performance in relation to patients seen within four hours of arrival.

One of the key components of Transforming Health is to transform the design and structure of metropolitan hospitals, including Emergency Departments, so people are provided the best care by the right person or group of people, first time, every time. This includes the development of super-sites for major emergencies at the Royal Adelaide Hospital, Flinders Medical Centre and Lyell McEwin Hospital, where doctors will be available 24 hours a day, 7 days a week.

**Being treated well**

**10. Ask the South Australian Health and Medical Research Institute to investigate, in collaboration with the Aboriginal community, what action can be taken by primary and community health care sectors to reduce the rate of potentially preventable hospitalisations for Aboriginal people.**

**Supported**

SA Health and the South Australian Health and Medical Research Institute are currently involved in a range of joint initiatives which work towards reducing the rates of preventable hospitalisations. Where appropriate, consultation with the Aboriginal community is undertaken. These initiatives include:

- The Cancer Data and Aboriginal Disparities partnership project which seeks to develop an integrated cancer monitoring system;
- SA State of Aboriginal Heart Health Project which will develop a SA cardiovascular health and service profile, and development of State-wide strategy for Aboriginal cardiovascular care;
- The Aboriginal Diabetes Care project which will establish best practice standards for Diabetes care, develop a state-wide profile of diabetes and related health conditions and services and the development of a state-wide strategy for care for people with diabetes and related conditions;



- SA Childhood Rheumatic Heart Disease Screening project which aims to provide in-school rheumatic heart disease (RHD) screening for approximately 2000 South Australian Aboriginal children aged 5-14 years;
- Aboriginal Cardiovascular Omega 3 trial is a multi-centre trial of omega 3 supplementation in Aboriginal patients with established coronary artery disease;
- COMMUNICATE is the acute cardiac in-hospital communication experiences of Aboriginal and Torres Strait Islander peoples project; and
- ESSENCE II is the name for projects to develop indicators and a primary health care project in relation to the ESSENCE standards for equitable cardiovascular care for Aboriginal and Torres Strait Islander people.

**11. Take action with the Minister for Ageing to develop a joint plan with the aged care sector that will reduce the rate of hospital patient days used by those eligible and waiting for Residential Aged Care to 1.0 per 100 patient days or less by 2018.**

**Agree in principle**

The responsibility for this matter falls to the Minister for Health. The Acute and Aged Care Taskforce has been set up to ensure clear communication and collaboration exists between these sectors. While access to Residential Aged Care is the Commonwealth's responsibility, SA Health wishes to ensure effective transition of older people between these sectors. A 90-day project has also been undertaken with the aged care sector and hospital staff to help develop a range of strategies to improve the transition of older people from hospital to residential aged care. It will provide foundations for the taskforce to build on.

Country Health SA Local Health Network continues to support the transition of older people from metropolitan hospitals to access Residential Aged Care, Multipurpose Services, respite or Transitional Care Packages, as required.

**12. Require SA Health to direct local health networks to investigate, in collaboration with Aboriginal leaders, the causes of each hospital's discharge against medical advice rates and develop appropriate implementation and monitoring strategies to achieve the SA Health target by July 2016.**

**Supported**

SA Health will continue to monitor and implement strategies to address Aboriginal self-discharge against medical advice rates. LHNs monitor self-discharge rates according to their Health Performance Agreements. Ongoing efforts to prevent Aboriginal patients from self-discharging include patient pathway support (including social and emotional wellbeing, cultural brokerage and interpreter services), social work services and referrals to Step Down Units, and availability and promotion of Aboriginal Hospital Liaison Officers, Aboriginal Patient Pathways Officers and Aboriginal Liaison Units in acute settings.

*Aboriginal Self Discharge Project*, completed by the Aboriginal Health Directorate, offers recommendations including greater flexibility of hospital discharge practices to enable nurse-discharge; solutions to having ready access to interpreters and encouraging "rooming in". Rates are evaluated by the CHSALHN Executive and Performance Committee, along with active monitoring by executive staff. Ceduna, Coober Pedy and Port Augusta Hospital all have an Aboriginal Patient Pathway Officer who works closely with patients identified at risk of self-discharge. Mechanisms implemented under the new Aboriginal Consumer Engagement Strategy also support making hospitals culturally safe and inclusive.

The Northern Adelaide Local Health Network engages with the Aboriginal community through consumer forums, the NALHN Aboriginal Advisory Board, and liaison with the Aboriginal community representative from the Lyell McEwin Hospital Consumer Advisory Council, to consider discharge strategies and patient feedback. The Women's and Children's Hospital Network monitors rates through its Executive Leadership Committee and the review of its Aboriginal Services Improvement Plan. Within the Central Adelaide Local Health Network, monitoring is undertaken through the Aboriginal Torres Strait Islander Advisory Committee, it also offers Aboriginal Torres Strait Islander Cancer Care Coordinators to identify and resolve

health and support issues for patients prior to discharge and support patients to maintain treatment regimes.

Drug and Alcohol Services South Australia (DASSA) delivers the Aboriginal Connection Program, funded by the Department of Communities and Social Inclusion. The Aboriginal Connection Program provides outreach and integrated assessment for Aboriginal people who are homeless or at risk of homelessness. The service also provides in-reach support to clients admitted to inpatient settings, including the Royal Adelaide Hospital and DASSA Withdrawal Services, with the aim of maintaining continuity of care and reducing the risks associated with premature discharge against advice. DASSA monitors the treatment completion rates of all clients admitted into its residential and non-residential services. Data indicates the rate of discharge against advice has decreased with the engagement and responsiveness of the Aboriginal Connection Program team.

The DASSA Consultation Liaison Service, located at the major metropolitan Adelaide hospitals, provides specialist drug and alcohol advice and support to hospital staff and clients admitted and referred to the service, improving treatment options and the appropriateness of interventions. This aims to improve outcomes and referral pathways for individuals admitted to the Emergency Department, often including referral to the Aboriginal Connection Program.

**13. Require the Department's Mental Health Unit to work with local health networks to assess rates of community follow-up within 7 days of discharge from a psychiatric care admission, and develop strategies to increase this rate to 75 per cent by 2018.**

**Agree in principle**

**Indicator not supported**

The Statewide Mental Health Quality Improvement Committee, chaired by the Chief Psychiatrist with representation from all Local Health Networks, meets monthly to discuss and problem solve matters regarding Safety and Quality KPIs, including 7-day community follow-up from discharge.

All Local Health Networks use the national target of 60 per cent as part of their KPI reporting framework and have set up systems and care pathways for focus on achieving this target. It is noted that the 60 per cent target reflects that some consumers are discharged to the care of their GP or private psychiatrist, some consumers do not require follow-up as the crisis was resolved, and some consumers do not want follow up.

**14. Require SA Health to work with the primary care sector to develop strategies to help people feel supported when they seek primary care.**

**Supported**

As a funding partner in Healthdirect, SA Health works with stakeholders to raise awareness of the Healthdirect and National Health Services Directory. SA Health works with Medical Locals to develop pathways, disseminate information resources for consumers and encourage after-hours services. SA Health works with Medicare Locals and Non-Government Organisations to develop pathways and address access issues for CALD, refugee and Aboriginal patients.

SA Health owns and operates two GP Plus Super Clinics and six GP Plus Health Care Centres. The clinics and centres provide a broad range of allied health services including physiotherapy, podiatry, occupational therapy, dietetics, clinical psychology and social work. Other services include Aboriginal health services, children and youth health services, breast screening, dental services, drug and alcohol services, mental health services and nursing and midwifery services. Work with Medicare Locals will be transitioned to Primary Health Networks.

## Getting good outcomes

**15. The SA Cancer Registry to include cancer stage at diagnosis as a core item in its database, and SA Health to make private hospital data available to SA-NT DataLink.**

**Supported in principle**

The SA Cancer Registry currently collects staging information on a limited number of cancers and is about to conduct a pilot investigation of the feasibility of cancer staging for five major cancer sites in conjunction with Cancer Australia. A final decision regarding the feasibility from a resource perspective on staging cancers will depend on the results of the pilot and also pending legislative change to enable staging information to be collected. The HPC were advised in late 2014 by the Minister for Health that SA Health will work with the SA-NT DataLink, the private sector and privacy and ethics committees on this process.

**16. The Department to assess rates of adverse events, and develop strategies to reduce the rate to less than 10 per 100 overnight separations by 2018.**

**Agree in principle**

SA Health has a focused patient safety program targeting areas of patient harm which may result in an adverse consumer outcome. These strategies are aligned to the National Safety and Quality Priorities and National Safety and Quality Health Service Standards.

SA Health has established a suite of safety and quality metrics in LARS (LHN Analytics and Reporting Service) to support continuous monitoring and improvement. These include volume of incidents and near misses reported and the actual level of harm. Planned work includes establishing rate of event (i.e. fall, medication, pressure injury) by 1000 occupied bed days, consistent with Australian Council on Healthcare Standards (ACHS) indicators - allowing for peer comparison.

**17. SA Health through its Infection Control Service (ICS) continues implementation of quality programs aimed at improving infection control in hospitals, and monitoring the effectiveness of new interventions.**

**Supported**

ICS has developed policies, guidelines and resources on the prevention of infection in healthcare settings. Documents are renewed as required, including at the request of LHN CEOs. ICS continuously monitors and reports on the incidence of key infection indicators in all public acute hospitals. Surveillance data are reported to the Department and Hospital Executives on a monthly basis.

A focus on the development of additional educational resources, such as on-line learning modules in key infection prevention principles for SA Health staff, is planned for 2015.

**18. SA Health to develop strategies that will close the gap in the rates of potentially avoidable deaths between Aboriginal and non-Aboriginal people in South Australia by 2018.**

**Supported**

*Closing the Gap* commitments receive \$32 million over three years, until 30 June 2016. Chronic disease programs include Quit Smoking initiatives and Aboriginal Well Health Checks. Cancer Care Coordinators promote service improvements. Other strategies include immunisation, the Aboriginal Family Birthing Program, the Aboriginal Infant Support Service for vulnerable infants and Aboriginal oral and eye health programs. These programs are in addition to support from Aboriginal Patient Pathway Officers and Aboriginal Hospital Liaison Officers, along with Aboriginal Step Down Services at Ceduna and Port Augusta. Child and Adolescent Mental Health Services in the APY Lands provide consultation, assessments and referral to support services. SA Health supports a Ngangkari (Aboriginal Traditional Healers) brokerage program, in which esteemed members of the Aboriginal community encourage consumers and patients to continue receiving acute and primary health care. The Aboriginal Environmental Health Program promotes environmental improvements in remote areas.

As stated in the response to Recommendation 9, there is an agreement among all Local Health Networks and the Aboriginal Health Branch, as part of the Aboriginal Health Care Plan Steering Committee, to develop a cultural competency framework across SA Health. The aim is to support an approach through workforce development that ensures SA Health employees



have the required essential minimal skills and knowledge to be culturally competent and be flexibly responsive to the needs of Aboriginal people in their care.

**19. SA Health to develop strategies that support the community with the psychosocial and respite supports critical to helping people with a terminal illness remain at home if they wish.**

**Supported**

SA Health has various strategies and programs in place to support people to receive palliative care in their homes. Royal District Nursing Service (RDNS) are contracted by SA Health to provide palliative care services in the patient's home (day and/or night) for up to 6 months at the end stage of their disease. A new model of care will enable General Practitioners (GPs) to deliver palliative care in a shared care arrangement with hospital palliative care medical staff. The program includes development of shared care protocols and pathways, training and accreditation of GPs in palliative care.

In country South Australia, Country Health SA Local Health Network employs both community nurses and specialist palliative care nurses to support people with terminal illness and their families, with the main goal to remain at home if they wish. CHSALHN has also implemented End of Life Choices Packages to increase support to people and their families during the terminal phase of their illness.

An Acute and Aged Care Taskforce is developing a statewide model of 'hospital in residential aged care' to ensure that people residing in an aged care facility avoid unnecessary hospital admissions, and are cared for and can die with dignity in their place of choice.

The new *Advance Care Directive Act 2013* (SA) empowers adults to make legal arrangements for their future health care, end of life, preferred living arrangements and other personal matters.

**Working efficiently and remaining sustainable**

**20. Develop strategies and implement efficiencies that will reduce growth in health expenditure per person to bring South Australia's expenditure back to the Australian average within five years.**

**Qualified**

Spending on health care will always increase, however, SA Health continues to identify, implement and monitor strategies so we spend our money wisely including efficient ward configurations, product standardization, the negotiation of improved procurement terms, optimized pathology and pharmacy costs, and voluntary redundancies. Many of these programs will continue to deliver benefits across the forward estimates.

**21. Develop strategies that will improve length of stay by identifying patients that can be better cared for in non-acute hospital settings.**

**Supported**

New out-of-hospital strategies are being developed as part of the Transforming Health program.

A Residential Aged Care Policy Directive is in final stages of consultation. The policy will provide a framework to assist LHNs in the timely placement of individuals in residential aged care where patients are unable to return home. This policy has a focus on complex cases and includes escalation process if delays in placement result in a prolonged length of stay in the acute setting. In addition, there is provision for the timely transfer of patients from hospital to a supported interim residential aged care bed for a time limited period for those who are medically fit for discharge.

A proposed model of care for residential aged care and supported acute care is being developed to manage acutely unwell residents and includes alternative and direct pathways

for common emergency department presentations (e.g. falls) and emergency department telephone consultation service.

Country Health SA Local Health Network continues to support the transition of older people from metropolitan hospitals to access Residential Aged Care, Multipurpose Services, respite or Transitional Care Packages as required.

**22. Continue with its workforce commitments set out in the Strategic Plan, including identifying new approaches that further develop a competent, flexible, sustainable, responsive, and diverse workforce.**

**Supported**

Changes to workforce policy and practices are central to the implementation of the Transforming Health program, which aims to improve the quality and consistency of health care. For example, Transforming Health reforms anticipate greater access to senior clinical decision makers, seven-day access to allied health and clinical support services, such as diagnostic imaging.

Other significant initiatives to increase the responsiveness and diversity of the workforce include the development of a revised Aboriginal Workforce Strategy for SA Health and the Aboriginal Health Practitioner Project. This latter project aims to develop the Aboriginal Health Practitioner profession.

**23. Develop strategies and implement efficiencies that will reduce growth in cost per casemix to a nominated target (eg. Consumer Price Index) to bring down the South Australian average to the national average over a five year period.**

**Supported**

In addition to the response at Recommendation 20, Transforming our Health System is a means to structure our system around a central focus on quality. Improving patient outcomes and quality, through networked services, single governance arrangements where appropriate, improved flow and better access to services will contribute to economies of scale.

## Engaging with the community

**24. Build on its Framework for Active Participation by establishing a single point of contact to support units across SA Health to conduct quality engagement by:**

- providing engagement tools and advice
- contributing to continuous improvement in engagement practices and delivery of health care by monitoring and making public engagement processes and their outcomes
- implementing a strategic approach to relationships with community organisations, businesses, universities, consumers and the community
- linking in with whole of government efforts to improve engagement practice through the Better Together Principles.

**Supported**

Safety and Quality Branch coordinates the 'Partnering with Consumers and the Community' program. As the lead contact, it provides advice and assists health services in planning for assessment against the National Safety and Quality Health Standard 2 – Partnering with Consumers.

The *Framework for Active Partnership with Consumers and the Community* and *Guide for Engaging with Consumers and the Community* were released in 2013 and are due to review in November 2015.

The SA Health Partnering with Consumers and Community Advisory Group was set up in March 2013. The group is established under the governance structure of the SA Health Safety and Quality Strategic Governance Committee.

SA Health funds the Health Consumers' Alliance (HCA) as the peak agency in South Australia for consumer engagement. SA Health is collaborating with the HCA to co-create consumer and community engagement strategy and principles to support changes under the *Transforming Health* initiative. The Consumer and Community Peak forum will report to the Transforming Health board.

**25. Commission a Consumer Experience Survey of Aboriginal and culturally and linguistically diverse South Australians to complement its existing mainstream survey.**

**Supported**

The SA Consumer Experience Surveillance System (SACCESS) is a telephone survey where consumers are interviewed soon after an overnight stay in a metropolitan or country public hospital using a set of internationally validated questions. Since 2010, over 7180 patients have been interviewed. SA Health will continue to identify where gaps may exist such as Aboriginal health and culturally and linguistically diverse South Australians to increase the number of consumers sharing their experience with the health service and SA Health.

**Improving SA population health data collection and analysis**

**26. The Minister for Health recommend to Government that it supplements its data collection with purposeful sampling of specific population groups and routinely report on these groups on a cyclic basis.**

**Agree in principle**

Under an agreement with SA Health, the Population Resource and Outcome Study Unit at the University of Adelaide currently manages the South Australian Monitoring and Surveillance Survey (SAMSS). SAMSS includes data items such as Country of Birth, Indigenous Status and Language Spoken at Home, and captures information about carers, prevalence of disability and South Australians who are Veterans. Information on lesbian, gay, bisexual, transgender, intersex and queer people is not collected other than in a small community health services. Some of this group may not wish to be identified through administrative data collections, particularly if it is not relevant to their current treatment. As many population groups are small, the administrative burden of collecting the data and cost of changes to data capture systems may not be of benefit. SA Health will investigate whether other survey tools (including internationally) capture information on gender identity and sexual orientation and, if so, whether this could be incorporated into the SAMSS tool.

## 4. How Healthy are South Australians

The Health Performance Council identified areas where SA Health is performing well, recognising that SA Health is improving services to the South Australian community. It also identifies areas where additional focus may improve health outcomes for South Australians. The formal response provides information on SA Health's strategies and activities to improve identified challenges.

## Health Performance Council identified improvements

- > Fewer women are smoking during pregnancy
- > Fewer children aged 5-9 are obese but overall rate remains high
- > The number of adults that don't smoke is growing
- > Aboriginal smoking rates are falling but overall rate remains high
- > Chronic bronchitis or emphysema rates are decreasing
- > Perinatal deaths are the lowest in Australia
- > Deaths from circulatory diseases are decreasing but are still in the top three cases of death
- > Deaths from colon cancer are decreasing but are still above the national average
- > More children are fully immunised
- > More children are having health checks
- > More children are being seen on time in emergency departments
- > More older people are having annual health assessments
- > More people are getting community follow-up in 7 days after psychiatric hospitalisation
- > Cancer survival rates are getting better
- > Infections associated with healthcare are very low and reducing
- > South Australians are spending less time in hospital
- > Most South Australian children participate in organised sports or dancing, with seven out of ten children participating in these physical activities, slightly better than the national average
- > Life expectancy in South Australia is increasing and the majority of life is expected to be lived in relatively good health, with less than 10 years expected to be lost to disability. The vast majority of South Australians feel that they are in good health.
- > The incidence of melanoma has been consistently lower than the national average over the last four years.
- > Nine in ten Aboriginal South Australians have access to support from outside the household which is higher than the Australian average. The large majority of South Australians agree that cultural diversity is good.
- > Just under one in five South Australians volunteer, the second highest nationally.
- > 11.8 per cent of South Australians provide unpaid care, help or assistance because of a disability, the highest rate nationally
- > There has been a slow decrease in smoking and the trend has been downwards from 2009. 40.3 per cent of Aboriginal people smoke but this has dropped nearly 7 percentage points in the last five years and South Australia's rank on this indicator nationally has improved
- > There has been a slight downward trend in chronic bronchitis or emphysema in the last five years
- > The South Australian death rate for all age groups has been trending down since 2009. Since 2008, the male death rate has been consistently higher than the female death rate, however in recent years the gap between the male and female death rate has gradually closed
- > The median age of death for South Australians is trending up, and now stands at 80.0 years for males, and 85.5 years for females
- > South Australia's perinatal death rate is lowest nationally, including for Aboriginal perinatal deaths. The infant death rate in South Australia has been trending down since 2008

- > Deaths from colon cancer have been trending down over the last six years, from 12.1 per 100,000 person in 2007 to 8.2 in 2012. While South Australia is still above the national average its ranking against other states and territories has dropped since 2010

## Health Performance Council identified challenges

- > The rate of awareness of the benefits of folic acid intake before and during pregnancy continues to decrease.

SA Health Perinatal Practice Guideline *Vitamin & Mineral Supplementation in Pregnancy* provides information for clinicians, and the general community, on dietary requirements, therapeutic levels and suggested subsequent supplementation regime. SA Health's website provides additional information for the general community who are seeking folic acid advice. Information leaflets are also available in GP surgeries, family planning clinics and reproductive medicine clinics. Folic acid is now required to be added to bread-making flour through a national food standard.

It should be noted that the PROS (Population Research and Outcome Studies) indicator report 2010 - 2011 shows awareness of folate's benefits in SA among adults was found to be 14.9 per cent. There is no data available to indicate it is increasing or decreasing.

- > Smoking during pregnancy is higher in areas of socioeconomic disadvantage and country areas.
- > Almost one in nine South Australian women and one in two South Australian Aboriginal women are at their first antenatal visit, but the overall trend has been decreasing over the last five years.
- > Aboriginal babies born with a low birth weight more than double the non-Aboriginal rate.

Since 2010, the SA Health 'SA Pregnancy Record' has included a prompt for perinatal clinicians to assess the smoking status of pregnant women at each antenatal visit.

SA Health funds Cancer Council SA to deliver the Quitline service, which provides cessation support for pregnant women. Drug and Alcohol Services SA worked in partnership with Women's and Children's Health Network in developing the South Australian Safe Infant Sleeping Standards. They include Standard 4 that guides staff to inform families of the need to avoid exposing babies to tobacco smoke during pregnancy, and to provide quit smoking support and referral.

SA Health has a key commitment to reduce smoking rates of Aboriginal women during pregnancy. Under the Aboriginal Health Care Plan 2010-2016, a SA Health Priority Initiative is for Regions to report on progress in achieving the target of a 2.1 per cent annual reduction in smoking during pregnancy for Aboriginal women.

Under the Closing the Gap program Quit Smoking initiatives, SA Health funds the Aboriginal Health Council of SA to deliver the Maternal Health program, designed to reduce smoking during pregnancy. Aboriginal Maternal and Infant Care workers engage smokers directly. SA Health funds the delivery of 'Give up Smokes for Good', a community based campaign which encourages smoke-free homes and cars.

The proportion of low birthweight live births is consistently higher in Aboriginal babies, but these rates may show variation from year to year due to small numbers. Notwithstanding, national and international literature indicates that the complex nature of risk factors make it difficult to address. The Aboriginal Family Birthing Program specifically targets this issue and since implementation of the program low birth rates have been decreasing. Antenatal care programs which address risk factors and provide preconception education have been implemented progressively. These include education relating to smoking, use of alcohol and illicit drugs, nutrition and medical conditions. Programs include Anangu Bibi Aboriginal Family Birthing program at Port Augusta, Tjurni Miminis Birthing Program at Whyalla, Nyuntju Tjuta Iti Tjuta Aboriginal Birthing Program at Ceduna, Tumake Tinyeri Aboriginal Birthing Program at Murray Bridge, and the Aboriginal Family Birthing Program at Gawler, the Metropolitan Aboriginal Family Birthing Program, Nganampa Health Council Child and Maternal Health Program, Northern Women's Community Midwifery Program and Muna Paendi and the Southern Aboriginal Maternity Care Project.

The *SA Health Perinatal Practice Guideline: Fetal Growth Restricted* outlines appropriate care and referral pathways for pregnant women with fetal growth restriction.

- > Over half of South Australian women giving birth are overweight or obese.
- > Nearly a quarter of South Australian children are overweight or obese but South Australia is still below the national average.
- > Highest rate of gestational diabetes in Australia.

In 2012, SA Health endorsed the *Standards for the Management of Obese Obstetric Women* as a state-wide directive, to assist health care staff in safe patient management. SA Health funds the *Get Healthy* information and coaching service. This free telephone coaching service offers personal professional support to help promote healthy eating, increase physical activity and manage weight. It is suitable for use by pregnant women. WCHN is working with relevant clinical networks to identify opportunities for intervention to prevent excessive gestational weight gain.

OPAL (Obesity Prevention and Lifestyle) is a community-based, childhood obesity prevention initiative which reaches 400,000 people (25 per cent of the population). OPAL has been operating in 19 of the most disadvantaged SA council areas since 2009. SA Health is co-funding Nature Play SA, which aims to make unstructured, outdoor play an everyday part of childhood. The SA Health *Healthy Living* website provides information on healthy weight. In 2014, more than 26,000 resources targeting children and families were distributed.

The Public Health Partnerships Branch, and the Department of the Premier and Cabinet, are collaborating on a 'Healthy Children's Menu Options' project. The project, being led by industry, aims to create a more supportive environment for healthy eating by increasing the number of healthy menu options for children in restaurants, cafes, clubs and hotels across the State.

In relation to gestational diabetes, obesity or overweight may be a risk factor. Women and Children's Health Network advises supportive antenatal and prenatal care for women to manage gestational diabetes and referrals to primary health providers.

- > The rate of caesarean births remains high but has been steady since 2007 but the rate is significantly higher than the OECD average.

Under proposed standards in Transforming Health program, clinical groups have called for the South Australian Perinatal guidelines to be used 'when caesarean sections are appropriate and parents should be informed of risks' (standard 218) and for categorisation of emergency caesarean sections to reduce 'misunderstanding between health care professionals' (standard 241).

- > South Australia has the lowest breastfeeding initiation rate nationally.

South Australia's Breastfeeding Initiation rates are greater than 90 per cent as reported through the Baby Friendly Health Initiative (BFHI), a joint UNICEF and the World Health Organization (WHO) project. This rate is comparable to national breastfeeding initiation rates.

'Baby Friendly' accreditation is a quality assurance measure that demonstrates a commitment by the facility to offer the highest standard of maternity care. All SA Health Metropolitan Maternity Hospitals and many country hospitals are accredited by the Baby Friendly Hospitals Initiative (BFHI).

- > Almost a quarter of South Australian students overall and over a half of South Australia's Aboriginal students in their first year of school are developmentally vulnerable.

Offering support to vulnerable Aboriginal children begins with culturally inclusive maternal and infant care, and continues by connecting carers of vulnerable children with quality early learning, child care and appropriate parenting and health services.

The *Aboriginal Family Birthing Program* supports increased engagement between Aboriginal Maternal Infant Care workers, midwives, general practitioners and obstetricians. *SA Health's Aboriginal Infants*



*Support Service (AISS)* provides a culturally appropriate, psycho-social model of services to highly vulnerable infants and parents experiencing adversity.

A wellbeing team and children's program coordinator at Watto Purrinna Health Service promote health in childcare centres and preschools through the provision of programs that support good parenting and healthy eating programs.

The *Aboriginal Early Childhood Health Promotion* program promotes health and wellbeing for Aboriginal children and families through supporting and training staff in early childhood settings. More than 1300 children and family members have attended health promotion events focussed on active play, child safety, personal care and child development. Following these events, more than 500 referrals were made to other services including immunisation, dental and allied health. The *Under Five Ear Health Program* provides ear health and hearing screening services to Aboriginal children up to five years.

- > One in five South Australians has a disability, and 5.5 per cent of South Australians have a need for assistance due to a profound or severe disability. Both of these rates are the second highest nationally.

SA Health is involved in the implementation of the National Disability Insurance Scheme (NDIS) to enable people with a disability to access appropriate services. Significant work on scoping and costing services has occurred. The health system has responsibility for the diagnosis, assessment and treatment of health conditions, while the NDIS is responsible for supports that assist a participant to undertake activities of daily living required due to the person's disability.

An executive level committee has been set up between the Department of Communities and Social Inclusion and SA Health to discuss key issues relating to aged care, disability services and health and community services.

- > Almost a third of South Australians adults are living with two or more risk factors and this is higher in country areas and areas of socioeconomic disadvantage.
- > One in five South Australians has high blood pressure, one in six has high cholesterol and one in eight smokes cigarettes. This is on, or above, the national average. High cholesterol and smoking are more prevalent in country areas.
- > High blood pressure & high cholesterol rates are increasing with higher cholesterol rates for those living in country communities.
- > Around 1 in 13 South Australians aged 16 years or more are living with cardiovascular disease or its consequences. The prevalence of cardiovascular disease is higher in country areas and is almost twice as high in males than females.
- > Obesity rates are increasing with higher rates for Aboriginal adults and those living in country communities.
- > One in four South Australian adults are overweight or obese, and this trend has been increasing since 2009 (2009- 21.6 percent; 2013- 24.1 percent). Obesity rates are significantly higher in country SA. Overweight and obese in Aboriginal people is high at 70 percent, but below the national average.
- > South Australia has the highest rate of diabetes nationally.
- > About 8 percent of South Australian adults have diabetes. The rate of diabetes in South Australia has been increasing over the last ten years and is now the highest in Australia and a percentage point above the national average.
- > One in six South Australians is living with multiple chronic conditions. The prevalence of multiple chronic conditions increases with age and socioeconomic disadvantage.

- > Over a quarter of South Australians are drinking at risky levels. This is higher for men and for those living in country areas.\*

SA Health is working in partnership with not-for-profit, community and primary health care providers on a number of strategies aimed at improving the management of chronic disease conditions. This includes the *Strategy to Provide Integrated Chronic Disease Care Planning and Care Coordination*, and the *Strategy to Increase the Primary Health Care Response to Chronic Disease*. SA Health has a partnership with the Royal Australian College of General Practitioners to deliver training for GPs to increase their knowledge about current best practice for identifying high-risk individuals, interventions to prevent chronic disease and practice models to support preventative care.

In addition, SA Health is developing an Intermediate Care Services model to support people in the community with highly complex chronic conditions. Intermediate Care Services target complex patients, often (but not always) older people, who are frequently admitted to hospital or present at an emergency department.

GP Plus Super Clinics at Noarlunga and Modbury and six GP Plus Health Care Centres provide a range services to support people with chronic disease. A multidisciplinary Ambulatory Consulting Service (MACS) is provided at the Royal Adelaide Hospital and the Queen Elizabeth Hospital.

The *Get Healthy* telephone coaching service is aimed at preventing chronic diseases such as Type 2 diabetes, but also offers support to adults to help promote physical activity and manage weight.

*Healthy Workers – Healthy Futures* initiative works with industry peak bodies, unions and regional business associations, such as Primary Producers SA, to improve the chronic disease risk factors of smoking, poor nutrition, harmful alcohol consumption and physical inactivity. This initiative targets high-need male dominated industries.

The SA Health-funded *Strength for Life* is a balance and strength training program implemented by the Council on the Ageing. Its primary aim is to prevent falls in adults aged over 50 years. Improved strength and balance also improve mobility and allow individuals to be more physically active which assists with preventing and managing chronic diseases such as heart disease and Type 2 diabetes. Up to 10,000 people have participated in this program since it commenced in 2004.

SA Health's *Obesity Prevention and Lifestyle* program is working with local government, including 11 regional councils, to introduce healthy food policies, water fountains and community gardens. Specific Aboriginal-community programs by OPAL include Aboriginal Family Fun Days, an edible school garden grant at Raukkan Aboriginal School and the Ngaityu Wardli (My Home) Healthy Eating and Physical Activity Program.

Dieticians work with Aboriginal Community Controlled Health Organisations to deliver healthy eating messages in chronic disease programs. SA Health also funds the delivery of smoking cessation television advertising designed to help reduce smoking prevalence. A range of quit smoking ads are regularly played across South Australia at an average of 400 target audience rating points (TARPs) per month and target audiences include people from lower socioeconomic backgrounds and people living in rural areas. SA Health funds Cancer Council SA to deliver the Quitline telephone counselling service. SA Health funds the services to support smoking cessation in metropolitan and regional locations under the Closing the Gap commitment.

An allied health and community nursing prioritisation process is being implemented across country areas that has a stronger emphasis on shorter response timeframes for those clients at higher risk of clinical deterioration. The process allocates a higher priority to those who have complex needs, including socioeconomic disadvantage and remoteness. The *Better Care in the Community* program is available at 13 sites across country South Australia, and continues to support clients with chronic conditions. Services may include inpatient or outpatient chronic condition education, cardiac rehabilitation, pulmonary rehabilitation, insulin titration clinics and care planning. During 2013-14, the program supported more than 5000 clients resulting in more than 2000 admissions avoided, and more than 1000 bed days saved.



SA Government intends to introduce smoke-free outdoor dining areas by July 2016. There are display restrictions on all tobacco retail points of sale across South Australia, including from 1 January 2015 all 'specialist tobacconists' must have their displays out of sight to further decrease exposure to tobacco products by young people. Smoking is banned at all covered public transport waiting areas and within 10 metres of children's public playground equipment. Smoking is banned on all SA Health premises throughout South Australia and the SA Health Smoke-free Policy requires that all consumers are to be assessed for tobacco smoking status and intention to quit.

Drug and Alcohol Services South Australia (DASSA) has implemented a range of treatment, policy and population health monitoring approaches to address alcohol misuse. This includes contributing to government policy deliberations on alcohol regulations, oversight of the Public Intoxication Act; telephone counselling and triage through the Alcohol and Drug Information Service and by providing and funding withdrawal and treatment services throughout the State.

The *South Australian Public Health Act 2011* and State Public Health Plan, 'South Australia: A Better Place to Live' have introduced the concept of Public Health Partner Authorities. Their development is an opportunity to collaboratively improve health and wellbeing for South Australians.

\* Note amendment to indicator: More than 18 per cent of South Australians are drinking alcohol at levels that pose a long-term risk. This is higher for men, and for those living in country areas.

- > One in eight South Australians adults has asthma. Overall, rates are higher among women than men.

Asthma is a condition that is often well managed by sufferers in partnership with GPs, but the public health system provides support with emergency, specialist outpatient, and inpatient services. In 2013-14 there were 1856 inpatient admissions to metropolitan hospitals for asthma that could potentially (with increased access to comprehensive primary care management) be avoided. This is a reduction from 2012-13 when there were 2119 potentially avoidable admissions. As part of the Transforming Health program, self-care plans will be promoted and alternative models of care will be developed. SA Health will contribute to the development of a new National Asthma Strategy for 2016-2020.

- > South Australia is ranked highest nationally for prevalence of back pain/problems or disc disorders.
- > Osteoporosis in South Australia is four times more prevalent in women than men. It affects one in four South Australia over 75 years.
- > Arthritis rates are the second highest nationally with higher rates for those living in country communities.
- > Arthritis is the most prevalent chronic condition in South Australia with one in five of South Australian adults living with the condition and the prevalence of arthritis is statistically significantly higher in country SA. SA is ranked second highest of the states and territories.

Only a small proportion of patients with lumbar disorders, arthritis or osteoporosis require scans or specialist consultation. For those patients, SA Health is working with Medicare Locals to develop and promote best practice pathways and GP referral guidelines. SA Health provides a range of inpatient and outpatient acute services, including exercise physiology, physiotherapy, podiatry, social work, psychology, rehabilitation and hydrotherapy. The remainder of patients are best managed through accessing community-based health care services according to recommendations that can be provided by their General Practitioner.

Under the Transforming Health program, allied health and integrated rehabilitation services will be expanded. A single statewide model of care for orthogeriatric services will be developed.

- > There has been a 4 percentage point increase in ear/hearing problems in Aboriginal people over ten years. South Australia is now ranked highest in terms of ear/hearing problems nationally and is 3.5 percentage points above the national average of 12.3 per cent.

Closing the Gap funding between 2011 and 2014 was directed at improved ear health services to remote Aboriginal communities, and to ensure improved access to ear, nose and throat medical specialists and audiologists. Access to specialist ear health services to Aboriginal children living in

rural and remote South Australia has improved and remains a priority. Equally important is the early detection and effective treatment of otitis media ear infections to prevent potential hearing loss.

SA Health chairs the SA Aboriginal Ear Health Reference Group, which meets every eight weeks and includes representation from the Aboriginal Health Council of SA, Watto Purrunga Aboriginal Health Service, Southern Adelaide Aboriginal Family Health Service, Country Health SA LHN, CaFHS, Rural Doctors Workforce Agency, Hearing Australia and a number of private audiological and ENT service providers. The group undertakes planning for statewide activity to improve Aboriginal ear health and hearing.

Since mid-2013, Nganampa Health Council has taken responsibility for coordinating visiting ear health specialist services. Ceduna Hospital coordinates the visits of ENT specialists to the remote communities of Oak Valley and Yalata. The Rural Doctors Workforce Agency supports ear health outreach audiology services. Training of remote health clinic staff in the revised Clinical Care Guidelines on the management of otitis media has occurred in 2012 and 2013.

Attention to early detection and assertive follow up by remote health clinic staff remains an ongoing strategy. The Women's and Children's Hospital Ear, Nose and Throat (ENT) Department has been working with Nganampa Health Council, to develop and maintain a regular visiting ENT service to the APY Lands. The aim is for ENT surgeons to provide a service to two communities and visit these communities twice yearly. This model commenced approximately 18 months ago. It is also envisaged groups will be brought to Adelaide for surgery two to three times a year. In April 2015, seven Aboriginal children and their families travelled to Adelaide for surgery. Another surgical list is planned for October 2015.

The Under Fives Ear Health Program provides screening and management of middle ear disease in the north and west of Adelaide for Aboriginal children under the age of five. Since the program commenced, a number of partnerships with local schools and early childhood settings have been strengthened, resulting in more than 500 children receiving initial screening and 130 children being re-screened. Management pathways are being continually strengthened.

An additional service is provided by the Australian Hearing Association which provides amplification devices for children and adults with hearing loss.

- > One in six South Australians are living with a doctor-diagnosed mental health condition. Prevalence is higher for women and those living in disadvantaged areas. The trend has been increasing over the last 5 years, up from 14.4 per cent in 2009 to 16.9 per cent in 2013. The metro Adelaide rate is statistically significantly higher than country SA in 2013. Psychological distress is also relatively high in SA.
- > Highest rate of women with perinatal depression in Australia.
- > Intentional self-harm is now the main cause of death for South Australians aged 15 to 44 years.
- > Although suicide rates in South Australia are low, the rate among men is three times that of women.
- > Psychological distress in the Aboriginal population is exceptionally high and one of the highest nationally and is around three and a half times that of the general SA population.

SA Health has invested in multiple well-being strategies, and acute and community-based mental health services. It is also working with the South Australian Health and Medical Research Institute under its 'Mind and Brain' theme to translate research for future treatments.

Many SA Health mental health services employ lived experience workers whose role is to provide peer based services to consumers and carers to support their wellbeing and develop strategies for addressing mental health issues.

The National Perinatal Depression Initiative (NPDI) has been better put into practice in SA than through the rest of Australia (with resultant high rate). Screening has become universal at all public and some private hospitals in SA including country. There has been a strong focus during 2014-15 to provide training and education for GPs, perinatal nurses and midwives, and other relevant service providers to ensure they are equipped to continue with the initiative as part of everyday business after the cessation of the funding for the program on 30 June 2015.

Suicide rates are a critical area which requires ongoing investigation and policy development. SA Health's Mental Health Unit has specific policy officer focussing on suicide prevention strategies and community based interventions.

The South Australian Suicide Prevention Strategy 2012-2016: *Every life is worth living* (SASPS) was released in September 2012. The SASPS takes a whole of community, whole of government approach to suicide prevention. Among the goals of the strategy are to improve the evidence base and understanding of suicide and suicide prevention, and to implement standards and continuous practice improvement in suicide prevention. Examples of this work include 10 Suicide Prevention Networks across SA, and postvention services, *Standby Response* and *Living Beyond Suicide*, to reduce the impact of contagion in suicide. In addition, Anglicare have started 'A Cry for Help' program in the Flinders Medical Centre to engage with the suicidal person and their families.

Work to reduce the rate of suicide in men is continuing. This is a nation-wide phenomenon and has been recognised in the SASPS. The Suicide Prevention Networks are addressing the 'help-seeking behaviour' of men in their action plans. Dr Conrad Neumann is doing a PHD on understanding the needs of men in distress presenting to the Emergency Department. A 2014 project in the Lyell McEwin Emergency Department has resulted in changes in the way staff respond to the suicidal person. Applied Suicide Intervention Skills Training (ASIST) was offered to emergency staff. Consumers are contacted and encouraged to keep follow-up appointments for ongoing care. SA Health has produced the second iteration of *Engaging with the Suicidal Person* a handbook for clinicians in Emergency Departments and clinical settings.

SA Health will continue to advance recommendations of the *Aboriginal Mental Health Action Plan*. The Aboriginal Mental Health Reference Group has been established and is providing strategic direction to LHN based working groups to coordinate activity. LHN working groups have developed implementation plans relevant to local services and communities. A survey of access to services by Aboriginal people experiencing mental health issues has been completed to guide strategies to address barriers including cultural competence and safety training. The Aboriginal Suicide Prevention Working Group was convened in 2013 to develop a South Australian Aboriginal Suicide Prevention Action Plan. SA Health provides a range of mental health services, including health promotion and prevention, education and information targeting Aboriginal young mothers and fathers and health professionals, a targeted program for young Aboriginal people in the justice system and targeted programs for the APY Lands through Child and Adolescent Mental Health (CAMHS) and SHine SA. The Strategic Mental Health Quality Improvement Committee monitors 7 day follow-up rates across LHN services as part of the suite of high risk indicators. The additional reporting of rates specific to Aboriginal consumers will be submitted to the committee for action.

- > The rate for Aboriginal people for avoidable, preventable and treatable deaths is three times higher than for all persons in South Australia

While this is a shared responsibility, SA Health aims to connect Aboriginal people with to effective and accessible services, and acknowledges Aboriginal people require access to services and supports which are safe, culturally respectful and responsive. This can be achieved through respectful engagement with Aboriginal people.

SA Health continues to implement a whole of health sector approach to providing health care, which is relevant to the Aboriginal population in the management of chronic and acute conditions and preventative health measures.

As stated in the response to Recommendation 9, there is an agreement amongst all LHNs and the Aboriginal Health Branch, as part of the Aboriginal Health Care Plan Steering Committee, to develop a cultural competency framework across SA Health. The aim is to support an approach through workforce development that ensures SA Health employees have the required essential minimal skills and knowledge to be culturally competent and be flexibly responsive to the needs of Aboriginal people in their care.

Aboriginal people (like the non-Aboriginal population) may be seen in general health and mental health facilities (including public mental health services, Drug and Alcohol Services of South Australia,

Medicare Locals and SA Health funded non-government organisation psychosocial support services). Aboriginal people may also access Aboriginal Community Controlled Health Services. Each of these services promotes referral to, and sharing of appropriate information, with other relevant health agencies or service providers to allow for collaborative and culturally respectful assessment, treatment and care.

SA Health's mental health services are integrating the Flinders Closing the Gap Program of chronic disease self-management into treatment plans. The program aims to assist Aboriginal consumers to develop goals to help co-manage their conditions in partnership with other services, organisations and individuals.

SA Health staff utilise the cultural knowledge of Aboriginal Liaison Officers, who assist consumers with clinical liaison and interpreters. Ceduna, Coober Pedy and Port Augusta Hospital have Aboriginal Patient Pathway Officers. Aboriginal Step Down Services are available at Ceduna and Port Augusta.

> Some population sub groups are not well represented in state level quantitative data. We know from qualitative research that these groups face particular health challenges and require tailored responses:

South Australians from culturally and linguistically diverse backgrounds

South Australians living with a disability

South Australians who are carers

South Australians who are Veterans

South Australian lesbian, gay, bisexual, transgender, intersex and queer people

These population groups may seem invisible to health services and this data gap needs attention.

See earlier South Australian Monitoring and Surveillance Survey (SAMSS) response.

## 5. Health Performance Councils' specific areas of focus during 2011-2014

### Effectiveness of Country Health Advisory Councils

The report *Review of Country Health Advisory Councils' Governance Arrangements* was released on 4 April 2012. It identified that the Health Advisory Councils (HACs) were adapting to their new roles and functions under the *Health Care Act 2008*, as they transitioned from boards to HACs. At that time, many had developed a good understanding of their role as an advisory group and were involved in

robust community engagement initiatives, while some HACs expressed a desire to return to the previous board structure.

The Country Health SA Local Health Network (CHSALHN) has developed improvements to strengthen the HAC's role, along with better communication and reporting between itself and HACs. Quarterly performance reports, including finance summaries, quality and safety reports, and hospital activity data, are now provided to HACs. CHSALHN supports HACs to develop community partnerships with other agencies including Medicare Locals and local government. HACs are represented in the recruitment process for senior positions and in health service planning.

CHSALHN established a Presiding Member Panel as a sub-committee to the Governing Council to provide effective liaison between local HACs and the Governing Council. The Panel has operated since January 2014 with representative Presiding Members from each region. This mechanism has strengthened communication. All incorporated HACs now have gift fund trusts endorsed for Deductible Gift Recipient status and hence can solicit and receive donations and bequests. In February 2014, the Minister for Health and Ageing announced changes to how Special Purpose Funds can be accessed. HAC funds can now be accessed as needed in line with the objectives of the fund and CHSALHN governance procedures.

The recent Premiers' Review of all Government Boards and Committees provided an opportunity for HACs to reflect on their role and function. All HACs strongly advocated for their retention. The outcome was for local HACs to be reclassified under the Boards and Committees system, but remain with no HAC related changes to the *Health Care Act 2008* and no changes to their constitutions.

### **Mental Health in Rural and Remote Communities**

The report *Mental Health in Rural and Remote South Australian Communities* was released on 26 August 2013. It showed that while many rural and remote residents understood that specialist services could not be maintained in every location, a gap in mental health services existed compared to metropolitan services, and there was a variation between country regions. Country Health SA Local Health Network (CHSALHN) sought to redress this situation by introducing a range of services in several country locations and to raise awareness of the availability of mental health services.

CHSALHN has been successful in recruiting more than 50 new clinical and non-clinical staff into country locations for inpatient and community rehabilitation services. Improvements include intermediate care services in four locations, eight Nurse Practitioners with specific scope of practice in country locations, inpatient units in the country general hospitals at Whyalla, Berri and Mt Gambier (scheduled to open in mid-2015) offering six beds each and a local country-based psychiatrist, a targeted youth mental health service and temporary community rehabilitation services in Mt Gambier and Whyalla. In addition, the introduction of a Digital Telehealth Network has improved timely access to psychiatric assessments and other services. These new services have more assertive follow-up, which is being reflected in data and consumer records. Other initiatives include local campaigns to de-stigmatise mental health conditions, shared care programs with General Practitioners and regular forums to engage with communities, hosted by 'Experts by Experience' Development Officers.

In addition to the Aboriginal Mental Health Team based in Rural and Remote Mental Health Services, CHSALHN has introduced Aboriginal Cultural Support Workers as a key element of the workforce for new inpatient services, and cultural awareness training for all new staff, and community rehabilitation services. SA Health, in partnership with CHSALHN will continue to develop strategies for the exit of Commonwealth-funded crisis respite, older persons, perinatal, community rehabilitation and intensive home-based support.

### **Aboriginal Health in South Australia**

The report *Aboriginal Health in South Australia 2011-2104: A Case Study* was released publicly on 6 November 2014. It showed instances of successful programs, and the challenges for SA Health to improve health care for Aboriginal people. By taking a 'whole of health' approach and by engaging with Aboriginal people about culturally appropriate programs and care, SA Health has made improvements to health services, and is better managing chronic and acute conditions.



Under SA Health's commitment to Closing the Gap, a range of preventative and primary health care programs, in partnership with the Aboriginal community controlled sector, including Aboriginal Well Health Checks and Aboriginal Child Health Checks, are supported. This investment delivers better access to antenatal care, reproductive and sexual health services, mental health services, child and maternal health services and integrated child and family services which focus on quality early learning, child care and parent and family support. For example, a state-wide Aboriginal immunisation program has achieved a significant increase in Aboriginal child immunisation rates across all age groups with a reversal of the gap for the 12-15 months and the 60-63 months age cohort in the January to March 2015 quarter. [Additional details of relevant programs are provided in the body of this Interim Response.]

SA Health is strengthening its efforts to provide safe, culturally respectful and responsive health services. The Aboriginal Health Care Plan Steering Committee has established a Cultural Competency working group to develop a framework for Cultural Competency. Traditional Healer Brokerage Access program provides access to traditional healing for Aboriginal clients and patients within the South Australian public health system.

### Improving End of Life Care in South Australia

The report *Improving End of Life Care for South Australian* was released publicly on 19 December 2013. It detailed progress on the implementation of SA Health's *Palliative Care Services Plan 2009-2016* and reviewed ways to improve the quality of life for South Australians at the end of life. The implementation of Advance Care Directives (ACDs) and Resuscitation Plan 7 Step Pathway provides support for clinicians to make appropriate resuscitation and end of life care decisions which are person-centred and in advance of an acute crisis.

Implementation tools for ACDs have included broad education, awareness raising and information across the community, including seniors groups, carer and support groups, as well as to professionals in the aged, community and disability care and legal sectors. Education continues across LHNs and the SA Ambulance Service, led by 350 mentors and trainers. In 2015 there is a focus on General Practitioner and Practice Nurse education through the support of the Royal Australian College of General Practitioners, and the Rural Doctors Workforce Agency.

The inaugural *Planning Ahead: take control of your future today Day* to promote the use of legal tools available to document personal choice in the event of future incapacity was held on 4 September 2014. This year's activities, led by the Office of the Ageing, build on well-established collaborations. The Do-it-Yourself Advance Care Directive Kit is continuing to be promoted, including access through the ACD web site. Feedback on the ACD forms and kits will be reviewed in July 2015 to ensure it remains easy to understand and use. The Advance Care Yarning Booklet is being revised to align with the ACD Kit but with more specific advice for Aboriginal people. Similar work is being undertaken in collaboration with culturally and linguistically diverse population groups.

The Resuscitation Planning 7 Step Pathway policy, guideline and Resuscitation Alert Form have been developed after extensive consultation. These materials identify people at, or approaching, the end of life in a standardised, non-discriminatory, and person-centred manner, and support a consistent approach to decision-making for resuscitation planning.

SA Health has various strategies and program in place to support people to receive palliative care in their homes, including a Palliative GP Shared Care Model, as outlined earlier in this report. An Acute and Aged Care Taskforce is developing a statewide model of 'hospital in residential aged care' to ensure that people residing in an aged care facility avoid unnecessary hospital admissions, and are cared for and can die with dignity in their place of choice.

## 6. Conclusion

The South Australian health care system is changing.

The State Government's vision for *Transforming Health* is to deliver health care where quality is the focus. It is for all South Australians to have equitable access to the best and most reliable health care

possible, and the system is sustainable into the future. It is where an innovative service culture is developed across the whole health care system.

The alignments and service changes are being made to meet crucial clinical standards, overlooked by the Minister's Clinical Advisory Group (including doctors, nurses, midwives, scientific and allied health professionals).

SA Health acknowledges that in enhancing the care we offer, and meeting the full set of clinical standards, we will improve services and care to the whole community, but more particularly, to some of the most vulnerable South Australians.

As SA Health works to update the models of care to reach the goals of best practice, patient-centred care, consultation will continue with consumers, staff and bodies, including the Health Performance Council.

Every part of the system will be renewed to achieve consistent, safe, quality care. The program for transformation is not solely about hospital configuration and services, but it begins where the impact is greatest, metropolitan hospitals. The whole-of-system transformation will occur over the next four years.

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## For more information

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## Appendix 7.

### List of Health Performance Council Publications 1 January 2015 to 31 December 2018

Date	Health Performance Council Product Name	Access to Product
<b>2015</b>		
Sept 2015	Annual report 2014/15	<a href="http://www.hpcsa.com.au/files/696_annual_report_2014-15_web_version_final.pdf">www.hpcsa.com.au/files/696_annual_report_2014-15_web_version_final.pdf</a>
Oct 2015	Scoping Study for the Health Performance Council: Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse (CALD) Backgrounds	<a href="http://www.hpcsa.com.au/files/651_cald_scoping_study_final.pdf">www.hpcsa.com.au/files/651_cald_scoping_study_final.pdf</a>
Nov 2015	HPC factsheet: Aboriginal people in metropolitan Adelaide public hospitals	<a href="http://www.hpcsa.com.au/files/914_aboriginal_health_factsheet_nov_2015.pdf">www.hpcsa.com.au/files/914_aboriginal_health_factsheet_nov_2015.pdf</a>
Nov 2015	Aboriginal Leaders' Forum output report from 27 Nov 2015	<a href="http://www.hpcsa.com.au/files/852_15-hpc-1465_aboriginal_leaders_forum_no_4_output_report_final.pdf">www.hpcsa.com.au/files/852_15-hpc-1465_aboriginal_leaders_forum_no_4_output_report_final.pdf</a>
<b>2016</b>		
Feb 2016	HPC presentation: State of Our Health consultation with the SA Health Data Analysts Group	Refer Pages 27 to 35 of Output Report: <a href="http://www.hpcsa.com.au/files/799_output_report_on_sooH_consultation_with_attachments.pdf">www.hpcsa.com.au/files/799_output_report_on_sooH_consultation_with_attachments.pdf</a>
Feb 2016	HPC presentation: State of Our Health consultation with the Adelaide and Country SA Primary Healthcare Networks	Contact <a href="mailto:HealthHealthPerformanceCouncil@sa.gov.au">HealthHealthPerformanceCouncil@sa.gov.au</a>
Feb 2016	HPC presentation: State of Our Health consultation with the Wardliparingga Aboriginal Health Research Unit staff and their South Australian Aboriginal Health Landscape project community advisory group	Contact <a href="mailto:HealthHealthPerformanceCouncil@sa.gov.au">HealthHealthPerformanceCouncil@sa.gov.au</a>
Mar 2016	HPC presentation: Aboriginal Leaders' Forum outputs presented to the Health Consumers Alliance (HCA) Transforming Health Consumers and Community Advisory Group	Contact <a href="mailto:HealthHealthPerformanceCouncil@sa.gov.au">HealthHealthPerformanceCouncil@sa.gov.au</a>
April 2016	Output report from the State of Our Health consultation between 15 January 2016 and 19 February 2016	<a href="http://www.hpcsa.com.au/files/799_output_report_on_sooH_consultation_with_attachments.pdf">www.hpcsa.com.au/files/799_output_report_on_sooH_consultation_with_attachments.pdf</a>
April 2016	State of Our Health – 2016 edition	<a href="http://www.hpcsa.com.au/state_of_our_health">www.hpcsa.com.au/state_of_our_health</a>
May 2016	Aboriginal Leaders' Forum output report from 16 May 2016	<a href="http://www.hpcsa.com.au/files/833_alf_output_report_2016-05-18.pdf">www.hpcsa.com.au/files/833_alf_output_report_2016-05-18.pdf</a>
May 2016	HPC presentation: analysis of Aboriginal representation in the SA Health workforce and SA public hospital system	Contact <a href="mailto:HealthHealthPerformanceCouncil@sa.gov.au">HealthHealthPerformanceCouncil@sa.gov.au</a>
June 2016	Output report from the Culturally and Linguistically Diverse Communities (CALD) Leaders' Forum	<a href="http://www.hpcsa.com.au/files/831_hpc_cald_leaders_forum_output_report_june_2016.pdf">www.hpcsa.com.au/files/831_hpc_cald_leaders_forum_output_report_june_2016.pdf</a>
June 2016	HPC presentation: analysis of demographic data about people living in South Australia who were born overseas, and analysis of culturally and linguistically diverse communities health workforce data	<a href="http://www.hpcsa.com.au/files/828_3-nick_cugley_cald_presentation_final.pdf">www.hpcsa.com.au/files/828_3-nick_cugley_cald_presentation_final.pdf</a>

June 2016	State of Our Health – 2016 edition as a Portable Document Format (PDF) document	<a href="http://www.hpcsa.com.au/files/825_state_of_our_health_pdf_edition_v1-1.pdf">www.hpcsa.com.au/files/825_state_of_our_health_pdf_edition_v1-1.pdf</a>
June 2016	State of Our Health – 2016 edition Technical Appendix	<a href="http://www.hpcsa.com.au/files/800_state_of_our_health_technical_appendix_v100_2016-05-19_final.pdf">www.hpcsa.com.au/files/800_state_of_our_health_technical_appendix_v100_2016-05-19_final.pdf</a>
June 2016	HPC presentation: Update on the HPC review of Country HACs' Governance Arrangements for the Country Health SA LHN Governing Council and Presiding Members Panel	Contact <a href="mailto:HealthHealthPerformanceCouncil@sa.gov.au">HealthHealthPerformanceCouncil@sa.gov.au</a>
June 2016	HPC presentation: Update on the HPC review of Country HACs' Governance Arrangements and consultation on HPC 4-Yearly Review (2015-18) priority topics with the Combined HAC Conference	Contact <a href="mailto:HealthHealthPerformanceCouncil@sa.gov.au">HealthHealthPerformanceCouncil@sa.gov.au</a>
Jul 2016	HPC factsheet: Primary and acute care measures for older people in South Australia	<a href="http://www.hpcsa.com.au/files/915_cota_factsheet_jul_2016.pdf">www.hpcsa.com.au/files/915_cota_factsheet_jul_2016.pdf</a>
July 2016	Minutes from meetings – 14 July 2016	<a href="http://www.hpcsa.com.au/files/919_16-hpc-1542_official_confirmed_minutes_hpc_meeting_40_14_july_2016.pdf">www.hpcsa.com.au/files/919_16-hpc-1542_official_confirmed_minutes_hpc_meeting_40_14_july_2016.pdf</a>
Aug 2016	HPC factsheet: Health Performance Council's monitoring of the implementation of Transforming Health	<a href="http://www.hpcsa.com.au/files/916_hpc_th_eval_workshop_poster_aug_2016.pdf">www.hpcsa.com.au/files/916_hpc_th_eval_workshop_poster_aug_2016.pdf</a>
Sept 2016	Annual Report 2015/16	<a href="http://www.hpcsa.com.au/files/925_161281_hpc_annual_report_2015-final_with_amendment.pdf">www.hpcsa.com.au/files/925_161281_hpc_annual_report_2015-final_with_amendment.pdf</a>
Sept 2016	Minutes from meetings – 8 September 2016	<a href="http://www.hpcsa.com.au/files/922_16-hpc-1582_official_confirmed_minutes_hpc_bi-monthly_meeting_no_41_8_september_2016.pdf">www.hpcsa.com.au/files/922_16-hpc-1582_official_confirmed_minutes_hpc_bi-monthly_meeting_no_41_8_september_2016.pdf</a>
Nov 2016	Minutes from meetings – 10 November 2016	<a href="http://www.hpcsa.com.au/files/983_17-hpc-1645_official_confirmed_minutes_hpc_bi-monthly_meeting_no_42_10_november_2016.pdf">www.hpcsa.com.au/files/983_17-hpc-1645_official_confirmed_minutes_hpc_bi-monthly_meeting_no_42_10_november_2016.pdf</a>
Nov 2016	Aboriginal Leaders' Forum output report from 24 November 2016	<a href="http://www.hpcsa.com.au/files/933_alf_output_report_2016-11-24.pdf">www.hpcsa.com.au/files/933_alf_output_report_2016-11-24.pdf</a>
<b>2017</b>		
Feb 2017	Submission from Health Performance Council SA to the Productivity Commission – Reforms to Human Services: Issues Paper December 2016	<a href="http://www.hpcsa.com.au/files/982_20170210_final_submission_hpc_to_productivity_commission_inquiry_into_human_services.pdf">www.hpcsa.com.au/files/982_20170210_final_submission_hpc_to_productivity_commission_inquiry_into_human_services.pdf</a>
Mar 2017	Indicator report: Monitoring the implementation of Transforming Health – first edition	<a href="http://www.hpcsa.com.au/files/991_hpc_monitoring_implementation_of_the_indicator_report_march_2017.pdf">www.hpcsa.com.au/files/991_hpc_monitoring_implementation_of_the_indicator_report_march_2017.pdf</a>
Mar 2017	Minutes from meetings – 16 March 2017	<a href="http://www.hpcsa.com.au/files/993_17-hpc-1645_official_confirmed_minutes_hpc_bi-monthly_meeting_no_43_16_march_2017.pdf">www.hpcsa.com.au/files/993_17-hpc-1645_official_confirmed_minutes_hpc_bi-monthly_meeting_no_43_16_march_2017.pdf</a>
Mar 2017	HPC/ Health Translation SA Data Access Workshop Output Report	<a href="http://www.hpcsa.com.au/files/988_data_access_workshop_output_report_16_march_2017.pdf">www.hpcsa.com.au/files/988_data_access_workshop_output_report_16_march_2017.pdf</a>

March 2017	Productivity Commission's Report on Government Services 2017 - How South Australia compares with other states and territories for selected health performance indicators	<a href="http://www.hpcsa.com.au/files/1111_rogs_performance_report_2017_sa_vs_aust.pdf">www.hpcsa.com.au/files/1111_rogs_performance_report_2017_sa_vs_aust.pdf</a>
May 2017	Indicator report: Monitoring the implementation of Transforming Health – 2nd edition	<a href="http://www.hpcsa.com.au/files/995_hpc_monitoring_implementation_of_th_indicator_report_may_2017_updated.pdf">www.hpcsa.com.au/files/995_hpc_monitoring_implementation_of_th_indicator_report_may_2017_updated.pdf</a>
May 2017	Minutes from meetings - 18 May 2017	<a href="http://www.hpcsa.com.au/files/1002_17-hpc-1701_official_confirmed_minutes_hpc_bi-monthly_meeting_no_44_18_may_2017.pdf">www.hpcsa.com.au/files/1002_17-hpc-1701_official_confirmed_minutes_hpc_bi-monthly_meeting_no_44_18_may_2017.pdf</a>
May 2017	Aboriginal Leaders' Forum output report from 31 May 2017	<a href="http://www.hpcsa.com.au/files/1005_alf_output_report_2017-05-31.pdf">www.hpcsa.com.au/files/1005_alf_output_report_2017-05-31.pdf</a>
Jun 2017	HPC factsheet: A guide to assist SA Health agencies and staff to collect data relating to the cultural and linguistic diversity of health consumers	<a href="http://www.hpcsa.com.au/files/1016_20170629_final_guide_hpc_advice_to_isaac_cald_data_items.pdf">www.hpcsa.com.au/files/1016_20170629_final_guide_hpc_advice_to_isaac_cald_data_items.pdf</a>
June 2017	HPC presentation to the Combined Health Advisory Council Conference	<a href="http://www.hpcsa.com.au/files/1001_hpc_country_hacs_presentation_june_2017.pdf">www.hpcsa.com.au/files/1001_hpc_country_hacs_presentation_june_2017.pdf</a>
July 2017	Indicator report: Monitoring the implementation of Transforming Health - 3 <sup>rd</sup> edition	<a href="http://www.hpcsa.com.au/files/1004_hpc_monitoring_implementation_of_th_indicator_report_july_2017.pdf">www.hpcsa.com.au/files/1004_hpc_monitoring_implementation_of_th_indicator_report_july_2017.pdf</a>
Jul 2017	Minutes from meetings – 27 July 2017	<a href="http://www.hpcsa.com.au/files/1015_17-hpc-1725_official_confirmed_minutes_hpc_bi-monthly_meeting_no_45_27_july_2017.pdf">www.hpcsa.com.au/files/1015_17-hpc-1725_official_confirmed_minutes_hpc_bi-monthly_meeting_no_45_27_july_2017.pdf</a>
Aug 2017	HPC webinar about Review of Country Health Advisory Councils' (HACs) Governance Arrangements report	<a href="https://www.youtube.com/watch?v=jlxDUZpfMxo">https://www.youtube.com/watch?v=jlxDUZpfMxo</a>
Aug 2017	Presentation slides from the report of findings webinar 24 August 2017	<a href="http://www.hpcsa.com.au/files/1014_20170824_final_presentation_hpc_hac_report_webinar_24aug17.pdf">www.hpcsa.com.au/files/1014_20170824_final_presentation_hpc_hac_report_webinar_24aug17.pdf</a>
Sept 2017	Aboriginal health in South Australia: 2017 case study	<a href="http://www.hpcsa.com.au/files/1107_hpc_aboriginal_health_case_study_2017_final_report.pdf">www.hpcsa.com.au/files/1107_hpc_aboriginal_health_case_study_2017_final_report.pdf</a>
Sept 2017	Annual Report 2016/17	<a href="http://www.hpcsa.com.au/files/1042_20170930_final_signed_report_hpc_annual_report_2016-2017.pdf">www.hpcsa.com.au/files/1042_20170930_final_signed_report_hpc_annual_report_2016-2017.pdf</a>

Sept 2017	Minutes from meetings - 21 Sep 2017	<a href="http://www.hpcsau.com.au/files/1028_17-hpc-1757_official_confirmed_minutes_hpc_meeting_no_46_21_september_2017.pdf">www.hpcsau.com.au/files/1028_17-hpc-1757_official_confirmed_minutes_hpc_meeting_no_46_21_september_2017.pdf</a>
Sept 2017	Indicator report: Monitoring the implementation of Transforming Health – 4 <sup>th</sup> Edition	<a href="http://www.hpcsau.com.au/files/1023_hpc_monitoring_implementation_of_th_indicator_report_sept_2017.pdf">www.hpcsau.com.au/files/1023_hpc_monitoring_implementation_of_th_indicator_report_sept_2017.pdf</a>
Sept 2017	Revisit Review of Country Health Advisory Councils Governance Arrangements: A Health Performance Council report as part of the 4-Yearly Review (2015-2018)	<a href="http://www.hpcsau.com.au/files/1011_final_report_hpc_revisit_review_country_hacs_2016_2017.pdf">www.hpcsau.com.au/files/1011_final_report_hpc_revisit_review_country_hacs_2016_2017.pdf</a>
Nov 2017	Indicator report: Monitoring the implementation of Transforming Health – 5 <sup>th</sup> Edition	<a href="http://www.hpcsau.com.au/files/1048_hpc_monitoring_implementation_of_th_indicator_report_nov_2017.pdf">www.hpcsau.com.au/files/1048_hpc_monitoring_implementation_of_th_indicator_report_nov_2017.pdf</a>
Nov 2017	Minutes from meetings – 16 Nov 2017	<a href="http://www.hpcsau.com.au/files/1067_17-hpc-1770_official_confirmed_minutes_hpc_meeting_no_47_16_nov_2017.pdf">www.hpcsau.com.au/files/1067_17-hpc-1770_official_confirmed_minutes_hpc_meeting_no_47_16_nov_2017.pdf</a>
Dec 2017	Bitesize report: Hotspots of potentially preventable hospitalisations in South Australia's public hospitals	<a href="https://www.hpcsau.com.au/files/1043_hotspots_of_potentially_preventable_hospitalisations_v1_2017-12-12.pdf">https://www.hpcsau.com.au/files/1043_hotspots_of_potentially_preventable_hospitalisations_v1_2017-12-12.pdf</a>
<b>2018</b>		
Feb 2018	Minutes from meetings – 22 Feb 2018	<a href="http://www.hpcsau.com.au/files/1114_18-hpc-1815_official_confirmed_minutes_hpc_meeting_no_48_22_feb_2018.pdf">www.hpcsau.com.au/files/1114_18-hpc-1815_official_confirmed_minutes_hpc_meeting_no_48_22_feb_2018.pdf</a>
March 2018	Productivity Commission's Report on Government Services 2018 - How South Australia compares with other states and territories for selected health performance indicators	<a href="http://www.hpcsau.com.au/files/1112_rogs_performance_report_2018_sa_vs_aust.pdf">www.hpcsau.com.au/files/1112_rogs_performance_report_2018_sa_vs_aust.pdf</a>
May 2018	Aboriginal Leaders' Forum output report from 22 May 2018	<a href="http://www.hpcsau.com.au/files/1116_alf_output_report_2018-05-22_final.pdf">www.hpcsau.com.au/files/1116_alf_output_report_2018-05-22_final.pdf</a>
May 2018	Indicator report: Monitoring the implementation of Transforming Health – 6 <sup>th</sup> and final edition	<a href="http://www.hpcsau.com.au/files/1115_hpc_monitoring_effects_of_implementing_transforming_health_6th_and_final_ed_may_2018.pdf">www.hpcsau.com.au/files/1115_hpc_monitoring_effects_of_implementing_transforming_health_6th_and_final_ed_may_2018.pdf</a>
May 2018	Minutes from meetings – 4 May 2018	<a href="http://www.hpcsau.com.au/files/1120_hpc_meeting_no_49_03_may_2018_minutes_signed_copy.pdf">www.hpcsau.com.au/files/1120_hpc_meeting_no_49_03_may_2018_minutes_signed_copy.pdf</a>
Jun 2018	HPC response to the Australian Bureau of Statistics (ABS) consultation on 2021 Census topics	<a href="http://www.hpcsau.com.au/files/1119_20180613_18-hpc-1859_abs_2021_census_consultation_hpc_response.pdf">www.hpcsau.com.au/files/1119_20180613_18-hpc-1859_abs_2021_census_consultation_hpc_response.pdf</a>
June 2018	Bitesize report: South Australian prisons	<a href="http://www.hpcsau.com.au/files/1117_sooh_prisons_bitesize_report_final.pdf">www.hpcsau.com.au/files/1117_sooh_prisons_bitesize_report_final.pdf</a>
Jul 2018	Minutes from meetings – 5 July 2018	<a href="http://www.hpcsau.com.au/files/1332_18-hpc-1878_hpc_meeting_no_50_5_july_2018_minutes_signed.pdf">www.hpcsau.com.au/files/1332_18-hpc-1878_hpc_meeting_no_50_5_july_2018_minutes_signed.pdf</a>

Aug 2018	Comment from Health Performance Council SA on the SA Health Equity and Access in Health Care Policy Directive Version No 1 - Consultation draft issued August 2018	<a href="http://www.hpcs.com.au/files/1276_20180831_18-hpc-1899_hpc_response_to_policy_directive.pdf">www.hpcs.com.au/files/1276_20180831_18-hpc-1899_hpc_response_to_policy_directive.pdf</a>
Sept 2018	State of Our Health (2018)	<a href="http://www.hpcs.com.au/files/1330_state_of_our_health.pdf">www.hpcs.com.au/files/1330_state_of_our_health.pdf</a>
Sept 2018	State of Our Health - Technical Appendix (2018)	<a href="http://www.hpcs.com.au/files/1329_sohh_technical_appendix_2018.pdf">www.hpcs.com.au/files/1329_sohh_technical_appendix_2018.pdf</a>
Sept 2018	Riverland leaders' forums – Elders lunch output report	<a href="http://www.hpcs.com.au/files/1334_berri_lunch_output_report.pdf">www.hpcs.com.au/files/1334_berri_lunch_output_report.pdf</a>
Sept 2018	Riverland leaders' forums – Life without Barriers thank you letter	<a href="http://www.hpcs.com.au/files/1333_18-hpc-1916_life_without_barriers_thank_you_letter_signed.pdf">www.hpcs.com.au/files/1333_18-hpc-1916_life_without_barriers_thank_you_letter_signed.pdf</a>
Sept 2018	Riverland leaders' forums – Regional stakeholder dinner output report	<a href="http://www.hpcs.com.au/files/1335_renmark_dinner_output_report.pdf">www.hpcs.com.au/files/1335_renmark_dinner_output_report.pdf</a>
Oct 2018	Post-implementation review of Country Health Aboriginal Community and Consumer Engagement Strategy Webinar 5 October 2018 - Klynton Wanganeen's video segment	<a href="https://youtu.be/PSPrcMasOLU">https://youtu.be/PSPrcMasOLU</a>
Oct 2018	Post-implementation review of Country Health Aboriginal Community and Consumer Engagement Strategy Webinar Powerpoint presentation - 5 October 2018	<a href="http://www.hpcs.com.au/files/1338_acce_review_webinar_slides.pptx">www.hpcs.com.au/files/1338_acce_review_webinar_slides.pptx</a>
Nov 2018	Report on the Revisit review of South Australia's Palliative Care Services Plan 2009-16	<a href="http://hpcs.com.au/reports">http://hpcs.com.au/reports</a>
Nov 2018	Aboriginal Leaders' Forum output report from 26 October 2018	<a href="http://hpcs.com.au/get_involved">http://hpcs.com.au/get_involved</a>
Nov 2018	Minutes from meetings – 13 September 2018	<a href="http://hpcs.com.au/about_us/meeting_minutes">http://hpcs.com.au/about_us/meeting_minutes</a>