

What's working, what's not

Review of the
South Australian Health
System Performance
for 2011–2014

December 2014

Health Performance Council



Government
of South Australia

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- Review of South Australia Health System Performance for 2011-2014

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What's working, what's not

What's working, what's not is our second Health Performance Council (HPC) report to the South Australian public through the Minister for Health and Parliament. We were established in 2008 to independently monitor and report on the health system's performance in delivering a quality healthcare system for all.

In 2012 we compiled a comprehensive collection of the statistical information available on the health status of South Australians and the factors shaping their health. Understanding who we are, where we live and how these factors are changing are critical to understanding our health needs and the work of the health system. Our review priorities were determined from this picture of who is doing well and who isn't and what we heard through extensive consultations with community representatives, clinicians, health leaders and relevant organisations.

In evaluating the health system, we assessed how it performed across five dimensions of quality derived from the National Health Performance Framework: building healthy communities, getting into the system, being treated well, having good outcomes and working efficiently and remaining sustainable.

In addition we considered four specific areas: End of life care, Aboriginal health, mental health in rural and remote communities and the effectiveness of country Health Advisory Councils.

This report is the outcome of our health system review during 2011-2014. Overall we found that:

1. We have a health system that by world standards is delivering effective services to many South Australians whose health care needs range across their lifespan from simple to highly complex.

During 2011-2014 our health system faced increasing budget and demand pressures but still achieved significant health gains for many South Australians. This is due to the dedicated efforts of its workforce who sought to deliver quality services and contain costs.

2. However, while many of us are living longer in good health some of us are not. The health system continues to face significant challenges in achieving quality health care outcomes for all South Australians. The health system fails to focus as much on vulnerable groups as it ought.

Not everybody is benefiting from our health services – many identified population groups are missing out on accessing suitable services or gaining equitable health care outcomes. These groups include people from culturally and linguistically diverse backgrounds, rural and remote communities, veterans, prisoners and Aboriginal South Australians as well as people with sexual and gender diversity.

3. While the poor health status of Aboriginal people is known in the health system there is no cohesive approach to improving the outcomes for this population group. We found that implementation and monitoring of the Aboriginal Health Care Plan was inadequate and illustrated the lack of attention paid to the failure of health services to reach set targets.

Actions for improvement when undertaken were often established as time limited projects and not incorporated into mainstream health delivery services. Successful projects were stopped when the (often short term Commonwealth) funding ran out creating a syndrome described by Aboriginal health leaders as "if it works – defund it".

4. Despite convincing evidence from around the world there is a focus on hospital performance rather than prevention or primary care services. Primary health care and early intervention services appear not to be valued as an integral part of the health system's efforts to achieve health for all.

Increasing demands on hospital services has led to increased efforts to improve the patient journey in hospitals by reducing the time spent waiting for elective surgery, emergency care, outpatient appointments and admission to hospital. While this is important work and improvements are urgently needed there has been less focus on building the capacity of the primary health care sector. It is now harder to meet the health care needs of vulnerable populations at an earlier and less costly stage.

5. The health system is awash with clinical, administrative and population health data. We found limited evidence that the system linked and analysed this data or disseminated results to inform decision making across the health system for continuous improvement purposes. Gaps evident in the collection of relevant data for vulnerable populations make it virtually impossible to develop a complete picture of the variations in their health outcomes and makes identification of progress or problems difficult.

The health system is also in danger of believing that creating a plan for change is the end of the journey. There are many plans – good plans - that have taken hours of work and consumed significant resources but little evidence that the plans have been effectively implemented and evaluated before further plans are developed.

6. The health system does not embrace consumer and community engagement and the benefits gained from greater transparency and public accountability for its performance. We have detected a defensive tone when feedback is provided and this is also reported by the community sector. There is a considerable opportunity being missed in engaging communities and front-line staff in collaborative problem solving to ensure better health for everyone.

The Health Performance Council has now been listed for abolition as part of the current Government's reform of boards and committees. The Council strongly urges the Minister to:

- a) take action to establish alternate systems for continued evaluation and reporting on the "State of Our Health" – developed by this Council and still the only comprehensive analysis of the health status of South Australians, and
- b) ensure the existence of an ongoing independent watchdog to monitor and report on health outcomes for Aboriginal people – a population group identified by the Health Department as of the highest priority but where few gains have been achieved during the 6 year life of this Council.



Anne Dunn
Chair, Health Performance Council

South Australia's health system

South Australia's health system comprises a mix of public, private, and non-government sector providers such as Aboriginal community controlled primary health services, that work independently and collaboratively at a national or state capacity for the achievement of health outcomes. The system is made complex with many different funding and accountability relationships that influence the achievement of health outcomes.

The South Australian health system encompasses medical research and training, capital investment such as the new Royal Adelaide Hospital, major eHealth initiatives, and all the essential health services provided to the community across the healthcare continuum – all delivered within diverse settings, geographical locations, and service delivery models.

To give you an idea of just how busy our health system is, consider that on a typical day there are, in South Australia...

21,970	GP consultations
19,941	SA Pathology tests performed
4,442	Non-admitted hospital occasions of service
2,456	Doses of vaccine distributed
2,359	Services by Royal District Nursing Service
1,247	Emergency Department presentations
1,134	Public hospital hospitalisations
817	Private hospital hospitalisations
719	Responses by SA Ambulance Service
466	Elective surgery admissions
447	Courses of dental care by SA Dental Service
420	Women screened for cervical cancer
349	Calls to <i>healthdirect Australia</i>
207	Women screened for breast cancer
182	Units of blood supplied to hospitals from the Australian Red Cross Blood Service
98	Older people having an annual health assessment
81	People screened for bowel cancer
27	Four-year olds getting a developmental health check
21	Requests for assistance to <i>Quitline</i>
17	Royal Flying Doctor Service transfers.

... and that's just a small, select snapshot of the huge range of services that the health system provides to the community all day, every day.

The South Australian government, along with its federal and local government counterparts, as well as various non-government sources, together contribute a total of **\$10.5 billion** per year in running the South Australian health system – an investment of over **\$6,000 per person** per year – and rising. It is huge, busy, and complex. So it is with respect for the complexity of this system, respect for the more than **100,000 people** that work in it, and respect for the nearly **1.7 million people** that it services, that we evaluate performance in responding to the health care needs of the community, and make its recommendations to the Minister for Health on areas of potential improvement.

Our advice to the Minister for Health

We have evaluated a priority set of key representative health system performance measures, in consultation with stakeholders, and produced the following advice to the Minister for Health on areas of potential improvement.

Building healthy communities

The Minister for Health:

1. Require SA Health to set a performance outcome that all Local Health Networks increase childhood immunisation rates to 92% 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% 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% by 2018.

Getting into the system

The Minister for Health:

1. Require SA Health to manage a reduction to 15% or less by 2018 of people living in country South Australia reporting delaying or not seeing a dental professional.
2. Request the Department for Health and Ageing investigate what actions South Australia can take to reduce household out-of-pocket medical expenditure.
3. 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% by 2018.
4. Require the SA Dental Service to reduce the percentage of people who wait one month or more for public dentistry to 70% or less by 2018.
5. 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% or above by 2018.

Being treated well

The Minister for Health:

1. 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.
2. 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.
3. 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.
4. 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% by 2018.
5. 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

The Minister for Health require:

1. 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.
2. 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.
3. 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.
4. 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.
5. 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

The Minister for Health require SA Health to:

1. 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.
2. Develop strategies that will improve length of stay by identifying patients that can be better cared for in non-acute hospital settings.
3. 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.
4. 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

The Minister for Health request that SA Health

1. 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.
2. 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

1. 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.

What factors are shaping our health?

At a glance

Understanding who South Australians are, where they live and how these factors are changing is critical to understanding health needs. Personal and community health status is widely recognised to be linked to social and economic capital. Differences in a range of factors including income, employment, education, housing, and social environment can produce inequalities in health outcomes.

...Data highlights

Who are we?

- > We have an older population than the rest of Australia.¹
- > Between 2006 and 2011, our population grew by 5.6%, mainly in the outer Adelaide area.² Overseas migration accounts for 80% of population growth, the third highest nationally.³
- > One in five of us was born overseas⁴ and one in seven does not speak English as their main language at home.⁵
- > More of us live alone than in any other state other than Tasmania, with almost one third of South Australians over 64 years old living alone.⁶
- > We have the third highest proportion of carers nationally. The number of carers has increased by 9 percentage points over the last four years.⁷
- > We are among the least likely of all Australians to live in a home with a computer, the internet or a motor vehicle.⁸

Other factors shaping us

- > Our unemployment is second highest nationally⁹ and the average household disposable income is second lowest nationally.¹⁰
- > More than one in five of our children live in low income families while nearly one in five households experienced financial stress in the previous 12 months.¹¹
- > The percent of us spending more than 30% of our gross income on housing costs is increasing¹² and one in nine Aboriginal South Australians adults live in overcrowded households.¹³
- > Less than half of us overall¹⁴ and less than a quarter of Aboriginal South Australians completed Year 12, below the national average.¹⁵
- > The proportion of Aboriginal South Australian participating in Vocational Education and Training is second highest nationally.¹⁶
- > More than half of us do not have the minimum health literacy to meet the demands of everyday life and work in today's South Australia.¹⁷

Chapter 1: How healthy are we?

At a glance

Health outcomes and health determinants identified where improvements have been noted, or that present a challenge to the health system.

✓ Strengths ✗ Challenges

South Australians getting the best start to life

- ✓ Less women are smoking during pregnancy
- ✓ Less children aged 5 – 9 years are obese but overall rate remains high
- ✗ Highest rate of women with gestational diabetes in Australia
- ✗ Highest rate of women with perinatal depression in Australia
- ✗ Aboriginal babies born with a low birth weight more than double the non-Aboriginal rate

South Australians staying healthy and ageing well

- ✓ The number of adults that don't smoke is growing
- ✓ Aboriginal smoking rates are falling but overall rate remains high
- ✗ Obesity rates are increasing with higher rates for Aboriginal adults and those living in country communities
- ✗ High blood pressure & high cholesterol rates are increasing with higher cholesterol rates for those living in country communities

South Australians living with chronic conditions

- ✓ Chronic bronchitis or emphysema rates are decreasing
- ✗ The percentage of people with a diagnosed mental health condition is increasing
- ✗ Arthritis rates are the second highest nationally with higher rates for those living in country communities
- ✗ South Australia has the highest rate of diabetes nationally.

End of life outcomes for South Australians

- ✓ Perinatal deaths are the lowest in Australia
- ✓ Deaths from circulatory diseases are decreasing but are still in top three causes of death
- ✓ Deaths from colon cancer are decreasing but are still above the national average

* 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
- > South Australians in custody

These population groups may seem invisible to health services and this data gap needs attention.

1.1 South Australians getting the best start to life

The foundations of adult health are laid in early childhood. Poor health as an infant can cast long shadows forward on both childhood and adulthood, increasing the risk of ill health from conditions ranging from asthma to cardiovascular disease later in life.

...More data highlights
✓ Strengths ✗ Challenges

Mothers

South Australian women in the metropolitan area are having an average of 1.82 children, compared to 2.23 in rural and remote areas and 2.41 for South Australian Aboriginal women.¹⁸

South Australian women are giving birth later, at an average age of 29.7 years old.¹⁹ Contributing to this trend is a decreasing teenage birth rate and the proportion of women over 34 years old giving birth—currently a fifth of all births.

- ✗ The rate of awareness of the benefits of folic acid intake before and during pregnancy continues to decrease.²⁰
- ✗ Almost one in eight South Australian mothers experience perinatal depression, the highest proportion nationally.²¹
- ✗ Almost one in nine South Australian women and one in two South Australian Aboriginal women are smoking at their first antenatal visit, but the overall trend has been decreasing over the last five years.²²
- ✗ Smoking during pregnancy is higher in areas of socioeconomic disadvantage and country areas.
- ✗ Over half of South Australian women giving birth are overweight or obese.²³
- ✗ South Australia now has the highest rate of gestational diabetes compared with the rest of Australia.²⁴

Babies

- ✗ The rate of caesarean births remains high but has been steady since 2007 but the rate is significantly higher than the OECD average.²⁵
- ✗ South Australia has the lowest breastfeeding initiation rate nationally.²⁶

Children

- ✓ 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.²⁷
- ✗ Nearly a quarter of South Australian children are overweight or obese but South Australia is still below the national average.²⁸
- ✗ 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.²⁹

1.2 South Australians staying healthy and ageing well

There are a range of factors that influence health status.

...More data highlights

✓ Strengths ✗ Challenges

- ✓ 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.³⁰
- ✓ The incidence of melanoma has been consistently lower than the national average over the last four years.³¹
- ✓ Nine in ten Aboriginal South Australians have access to support from outside the household which is higher than the Australian average.³² The large majority of South Australians agree that cultural diversity is good.³³
- ✓ Just under one in five South Australians volunteer, the second highest nationally.³⁴
- ✓ 11.8% of South Australians provide unpaid care, help, or assistance because of a disability, the highest rate nationally.³⁵
- ✓ There has been a slow decrease in smoking and the trend has been downwards from 2009.³⁶ 40.3% 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.³⁷
- ✗ One in five South Australians has a disability,³⁸ and 5.5% of South Australians have a need for assistance due to a profound or severe disability.³⁹ Both of these rates are the second highest nationally.
- ✗ 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.⁴⁰
- ✗ Over a quarter of South Australians are drinking at risky levels. This is higher for men and for those living in country areas.⁴¹
- ✗ 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%.⁴²
- ✗ One in four South Australians adults are overweight or obese, and this trend has been increasing since 2009 (2009 - 21.6%, 2013, 24.1%).⁴³ Obesity rates are statistically significantly higher in country SA. Overweight and obesity in Aboriginal people is high at 70% but below the national average.⁴⁴
- ✗ One in five South Australians has high blood pressure, one in six has high cholesterol and one in eight smokes cigarettes.⁴⁵ This is on, or above, the national average.⁴⁶ High cholesterol and smoking are more prevalent in country areas.⁴⁷
- ✗ Psychological distress in the Aboriginal population is exceptionally high and one of the highest nationally⁴⁸ and is around three and a half times that of the general SA population.⁴⁹

1.3 South Australians living with chronic conditions

Chronic conditions are diseases with a long duration that usually require ongoing management and treatment. An individual living with a chronic condition can experience significant effects on his or her life, not only physically, but also emotionally, psychologically, socially and economically. Families and communities can be impacted by the limitations caused by chronic disease due to increased caring demands and their emotional toll, as well as lost productivity.

...More data Highlights

✓ Strengths ✗ Challenges

- ✓ There has been a slight downward trend in chronic bronchitis or emphysema in the last five years.⁵⁰
- ✗ One in six South Australians is living with multiple chronic conditions. The prevalence of multiple chronic conditions increases with age and socioeconomic disadvantage.⁵¹
- ✗ About 8% 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.⁵²
- ✗ Arthritis is the most prevalent chronic condition in South Australia with one in five of South Australians 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.⁵³
- ✗ 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.⁵⁴ The trend has been increasing over the last 5 years, up from 14.4% in 2009 to 16.9% in 2013. The metro Adelaide rate is statistically significantly higher than country SA in 2013. Psychological distress is also relatively high in SA.
- ✗ One in eight South Australians adults has asthma. Overall, rates are higher among women than men.⁵⁵
- ✗ 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.⁵⁶
- ✗ Osteoporosis in South Australian is four times more prevalent in women than men. It affects one in four South Australian women over 75 years.⁵⁷
- ✗ South Australia is ranked highest nationally for prevalence of back pain/problems or disc disorders.⁵⁸

1.4 The causes of death for South Australians

Understanding patterns and trends in mortality is an important step in improving population health.

...More data highlights

✓ Strengths ✗ Challenges

The top three causes of death in South Australia are circulatory disease, cancer, and respiratory disease.⁵⁹

- ✓ The South Australian death rate for all age groups has been trending down since 2009.⁶⁰ 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.⁶¹
- ✓ The median age at death for South Australians is trending up, and now stands at 80.0 years for males, and 85.5 years for females.⁶²
- ✓ South Australia's perinatal death rate is lowest nationally,⁶³ including for Aboriginal perinatal deaths.⁶⁴ The infant death rate in South Australia has been trending down since 2008.⁶⁵
- ✓ Deaths from colon cancer have been trending down over the last six years, from 12.1 per 100,000 persons in 2007 to 8.2 in 2012.⁶⁶ While South Australia is still above the national average its ranking against other states and territories has dropped since 2010.⁶⁷
- ✗ The rate for Aboriginal people for avoidable, preventable and treatable deaths is three times higher than for all persons in South Australia.⁶⁸
- ✗ Intentional self-harm is now the main cause of death for South Australians aged 15 to 44 years.⁶⁹
- ✗ Although suicide rates in South Australia are low, the rate among men is three times that of women.⁷⁰

1.5 Stories of South Australians: at a glance

A Female South Australians

A girl and a boy born today in South Australia would have different experiences throughout their lives, including the factors that impact their health. They would therefore be likely to experience different health outcomes over the course of their lives.

...As a girl

A girl born today in South Australia would join almost 810,000 female South Australians, or about 50.7% of the state. If she was born in the Adelaide area, she would be part of the majority sex. If she was born in any of the state's regional areas, she and her female neighbours would be outnumbered, particularly in the northern region of the state, where women and girls are 48.6% of the population.

She would be born into a diverse state, where more than one in five people were born overseas and one in seven speak a language other than English at home. She would be more likely than her cousins interstate to have older people in her life, as South Australia has a larger proportion of older people than the national average, the majority of whom are women. The reverse would be true for having older Aboriginal people in her life because Aboriginal South Australians are underrepresented in all age groups beyond 30 years old.

She could expect to live to a relatively long life, about 84.2 years— longer than the average South Australian woman born at any time before her, a year longer than the average woman living in Organisation for Economic Co-operation and Development countries and more than 4 years longer than her brother. She could expect to spend most of those years in good health, with a health-adjusted life expectancy of 75.4 years. The story is different if she is an Aboriginal baby, though. Although the data is not available for South Australia, nationally an Aboriginal baby girl can expect to live about 10 years less than a non-Aboriginal baby girl but 5.5 years longer than her brother.

Before she was 4 years old, she could expect to have twice as many years of healthy life lost due to a chronic respiratory disease than her brother. While her brother would be much more likely to be diagnosed as having migraines or headaches before he reached nine years old, she would be almost three times as likely from 10 to 15 years old as more than one in ten girls in this age group have diagnosed migraines or headaches.

As a young adult, she would have a similar likelihood to her brother of drinking alcohol at risky levels, as more than one in four South Australians aged 16 to 24 are at risk of short-term harm from alcohol consumption. As a teenager between 15 and 19 years old, she would be slightly more likely to be called on to provide unpaid care for a family member than her brothers, potentially impacting her education, relationships and employment opportunities.⁷¹ If her family did not speak English at home, she and her brothers would be 2.5-3 times more likely to provide unpaid care.

...In her community

As she grew up, she would become more likely than her brother to provide care to an older person or someone with a disability. The likelihood of her caring for someone with a disability would peak in her mid-50s to mid-60s, as almost one in four South Australian women in that age group provide unpaid care to someone with a disability. And she would be almost twice as likely to be a primary carer, as 35% of female carers are primary carers compared to 19.6% of male carers. If she became a carer, she would be at an increased risk of experiencing social isolation due to her responsibilities, a low sense of wellbeing and poor health.⁷²

As an adult, she would be less likely to feel safe than her brother— both at home, particularly at night, and alone in her local area after dark. These relatively lower feelings of safety can have an impact on quality of life, resulting in social isolation, stress, anxiety, and or distance control – all of which are risk factors for poor health.⁷³ She would also be less likely than her brother to believe that people in the community can be trusted, and the least likely of all women in Australia. Although she would be very likely to be able to access support from people living outside the household, she would be less likely to have daily face-to-face contact with people outside her house than her cousins interstate, other than in the ACT. She would be more likely than her brother to report high or very high psychological distress, with more than one in ten women in South Australia experiencing psychological distress, and mental disorders would be the disease most likely to contribute to her living in less than optimum health. Despite these negative differences, she would only be a third as likely to commit suicide as her brother, though she would be slightly more likely to commit suicide than her cousins interstate.

Despite her feelings of not being safe, she is likely to participate and contribute to the community as she will be born into a South Australia where two-thirds of people participate in community events, similar with the rest of Australia. She would be more likely than her brother to volunteer, as 21.5% of South Australian women volunteer compared to 17.9% of men.

...As a mother

If she chooses to have children, she is likely to do so at an older age and with a higher risk of gestational diabetes than her mother. The average number of children she could expect to have would be lower if she lived in the metropolitan area, at 1.82 children, compared to 2.23 if she lived in a regional or rural area. She would likely be aware that she should take folic acid before and during pregnancy but not as aware as her counterparts four years earlier. She would less likely smoke during the pregnancy and less likely have a low birth weight baby. Her foetus would have a similar chance of viability compared to its Organisation for Economic Co-operation and Development counterparts and if it was a female, it would be slightly higher. For an Aboriginal woman, though, the infant mortality rate would be higher and would continue to be higher throughout early childhood.

If she was an Aboriginal woman, she could expect to have an average of 2.41 children. She would be less likely than her non-Aboriginal neighbours to have an antenatal assessment in the first trimester of pregnancy and more than four times as likely to smoke during pregnancy, increasing her risk for pregnancy complications and potentially impacting her child later in life.⁷⁴ She would be less likely than her non-Aboriginal neighbours to take her four year old to have a health assessment, her child at 5 years old would be least likely of any of its cousins interstate to be fully vaccinated.

She would be in the highest proportion of mothers experiencing perinatal depression in the country, with 12.8% of South Australian mothers diagnosed with depression between conception and their child's first birthday. She would also be among the least likely in Australia to breastfeed her child and ensure it is fully vaccinated. She would be more likely than the average Australian woman to have a baby with low birth weight, and even more so if she was Aboriginal, potentially resulting in a baby more vulnerable to illness as a child and as an adult.⁷⁵

...As a woman

She would be unlikely to make good choices on many factors that could have a protective impact on her health. She would be unlikely to eat the recommended five daily servings of vegetables, though she would be more likely than her brother to do so. Although only half of South Australian women eat the recommended two serves of fruit a day, she would be significantly more likely to than her brother to do so. She would be as likely as her brother to be sufficiently physically active, but less likely than her female cousins interstate. She would be as likely to have high cholesterol as her brother, and together they would have the highest likelihood of having high cholesterol in Australia.

She would be less likely than her brother to make lifestyle choices that put her at risk of disease, including smoking. Although she had a similar chance of drinking at risky levels as a young adult, over the course of her lifetime, the likelihood of her drinking at risky levels would be lower than her brother, particularly her short term risk of harm from alcohol.

She would be likely to report her own health as good or better, similar to her cousins interstate. Although she would have the same likelihood of having a limiting health problem as her brother, she would be more likely to need assistance due to a profound or severe disability. Despite this, she would be less likely to access a disability service as South Australian men consistently access disability services at higher rate than women. She would be more likely than her brother to have multiple chronic conditions, and significantly more likely to have arthritis and a doctor-diagnosed mental health condition. She would also be more likely to have asthma, but less likely to die from a respiratory disease.

As a woman, like all Australian women, she would have a very low risk of dying from cervical cancer, though her likelihood of dying from this cancer would be higher than the average Australian woman's. If she was an Aboriginal woman, she would have only a fourth of the likelihood of South Australian women overall of experiencing breast cancer but almost three times the likelihood of having cervical cancer.

...As an older woman

As she aged, her participation in community events would likely decrease, as would the likelihood of her having sufficient physical activity. She could expect her earlier positive behavioural choices to have a positive effect as she would be almost half as likely as her brother to die from lung cancer, as well as less likely to die from circulatory disease or cancer.

After her 65th birthday, she could expect to have more years of healthy life lost due to cardiovascular disease and nervous system and sense organ disorders than her brother. She would be significantly more likely than her brother to have a fall needing medical treatment or resulting in limitations. By the time she was 75 years, she would have a one in four likelihood of having osteoporosis compared to her brother who would have a one in fourteen likelihood.

B Male South Australians

A girl and a boy born today in South Australia would have different experiences throughout their lives, including the factors that impact their health. They would therefore be likely to experience different health outcomes over the course of their lives.

...As a boy

A boy born today in South Australia would join almost 790,000 male South Australians, or about 49.3% of the state. If he was born in the Adelaide area, he would be part of the minority sex. If he was born in any of the state's regional areas, though, he and his male neighbours would outnumber women and girls, particularly in the northern region of the state, where men and boys are 51.4% of the population.

He would be born into a diverse state, where more than one in five people were born overseas and one in seven speak a language other than English at home. He would be more likely than his cousins interstate to have older people in his life, as South Australia has a larger proportion of older people than the national average, the majority of whom are women. The reverse would be true for having older Aboriginal people in his life because Aboriginal South Australians are underrepresented in all age groups beyond 30 years old.

He would have a very good chance of living to his first birthday, and his chance would be slightly higher than his sister's. If he did survive, he could expect to live to a relatively long life. His life expectancy would be about 80.2 years if he was born in the greater Adelaide area and 78.9 years if he was born in a country area—longer than the average South Australian man born at any time before him. Regardless of where he lived, he would be likely to live about 4 and a half years less than his sister. He could expect to spend most of those years in good health, with a health-adjusted life expectancy of 70.5 years. The story is different if he is an Aboriginal baby. He would have a lower chance to live to his first birthday than a non-Aboriginal boy and although the data is not available for South Australia, nationally an Aboriginal baby boy can expect to live 12.5 years less than a non-Aboriginal baby boy and 8.1 years less than his sister.

He would be more likely than his sister to be diagnosed as having a severe behavioural problem, clumsiness, a developmental delay or a learning disorder.

If he came from a family that did not speak English at home, as an adolescent he would be more than 3.5 times more likely than the average South Australian boy to provide care for someone. Regardless of his background, as a young adult, he would have a similar likelihood to his sister of drinking alcohol at risky levels, as more than one in four South Australians aged 16 to 24 are at risk of short-term harm from alcohol consumption.

...In his community

As a South Australian adult, he would be among the highest proportion of volunteers in Australia but he would be less likely than his sister to volunteer. As an adult, he would have less likelihood than his sister of caring for an older person or someone with a disability but he would still have a one in eight chance of becoming a carer – the highest in Australia. This likelihood of him being a carer would increase with age until he was in his mid-60s, when he would have a one in seven chance of being a carer.

He could expect to feel safe and confident as an adult in South Australia. He would be very likely to be confident at home alone and more than two and a half times more likely than his sister to feel safe walking alone in his local area after dark. Although he would be less likely than his sister to feel he had the support of people outside his household in a crisis, and among the least likely to think so in Australia, he would be more likely to believe that people in the community can be trusted, and more likely than his cousins interstate. He would be less likely to report experiencing psychological distress.

Despite these positive factors, he would be more than three times as likely to commit suicide as his sister, and more likely than the average Australian man. Intentional self-harm is the leading cause of death for South Australian men from their mid teens to their mid-40s and he would be 2.5 times as likely as his sister to die from intentional self-harm between the ages of 25 and 34.

...As a man

He would be unlikely to make good choices on many factors that could have a protective impact on his health. One area he would not be likely to make good choices is his nutrition. **He** would be significantly less likely to eat the recommended two serves of fruit than his sister, particularly in his late 20s and early 30s, and over the course of his life, he would be less likely to do so than the average Australia man. He would also have only a one in ten likelihood of eating the recommended serves of vegetables a day, but across Australia, only his cousins in Tasmania would be more likely to eat the recommended serving. He would be as likely as his sister to have high cholesterol, and they would both have a significant chance of having high blood pressure over the course of their lives. He would be more likely to smoke and drink alcohol at risky levels.

He would be likely to report his own health as good or better. He will be significantly less likely than his sister to live with multiple chronic conditions, though both of their chances would increase with age. As an adult, his good health is more likely to be impacted by cardiovascular disease than his sister but he would be less likely to have asthma. Despite this, he would be significantly more likely to die from respiratory disease than his sister.

Although he would have a slightly lower likelihood of needing assistance due to a disability than his sister, he would have a higher likelihood of accessing a disability service as 56% of disability clients in South Australia are men. If he was Aboriginal, though, he would have a higher likelihood than his sister to need assistance due to a disability.

...As an older man

As he aged, his participation in community events would likely decrease, as would his likelihood of getting enough exercise. He would be significantly less likely than his sister to have a fall needing medical treatment or resulting in limitations. He would also be significantly less likely to have arthritis than his sister in his older age. His likelihood of drinking alcohol at risky levels would be the highest in his life, as almost two in five South Australian men over 55 years old drink at risky levels. He could expect these and his earlier behavioural choices to have an effect, as he would have an almost one in three chance of having cardiovascular disease.

After his 65th birthday, he could expect his most likely causes of death to be cancer and heart disease. His likelihood of dying from either of these causes would be higher than his sister. He would be almost twice as likely as his sister to die from lung cancer, as well as much more likely to die from cancer, including colon cancer. Nevertheless, he would be less likely than his cousins interstate to die from prostate cancer.

C Aboriginal South Australians

Imagine two cousins, a boy and a girl, born today...

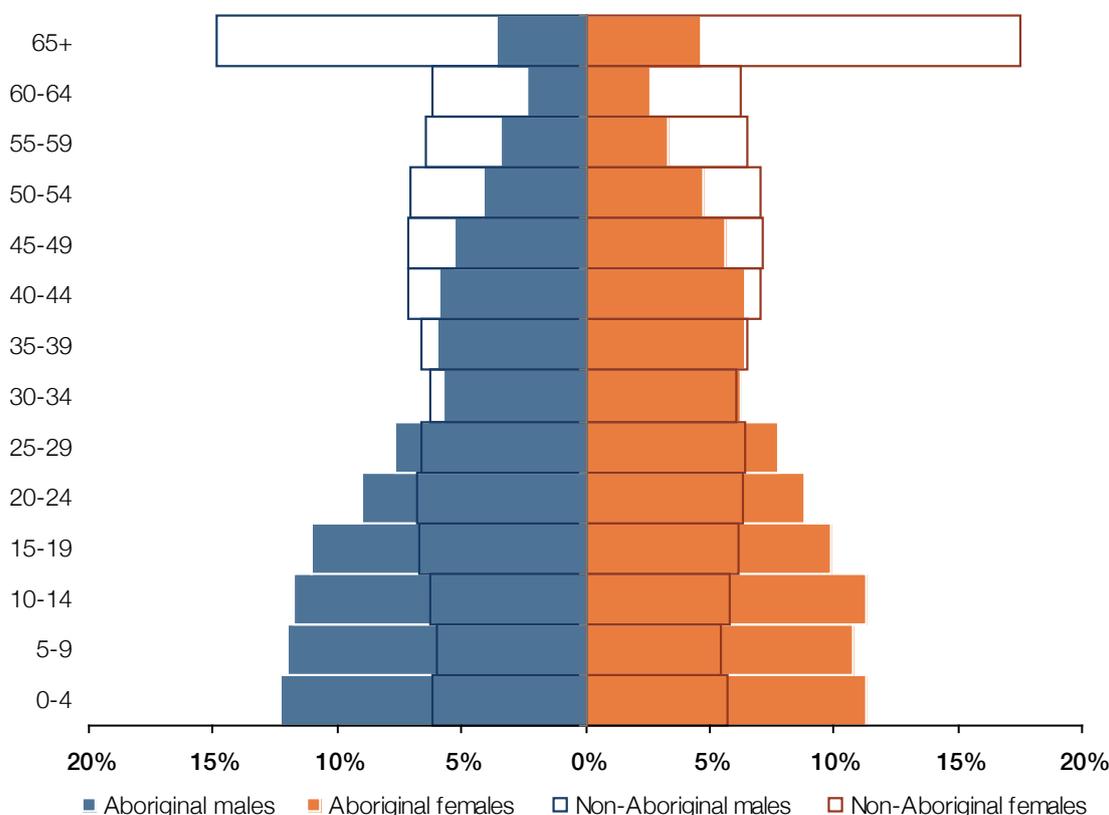
...As children

Aboriginal children born today in South Australia could expect to have different experiences than non-Aboriginal children throughout their lives, including factors impacting health.

The cousins would join over 30,000 Aboriginal people living in South Australia – 1 in every 50 South Australians. They would be just as likely to be born in the Adelaide metropolitan area as in one of the state’s rural or remote areas as half of Aboriginal South Australians live in country areas.

Regardless of where they lived, they would be more likely to have siblings than their non-Aboriginal neighbours. At the same time, they would be much more likely to attend the funerals of their aunts, uncles and grandparents as Aboriginal South Australians are underrepresented in all age groups over 30 years old.

Chart 1.1: Aboriginal people are underrepresented in older age groups



Source: ABS, 'Basic community profile, BO7 Indigenous status by age by sex', 2011 Census of population and housing

Although they could expect a higher chance to live to their first birthday than their cousins born before them, their chance would be lower than the average baby in South Australia. They could also expect to not live as long as their non-Aboriginal neighbours. Although the data is not available for South Australia, nationally an Aboriginal baby girl can expect to live to 72.3—almost 12 years less than a baby girl born to her non-Aboriginal neighbours. An Aboriginal baby boy can expect to live to 67.4—12.5 years less than a non-Aboriginal boy and 5 years less than his sister.

When the cousins reached year 5 at school, they would be at higher risk than their non-Aboriginal classmates and cousins interstate of not achieving the national minimum standards in reading and numeracy. If they lived in a very remote area, like the far north and west of the state, they would be even less likely to achieve these standards.

As they progressed in school, the cousins would be more likely to stay in school to year 12 than their cousins in most other states. This would increase their likelihood of accessing healthcare and participating in the labour market later in life.⁷⁶

...In their family

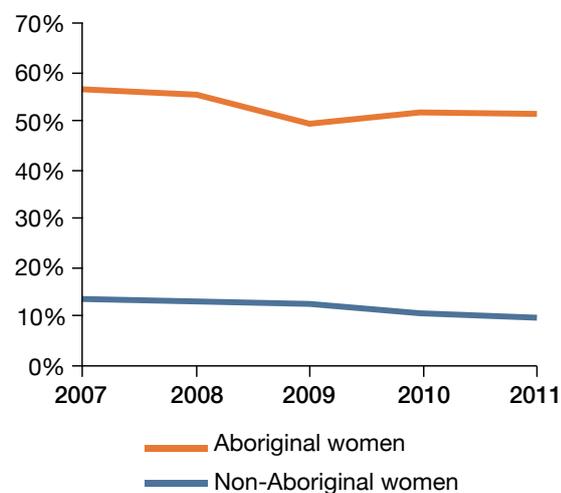
If the cousins' family lived in remote South Australia, they would have a one in three chance of living in a household where the main language spoken was an Aboriginal one. Their chance would drop to 1 in 16 if their family lived in rural South Australia. It would be even lower if they lived in Adelaide, as just fewer than 2% of Aboriginal people living in metropolitan Adelaide speak an Aboriginal language as their main language at home.

The cousins would be more likely than their non-Aboriginal neighbours to be born into a family experiencing housing stresses. Decent and affordable housing is a cornerstone of good health and a major determinant of health inequalities.⁷⁷ Their families would have only a one in three chance of owning or buying their own home, around half that of their non-Aboriginal neighbours. Their parents would have an almost a one in five chance of facing unemployment. This is three times higher than non-Aboriginal South Australians and one of the highest rates among Aboriginal people across all Australian jurisdictions.

Their family would also have a one in four chance of being significantly impacted by financial stress. Nearly 25% of Aboriginal South Australians reported that there were days in the last year when they had run out of money to buy food, clothing, or pay household bills – rising to 45% in remote South Australia (most areas outside of the greater Adelaide, Fleurieu, Yorke and Mid North and Southeast regions). Their family may also face the challenge of having a family member in custody. The Aboriginal imprisonment rate in South Australia is almost 15 times the non-Aboriginal rate, the third-highest Aboriginal imprisonment rate in Australia.

As they got older, the female cousin could expect to have two or three children, compared to one or two for South Australian women overall.

Chart 1.2: Smoking During Pregnancy is Decreasing but a Gap Remains (second half of pregnancy)



Source: SA Health, *Pregnancy outcome in South Australia, publications 2007-2011*

She would be five times more likely to smoke during pregnancy than her non-Aboriginal neighbours, but she would be less likely to do so than her cousins would have done in the past.

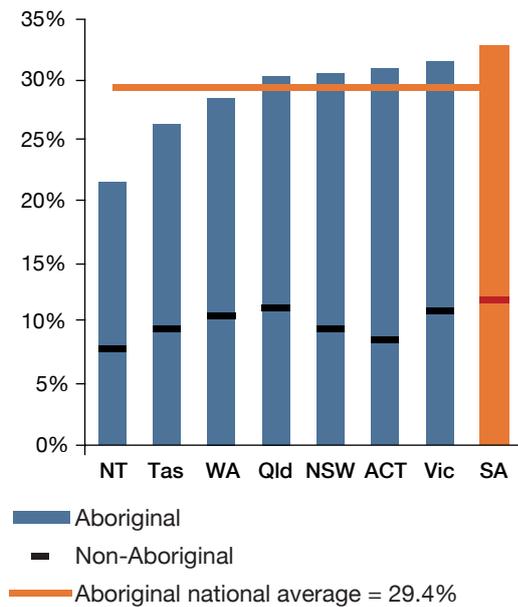
Despite these challenges, her pregnancy would be more likely to result in a live birth than pregnancies of non-Aboriginal South Australian women. As a South Australian Aboriginal woman, she would also have the greatest likelihood of having a live birth in Australia.

Regardless, her children would have twice the risk of having a low birth weight than other babies in the hospital and a slightly higher risk than the average Australian Aboriginal baby. This could potentially result in her baby being more vulnerable to illness as a child and as an adult, and could in turn impact future generations.⁷⁸

...In the community

The likelihood of the cousins growing up to be involved in Aboriginal cultural activities would be very high, with nearly three quarters of Aboriginal South Australians involved in at least one Aboriginal cultural activity over the last year. The cousins would also be reasonably likely to spend time caring for Country, with almost a third of Aboriginal people in SA spending a 'fair bit/heaps' of time on Country. This would depend on where the cousins lived, with the rate much higher in remote SA, at nearly 75% of Aboriginal people, compared to just over 10% in metropolitan Adelaide.

Chart 1.3: Aboriginal South Australians Have the Highest Rate of High to Very High Psychological Distress in Australia⁷⁶



Source: Productivity Commission, Report on government services 2014

The cousins would only be slightly more likely than their non-Aboriginal neighbours to drink alcohol at risky levels, and less likely than their cousins interstate. Yet they would be twice as likely as South Australians overall to smoke, similar to their cousins interstate.

The cousins would be very likely to include Aboriginal traditional foods in their diet, although this would vary greatly depending on where in South Australia they lived. More than half of Aboriginal people in South Australia eat traditional Aboriginal foods, but this ranges from nearly 90% in remote South Australia to 20% in metropolitan Adelaide. However, the cousins would be unlikely to eat the recommended amount of fruit or vegetables. They would only have a one in two chance of being physically active as frequently as recommended. These risk factors mean the cousins would have a 70% chance of being overweight or obese, slightly below the national average for Aboriginal people and a bit higher than all South Australians.

They would likely face some health challenges, including having a one in three chance of having three or more long-term health conditions. They would have a one in four chance of developing high blood pressure and diabetes or 'a touch of sugar.' They would also have a high chance of developing kidney disease, as 6.1% of Aboriginal South Australians have kidney disease compared to only 0.7% of all South Australians. The cousins' likelihood of developing kidney disease would be much higher if they lived in a remote area, as nearly one in five Aboriginal South Australians who live in remote areas have doctor-diagnosed kidney disease.

The likelihood of the cousins developing asthma would be twice that of non-Aboriginal South Australians and higher than the national average for Aboriginal people. They would also have a one in ten chance of having a heart or circulatory problem, similar to Aboriginal Australians overall.

The cousins would be part of an Aboriginal community in South Australia that says it has very high levels of health literacy. More than 90% of Aboriginal South Australians say information from their doctor helps them understand why they need to take prescribed medication. When asked, over 70% indicate that they read the instructions with new medicines most times or always. Most say they do not find it difficult to understand information provided with medicines and are able to take their medication as directed. Similarly, the overwhelming majority of Aboriginal people say they are very or quite confident in filling out medical forms.

As adults, the cousins would be likely to report they are in good health, similar to their cousins interstate. Despite their perception of being in good health, they would be two and a half times as likely to experience psychological distress as South Australians overall. This is the highest rate of any state or territory in Australia.

Yet the likelihood of the cousins receiving a diagnosis from a doctor of having a mental health condition would be similar to their non-Aboriginal neighbours if they lived in the metropolitan area. If they lived in a regional area, their likelihood of being diagnosed as having a mental health condition would be even lower, only one-third that of their urban cousins and non-Aboriginal neighbours.

D South Australians living in rural or regional communities

South Australia is a large state with diverse regions with different histories, geographies and economic and social strengths. Communities across South Australia therefore face varied challenges and health outcomes. Twins, a boy and a girl, born in rural and regional South Australia could therefore expect over the course of their life different health experiences than children born in metropolitan Adelaide.

...As children

Twins born today in country South Australia would join about 425,000 country residents, or about 27% of the state's population. Unlike their cousins in metropolitan Adelaide, they could expect more men in their lives than women, particularly in the northern region of the state, where men and boys are 51.4% of the population. Regardless of which region they lived in, they could expect to be part of a growing population of older people 65 and over.

The female twin could expect to live to a relatively long life, about 83.9 years—similar to her girl cousins in Adelaide, and longer than the average South Australian woman born at any time before her. The story would be different, though, for the boy. He could expect to live to 78.9, almost a year less than his counterparts in metropolitan Adelaide or across Australia.

Regardless of where they lived in South Australia, at age 5 they would be less likely to be fully vaccinated than their cousins in all states other than Western Australia, and this risk would be even more pronounced if they lived in a very remote area. When they started school, they would have a slightly lower likelihood than their city cousins of being developmentally at risk due to their physical health and well-being. During their childhood, they could expect a similar risk as their city cousins of having headaches and behavioural, coordination, developmental and learning problems. At school, if they were Aboriginal, they would have a lower likelihood of achieving the national minimum reading or numeracy standards during year 5.

...In their family

If they lived in the Murray Lands or the northern region of the state, their family would be more likely to be welfare dependent or have an income of less than about \$29,000 a year, putting them at a greater risk of poor health and educational outcomes in the short and long-term.⁷⁹ They would have about a one-in-two likelihood to think people in the community can be trusted – slightly less than their metropolitan cousins.

If the female twin chooses to have children, the average number of children she could expect to have would be higher than her cousins in the metropolitan area, at 2.23 children, compared to 1.82 if she lived in a regional or rural area. She would have a higher risk of smoking during the pregnancy than her metropolitan cousins.

...Living with chronic conditions

They would be likely to report they are in good health, though less likely to think so than their cousins living near Adelaide. They would be significantly more likely to live with two or more risk factors, like smoking or having high blood pressure or cholesterol. While they would be more likely than their cousins in metropolitan Adelaide to eat the recommended five or more daily serves of vegetables, they would be less likely to eat the recommended two or more daily serves of fruit or get enough exercise. They could also expect a higher likelihood of drinking at risky levels, obesity, high blood pressure, high cholesterol and smoking. If they were Aboriginal, they would also have a higher chance of having high blood pressure than their cousins living in Adelaide. They would be more likely to wear a hat and long-sleeved clothing than metropolitan Adelaidians, though they would be less likely to seek shade or wear sunscreen.

The increased likelihood of these risk factors have associated increased likelihoods of the twins living with chronic conditions, including multiple chronic conditions. They would have a higher likelihood of having arthritis, asthma, diabetes and cardiovascular disease. They would be slightly more likely than metropolitan South Australians to be limited due to impairment or health problem. They could expect slightly lower dental outcomes, with an average of 13.6 number of decayed, missing or filled teeth for people in country South Australia as opposed to 12.4 metropolitan Adelaide. On the positive side, they would be slightly less likely to have a doctor diagnosed mental health condition.

When the twins were older, they would be less likely to be immunised against the flu and Pneumococcal disease, potentially increasing their risk of serious complications and death after having the flu,⁸⁰ and they would be more likely than their city cousins to have a fall resulting in medical treatment or limitations.

E South Australians experiencing disadvantage

The Australian Institute of Health and Welfare has found that with as social disadvantage increases, so do less healthy lifestyles and poorer health outcomes.⁸¹ Children born in a socioeconomically disadvantaged area of South Australia could therefore expect over the course of their life different health experiences than children born in an area marked by socioeconomic advantage.

...As children

Two friends, a girl and a boy, born today in South Australia would have a higher chance of living in a socioeconomically disadvantaged area than in other states, except the Northern Territory and Tasmania. This is not surprising as South Australians' disposable income overall is one of the lowest in Australia, only surpassing that of Tasmanian households. They would have a one in five chance of living in families that are welfare dependent or had an income of less than about \$29,000 a year. If they lived in the Murray Lands or the northern region of the state, their families would be more likely to have a low income, putting them at a greater risk of poor health and educational outcomes in the short and long-term.⁸² They would have a one in five chance of living in a family experiencing financial stress, again, only less likely than Tasmania and the Northern Territory. If they were from Aboriginal families, they would have almost twice the likelihood of a child from a non-Aboriginal family of living in a family experiencing financial stress. Despite this, they would be less likely than their cousins interstate to live in a household paying 30% or more of their income on housing.

They would be more likely to have a parent unemployed than their cousins interstate as South Australia has the second highest unemployment rate of all jurisdictions. Unemployment has a close relationship with socioeconomic status, and in South Australia, unemployment was three times higher for people living in the lowest socioeconomic areas compared to those living in the highest. Similarly, they would be more likely to be born into families with no employed parents than in other jurisdictions other than Tasmania and the Northern Territory, increasing their risk of financial hardship, reduced social opportunities and overall health and well-being.⁸³

These socioeconomic factors also correlate with their ability to access resources, potentially impacting their ability to manage their health and well-being. As South Australians, they would be among the least likely of all Australians to live in a house with a computer, the internet or a motor vehicle.

If they lived in a socioeconomically disadvantaged area, they would have more than a one in three chance of being overweight or obese as a child, compared to a one in seven chance for children born to families living in the most advantaged areas. As they started school, they would have a one in three chance of being defined as developmentally vulnerable, three times higher than their friends from advantaged areas. They would also be significantly more likely to have severe behavioural problems during their childhood.

...As adults

Living in a socioeconomically disadvantaged area, as adults, they would have almost twice the chance of someone living in the most advantaged areas to have multiple risk factors, like being obese and smoking. The lower their socioeconomic status, the lower the likelihood of them believing their health is good or better. Similarly, as socioeconomic status decreases, so does the likelihood of them eating the recommended two daily serves of fruit, with those living in the most disadvantaged areas having a one in three chance of eating the recommended amount of fruit. If they lived in a disadvantaged area, they would have a significantly higher risk of being overweight or obese and having high blood pressure and cholesterol. They would also be more likely than their friends living in advantaged areas to experience psychological stress but they could expect to have a lower chance of drinking at levels causing risk in the short term.

These risk factors would have an impact on their health outcomes. If they lived in a disadvantaged area, they would have a slightly higher likelihood of limitations due to impairment or health problem. They would also be almost twice as likely to live with multiple chronic conditions and with diabetes. They would have a slightly higher likelihood of having a cardiovascular disease and being diagnosed as having a mental health condition.

1.6 South Australians – The incomplete stories

While data collection has improved, many South Australians' health status stories remain largely untold by state-level quantitative data. In particular, we know from qualitative research and our own consultations that these groups face particular health challenges which require tailored responses:

- > 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 custody.

Often we have an indication of how large these population sub-groups are in South Australia; where this is so, we've noted below in brackets the indicator from our *State of Our Health 2012*.

The information that is often missing, though, is state-wide quantitative measures of these groups' health status. Limited understanding of the impacts of physical, social and cultural aspects on people's health constrain health services' ability to plan, deliver and evaluate services which best serve the rich diversity of South Australia's people. Lack 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 seem invisible to health services.

We at the Health Performance Council think it is very important to report on these stories despite limitations in population- and state-wide health status data. These stories may have incomplete data, but they are no less important than those for which we have more comprehensive health status data.

...of South Australians from culturally and linguistically diverse backgrounds

South Australia is incredibly culturally diverse, with more than 200 culturally, linguistically and religiously diverse backgrounds represented in the state.⁸⁴

Culturally and linguistically diverse is a broad term which refers to people living in Australia whose culture is different than the dominant Australian culture. Culturally and linguistically diverse is defined in different ways in different data sets, including by:

- > Language, either first language, preferred language or language spoken at home
- > Proficiency in spoken English
- > Country of birth of an individual or of his or her parents
- > Year of arrival in Australia
- > Self-assessed race, ethnicity and cultural background, or
- > Religious affiliation.⁸⁵

A large number of culturally and linguistically diverse South Australians are migrants. One in five South Australians were born overseas. Another significant category is those who speak another language at home. One in seven South Australians do not speak English as their main language at home, with Italian, Greek, Mandarin and Vietnamese the most common non-English languages. Nearly 40,000, or 2.5%, of South Australians do not speak English well or at all.

The health of people who have settled in South Australia as refugees are another group of culturally and linguistically diverse South Australians of interest. Refugees are people recognised to be outside the country where they are nationals who are unable to return to that country due to a well-founded fear of persecution due to race, religion, sexuality, nationality or belonging to a particular social or political group.⁸⁶ The experiences leading to refugees resettling in Australia can result in unique health challenges, particularly for mental health.⁸⁷

Culturally and linguistically diverse communities face health disparities, possibly due to reduced access to health services.⁸⁸ Responding to this diversity requires culturally competent health services which:

- > proactively address barriers culturally and linguistically diverse communities face to accessing healthcare, like language barriers, lack of knowledge about available services, and previous experiences of discrimination, and
- > are flexible to tailor approaches to different communities when appropriate.

At an international level, the World Health Assembly has resolved that member states such as Australia should 'establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories' and 'devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery.'⁸⁹

Nationally, providing care that respects and is sensitive to different cultures is one of 21 agreed actions in the Australian Safety and Quality Framework for Health Care, which outlines how to improve the safety and quality of care provided in health care settings.⁹⁰

...of South Australians living with disability

People can experience many types of disabilities, including those which impact their vision, movement, remembering, learning and mental health.⁹¹ Some people are born with a disability, other people acquire a disability later in life.

One in five South Australians has a disability and one in eighteen has a profound or severe disability. Both of these rates are the second highest in Australia, with only people in Tasmania more likely to experience disability.

People with disability are more likely than people without a disability to report poorer overall health status, inadequate access to health care, and risk factors such as smoking.⁹² They are also at greater risk of secondary conditions such as injuries, pain, depression fatigue and becoming overweight.

The World Health Organization states that people with disabilities not only often face barriers accessing health and rehabilitation services, but that they may also experience a narrower margin of health,⁹³ therefore making access particularly important.

The National Disability Agreement commits the Commonwealth and all states and territories to address these barriers. In particular, the Agreement requires states and territories to address social inclusion for people with disability, to support 'an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens,' and to improve mainstream services to deliver outcomes for people with disability.⁹⁴ This includes improving continuity of care across health services for people with disability and improving supports for carers of people with disability.

...of South Australians who are carers

South Australia has the highest proportion of carers nationally. One in seven South Australians provides ongoing, unpaid care to someone with a disability, someone with long-term condition or an older person.

Women are disproportionately more likely to be carers, with this likelihood highest in women's mid-50s to mid-60s. Women are also almost twice as likely to be a primary carer than men, as 35.0% of female carers are primary carers compared to 19.6% of male carers.

For some South Australians, their role as a carer starts when they are young, with almost 4% of young men and almost 5% of young women aged 15 to 19 years old providing ongoing care to someone. The percentage is much higher for young people from culturally and linguistically diverse families, with around 13% of young people from culturally and linguistically diverse families caring for someone else. Caring can impact young people's education, relationships and employment opportunities.⁹⁵

Caring is recognised internationally as increasing an individual's risk of experiencing social isolation, a low sense of wellbeing, and poor health.⁹⁶

...of South Australian veterans

SA Health's 'Framework for Veterans' Health Care 2012-2016' defines a veteran as anyone who has served in the Australian Defence Force.⁹⁷ This includes those who served in conflicts until the 1970s, including World War II, Korea and Vietnam, as well as more contemporary veterans such as those who served in the Gulf Wars, East Timor and Afghanistan.

In March 2014 in South Australia and the Northern Territory, there were 18,178 veterans and their dependants who have a gold or white Department of Veterans Affairs medical card.⁹⁸ Generally, these are people who are ex-prisoners of war, served in World Wars I and II, are aged 70 or older and were in a conflict situation, or have a significant disability due to their service.⁹⁹

Veterans in Australia are more likely to have lower self-assessed health, higher rates of various diseases and their children are more likely to have some birth defects than the general population.¹⁰⁰ There is also a strong link between combat exposure, posttraumatic stress disorder and problems with interpersonal relationships¹⁰¹—mental health issues which can in turn impact physical health.

Although there is limited state-level data on veterans' health status, SA Health collects data on usage of its health services by whether someone uses a Department of Veterans Affairs card. This data is a valuable source, but of course, covers public health service usage only and excludes people who are ineligible or unregistered for a Department of Veterans Affairs card and those who chose not to use a card.¹⁰²

...of South Australian lesbian, gay, bisexual, transgender, intersex or queer people

The size of the lesbian, gay, bisexual, transgender, intersex and queer people population in South Australia is unknown but is estimated to range from 2% to 11% within the Australian population.

The World Health Organization states that experiences of social exclusion have a negative effect on people's health and wellbeing. Sexual and gender diverse people have a long history of stigma and discrimination. These experiences result in them being at increased risk of depression, anxiety disorders, self harm and suicide.¹⁰³

Some people's health is further compromised because they have reported delaying seeking treatment for common health conditions for fear of discrimination from health professionals.

There is a lack of population health and wellbeing data because questions about sexuality and gender identity are not commonly asked in national and state health surveys.

...of South Australians in custody

As of 30 June 2012, 2,078 people were held in prison custody in South Australia.¹⁰⁴ Of these, approximately two in five were unemployed when they were arrested and three in ten have an education level of year 10 or below.¹⁰⁵

In addition to South Australians in prison, young people aged 10 to 18 in South Australia who are involved in crime may enter the youth justice system. In 2012-13, 962 young people were held in supervision in South Australia, either in the community or in detention.¹⁰⁶

Prisoners in Australia are known to experience disproportionately poorer health outcomes, particularly in mental health. Prisoners are also more likely than the general population to do things that are known to be health risks, like smoking and using alcohol and other drugs.¹⁰⁷

What should happen to improve system data?

It is suggested that the government undertake purposeful sampling of specific population groups and routinely report on these groups on a cyclic basis.

Chapter 2: How is the health system going?

✓ Strengths ✗ Challenges

At a glance

1. Building healthy communities

- ✓ *More children are fully immunised*
- ✓ *More children are having health checks*
- ✗ Aboriginal childhood immunisation rates need to be higher
- ✗ Vaccination rates for preventable conditions like influenza and pneumonia need to be raised

2. Making it easy for people to get care

- ✓ *More people are being seen on time in emergency departments*
- ✓ *More older people are having annual health assessments*
- ✗ Financial barriers are limiting access to timely dental care
- ✗ Waiting times for public dentistry need to be reduced

3. Treating people well

- ✓ *More people are getting community follow-up in 7 days after psychiatric hospitalisation*
- ✗ Rates of potentially preventable hospitalisations for Aboriginal people need to be reduced
- ✗ The coordination of care for people waiting in hospital to access residential aged care needs to be better managed
- ✗ The rate of Aboriginal people discharging themselves from hospital care against the medical advice needs to be reduced

4. Having good outcomes

- ✓ *Cancer survival rates are getting better*
- ✓ *Infections associated with healthcare are very low and reducing*
- ✗ Open disclosure and analysis needs to achieve system safety improvements and reductions in adverse events
- ✗ The number of Aboriginal people dying from potentially avoidable causes needs to be reduced
- ✗ People's preferences for where they spend the end of their lives need to be supported by the health system

5. Working efficiently and remaining sustainable

- ✓ *South Australians are spending less time in hospital*
- ✗ The growth in health expenditure per person needs to be restrained without compromising quality
- ✗ SA's high average length of hospital stay need to be analysed and suitable strategies implemented
- ✗ The growth in acute hospital care costs needs to be restrained without compromising quality

2.1 Building healthy communities

The performance of the health system depends on the resilience of the community to meet health challenges. Preventative measures such as childhood immunisation and childhood health checks provide the foundation for ongoing good health and wellbeing into the adult years. Protective measures such as vaccination coverage amongst older people avoids unnecessary acute intervention by the healthcare system.

Under this performance domain, we considered a set of key measures that impact on community health and wellbeing.

Chart 2.1: More 5 year old children are being immunised

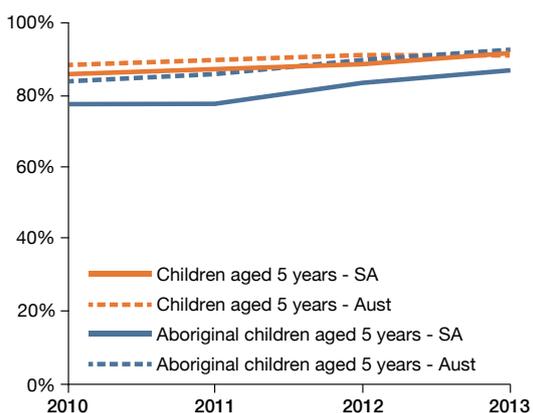
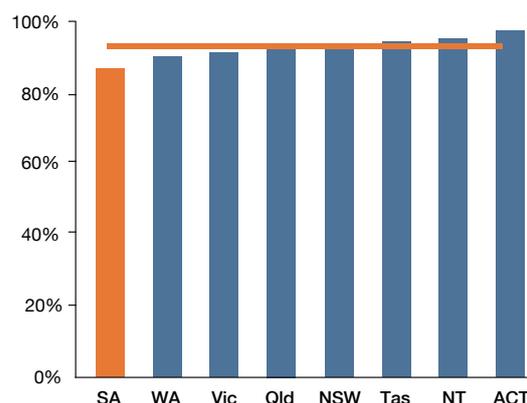


Chart 2.2: The immunisation rate for Aboriginal children aged 5 years is the lowest in Australia



Source: Department of Health, Australian childhood immunisation register 2014

Additional <i>Building Healthy Communities</i> measures	Latest SA result (year)	SA trend	Progress	Where should we be?
Five year olds fully immunised ¹⁰⁸	91.3% (2013)		Improvement	Greater than 92.0%. Best in Australia 92.8% (Tas). Australian average 91.9%
Hospitalisations of older people for vaccine-preventable conditions per 1,000 hospitalisations ¹⁰⁹	3.2 (2012-13)		Adverse increase	Back to less than 2.0 per 1,000 hospitalisations.
Vulnerable families with young children receiving sustained home visiting services ¹¹⁰	69.0% (2011-12)		No clear trend	Was 79.6% in 2009-10. The 2012-13 target was 70%.
Aboriginal clients in the statewide Family Home Visiting Program ¹¹¹	11.5% (2013)		Declining trend	Was 17.8% in 2010.
Four year olds receiving developmental health checks ¹¹²	48.4% (2012-13)		Improvement	Best in Australia 70.8% (Qld). Australian average 51.8%.

What needs attention in South Australia?

Childhood immunisation rates need to be higher so the risk to the community is reduced

RISK: Immunisation coverage that falls below 92% across a population puts at risk the protection of individuals who are not immunised, and increases the risk that vaccine-preventable diseases will spread.

In 2013, 90.6% of all one-year-olds were fully immunised, 92.4% of two-year-olds, and 91.3% of five-year-olds.¹¹³

Significant gaps remain for the Aboriginal population. In 2013, 77.5% of Aboriginal one-year-olds were fully immunised, 86.6% of two-year-olds, and 87.3% of five-year-olds. These were the lowest rates in Australia.¹¹⁴

Rates of five-year-olds fully immunised varied from 92.1% in the Northern Adelaide Local Health Network to 88.7% in the Central Adelaide Local Health Network.¹¹⁵

ADVICE: The Minister for Health require SA Health to set a performance outcome that all Local Health Networks increase childhood immunisation rates to greater than 92% by 2018, with a priority focus on Aboriginal rates.

Vaccination rates for preventable conditions amongst the older population need to be raised

RISK: Older people that aren't immunised against vaccine-preventable diseases such as influenza and pneumonia have an increased risk of being hospitalised for potentially preventable conditions.

The underlying numbers are relatively small, but we have noted a significant increase in older people being hospitalised for vaccine-preventable conditions. In 2009-10 there were 506 public and private hospitalisations of older people for diseases such as influenza, pneumonia, and other commonly vaccine-preventable diseases.¹¹⁶ This represented a rate of 1.9 per 1,000 hospitalisations in 2009-10 but has risen to 933 hospitalisations, or 3.0 per 1,000 in 2013-14.

The average length of hospital stay associated with an older person's hospitalisation for a vaccine-preventable condition in 2013-14 points to a considerable health burden on the patient, at 10.1 days.

There was also variation amongst Local Health Networks in 2013-14, from 2.2 per 1,000 hospitalisations for older people in Country Health SA and Southern Adelaide, up to 3.6 for residents in the Northern and Central Adelaide Local Health Networks.

ADVICE: The Minister for Health 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.

Vulnerable families with young children need access to sustained support

RISK: Lack of support for young children from vulnerable families may lead to poor outcomes in developmental, safety, educational, employment and health.

In 2011-12, 1,500 families received sustained home visiting services, and 69.0% were vulnerable families with young children.¹¹⁷ This is slightly below a target set at 70.0%¹¹⁸ and 10.6 percentage points below the 79.6% recorded in 2009-10.¹¹⁹

As at 30 June 2013, the statewide Family Home Visiting Program had 1,602 active clients, of which 184 (11.5%) were Aboriginal clients.¹²⁰ This is significantly down from the 17.8% Aboriginal active clients as at 30 June 2010.

In 2014-15, the service moved to the Department for Education and Child Development.

ADVICE: The Minister for Health require the Minister for Education and Child Development to set a target of 80% by 2018 for the percentage of vulnerable families with young children accepting sustained home visiting services with a particular focus on Aboriginal families.

More young children would benefit from a developmental health check before starting school

RISK: Lack of developmental health checks may lead to lifestyle risk factors, delayed development illness, and no guidance for healthy lifestyles and early intervention strategies.

In 2012-13, 48.4% of children had received a fourth-year "Healthy Kids' Check", up from 10.2% in 2009-10.¹²¹

The percentage of Aboriginal children receiving a fourth-year developmental "ATSI Child Health Check" trailed the "Healthy Kids' Check" rate at 37.8% – but has also increased significantly over the last several years.

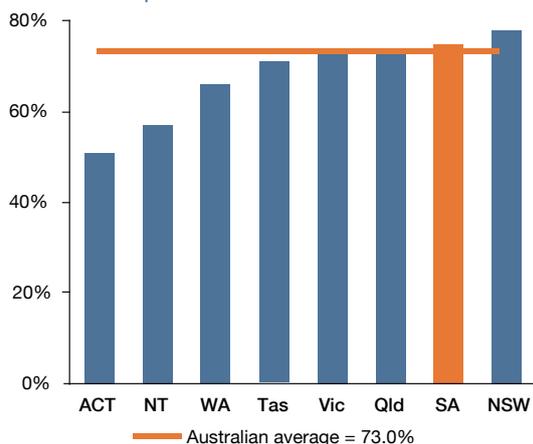
ADVICE: The Minister for Health require SA Health to work with the Primary Health Care Networks to raise the rate of all children receiving fourth year developmental checks to 70% by 2018.

2.2 Getting into the system

Access is key to the performance of the health system. People need to be able to obtain appropriate health care at the right place and right time irrespective of their income, physical location and cultural background. Healthcare costs can be a barrier to people accessing the health system when they need it. People deferring or not accessing healthcare when they need it due to waiting times or cost can also have serious flow-on effects – not just for the individual but for the health system as a whole.

Under this performance domain, we considered a set of key measures including cost and lack of timely access.

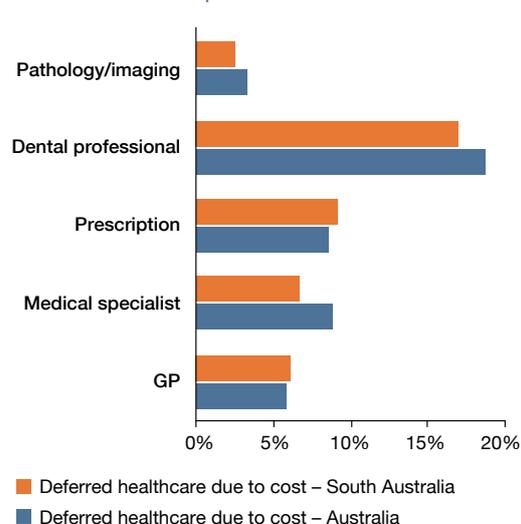
Chart 2.3: Most people attending an emergency department are seen on time



State and territory data above are from 2012-13.

Source: Productivity Commission, Report on government services 2014

Chart 2.4: Large numbers of people delay or don't see a dental professional due to cost



Source: COAG Reform Council, Healthcare 2010-11: Comparing performance across Australia

Additional <i>Getting Into the System</i> measures	Latest SA result (year)	SA trend	Progress	Where should we be?
People delaying or not seeing a dentist in the last year due to cost ¹²²	17.0% (2012-13)		Improvement	Best is 16.7% (NSW). Australian average 18.8%
Average household income per week on health expenses ¹²³	4.0% (2009-10)		Steady	Australian average 3.9%.
Older people who receive annual health assessments ¹²⁴	27.2% (2012-13)		Improvement	Best is 34.3% (Tas). Australian average 29.2%.
People who waited one month or more for public dentistry ¹²⁵	84.9% (2012-13)		Adverse increase	Australian average 69.5.
Hospital emergency department patients seen on time ¹²⁶	74.6% (2013-14)		Steady	NSW in 2012-13 was 78.0%. Australian average in 2012-13 was 73.0%.

What needs attention in South Australia?

Financial barriers that are limiting access to dental care for some people need to be addressed

RISK: Financial barriers are limiting vulnerable segments of the South Australian population in accessing appropriate, high-quality health care services.

In 2012-13, 6.1% of people delayed or did not see a general practitioner in the previous 12 months due to cost, 6.6% a medical specialist, 9.1% getting a prescription filled, 2.5% pathology or imaging, and 17.0% a dental professional.¹²⁷ During 2012-13, the proportion of people deferring access to a dental professional in the previous 12 months was higher in country South Australia (21.8%) compared to metropolitan Adelaide residents (15.6%).

ADVICE: The Minister for Health require SA Health to manage a reduction to 15% or less by 2018 of people living in country South Australia reporting delaying or not seeing a dental professional.

High out-of-pocket costs that are limiting access to timely health care for vulnerable people with long term or chronic conditions needs to be addressed

RISK: Vulnerable populations with long-term or chronic conditions avoid seeking necessary health care in a timely manner due to high out-of-pocket costs such as gap fees, private health insurance rates, and services not covered by Medicare.

In 2009-10, households spent an average \$59.25 per week on medical care and health expenses – with the majority of this amount going on accident and health insurance (\$28.27 per week), health practitioners' fees (\$15.14) and medicines, pharmaceutical products and therapeutic appliances (\$13.94).¹²⁸ In total, spending on medical care and health expenses accounted for 4.0% of the \$1,492 mean gross household income per week in 2009-10.

ADVICE: The Minister for Health require the Department for Health and Ageing investigate what actions South Australia can take to reduce household out-of-pocket medical expenditure.

The rate of older people receiving health assessments is low and needs to increase

RISK: Lack of annual health assessments for older people risk identification of health issues and conditions that are potentially preventable or amenable to interventions.

In 2012-13, over one in four (27.2%) older people received an annual health assessment. The rate has been steadily increasing, up from 22.1% in 2008-09.¹²⁹ The rate for older Aboriginal people in 2012-13 was slightly lower than the overall rate at 21.0%, but a significant improvement from the 5.9% recorded in 2008-09.¹³⁰

ADVICE: The Minister for Health 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% by 2018.

Waiting times for public dentistry need to be reduced

RISK: Lack of proper dental care is linked to prevalence of chronic conditions.

In 2012-13 more than four in five people (84.9%) on the waiting list for public dentistry had been waiting for one month or more, up from 65.0% recorded in 2011-12.¹³¹ This ranks South Australia highest in Australia, and well above the national average of 69.5%.

ADVICE: The Minister for Health direct the SA Dental Service to reduce the percentage of people who wait one month or more for public dentistry to 70% or less by 2018.

Variation in emergency department waiting times by Local Health Network and for particular population groups needs to be addressed

RISK: Long hospital emergency department waiting times lead to poor health outcomes.

In 2013-14, 73.4% of people attending emergency departments were seen on time, relatively steady compared to the 75.0% in 2012-13,¹³² but varying from 62.0% in the Northern Adelaide Local Health Network and up to 93.1% amongst the seven major Country Health SA hospitals.¹³³

In 2013-14, 67.7% of Aboriginal people presenting at emergency departments in Peer Group A and B hospitals were seen on time.¹³⁴ Rates varied by South Australian Local Health Network, from 59.2% recorded by hospitals in the Northern Adelaide Local Health Network, and up to 89.2% in the Women's and Children's Local Health Network.

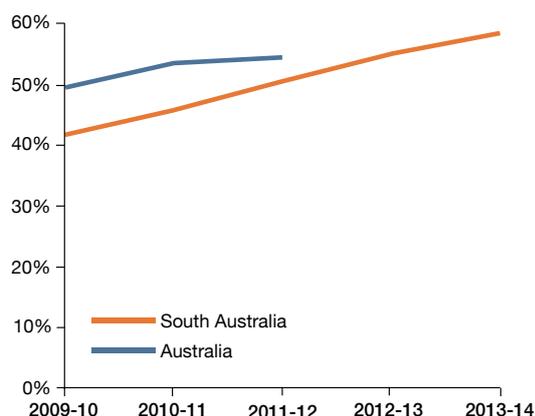
ADVICE: The Minister for Health require SA Health to set a performance outcome that all Local Health Networks increase the rate that Aboriginal people attending hospital emergency departments are seen to 75% or above by 2018.

2.3 Being treated well

Health services ideally aim to be client-oriented. People want to be treated with dignity, confidentiality, and participate in choices about their care. A high performance system provides appropriate and relevant healthcare, regardless of financial, geographic or cultural barriers. A quality health system should also provide uninterrupted, coordinated care across services over time.

Under this performance domain, we considered a set of key measures including responsiveness, appropriateness, and continuity of care.

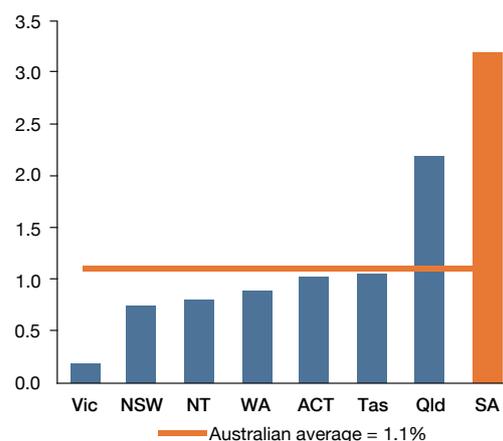
Chart 2.5: Community follow-up within 7 days of discharge after a psychiatric hospitalisation is improving



No data for Australia available for 2012-13 or 2013-14

Source: SA Health, Customised report, 2014

Chart 2.6: Too many people are waiting in hospital for residential aged care



State and territory data above are from 2011-12.

Source: COAG Reform Council, National healthcare agreement: Performance report for 2009-10

Additional <i>Being Treated Well</i> measures	Latest SA result (year)	SA trend	Progress	Where should we be?
Potentially preventable hospitalisations per 1000 people ¹³⁵	25.0 (2011-12)		Slightly improving downward trend	Lowest is 18.0 (Tas). Australian average 24.0.
Hospital patient days used by those waiting for residential aged care per 100 patient days ¹³⁶	3.1 (2012-13)		Steady but comparatively high	Lowest in 2011-12 was 0.2 (Vic). Australian average in 2011-12 was 1.1.
Aboriginal inpatients who discharged themselves against medical advice from public hospitals ¹³⁷	3.1% (2013-14)		Steady, but many times higher than non-Aboriginal rate	Non-Aboriginal rate is 0.7%. Australian average for Aboriginal people 2008-2010 (public and private) was 2.0%.
Overnight psychiatric hospitalisations with community mental health contact in the seven days following discharge ¹³⁸	58.6% (2013-14)		Improvement	Australian average in 2011-12 was 54.6%.
People not seeing a GP when they needed to as they disliked the service/professional, were afraid, or embarrassed ¹³⁹	5.0% (2011-12)	No time series data available for this measure	SA ranked highest in Australia	Lowest is 1.8% (ACT). Australian average is 3.0%

What needs attention in South Australia?

Rates of potentially preventable hospital admissions for Aboriginal people need to be reduced

RISK: Lack of effective primary and community health services leads to unnecessary hospitalisations.

In 2011-12, there were 25.0 hospitalisations per 1000 people for potentially preventable conditions – slightly above the national average of 24.0 per 1000 people.¹⁴⁰ The rate for Aboriginal people was more than three times the overall South Australian rate.¹⁴¹

ADVICE: The Minister for Health 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.

Coordination of care for older people waiting in hospital to access residential aged care needs to be better managed

RISK: Poor coordination of services between aged care providers and hospitals puts at risk the delivery of cost effective and appropriate care to older South Australians.

In 2011-12, South Australia had the highest rate in Australia of hospital patient days for people eligible and waiting for residential aged care, at 3.2 patient days per 100 patient days.¹⁴² However, in 2013-14 this had fallen to 2.1.¹⁴³ In 2013-14 the rate was highest in the Northern Adelaide Local Health Network at 6.3, and lowest in the Central Adelaide Local Health Network at 1.9 patient days per 100 patient days.

ADVICE: The Minister for Health 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.

Aboriginal people are discharging themselves from hospital care early, against the advice of their doctors, and this rate needs to be reduced

RISK: Self-discharge from hospital against medical advice contributes to poor health outcomes.

The rate of self-discharge against medical advice from public hospitals for the Aboriginal population was 3.1% in 2013-14, and up to 4.5% in Country Health.¹⁴⁴ The rate was also higher than the 2008-2010 Australian Aboriginal average of 2.0% (all hospitals, excluding hospitalisations for mental and behavioural disorders).¹⁴⁵ Just 0.8% of non-Aboriginal inpatients discharged themselves from public hospital against medical advice in 2013-14.

ADVICE: The Minister for Health 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.

Community follow-up within 7 days of discharge from a psychiatric care admission needs to be increased

RISK: Lack of follow-up visits within seven days of discharge leads to increased vulnerability for patients admitted for mental health treatment.

Over half (58.6%) of overnight separations from acute psychiatric inpatient services during 2013-14 had community mental health contact in the seven days following separation.¹⁴⁶ This is a significant increase from the 41.8% recorded in 2009-10. Rates varied by Local Health Network from 40.7% in Country Health (Glenside Rural and Remote) up to 68.7% in the Southern Adelaide Local Health Network. In 2011-12 the rate for Aboriginal people was 45.2%.

ADVICE: The Minister for Health 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% by 2018.

More people need to feel supported in seeking primary health care

RISK: People that "don't like" their general practitioner or general practitioner service, or feel embarrassed about their health issue, or are afraid to ask for help, risk delaying or avoiding essential primary care which may lead to poorer health outcomes.

In 2011-12, a small but significant percentage (5.0%) of people that did not see a general practitioner when they needed to nominated disliking the service/professional, being afraid, or being embarrassed as a reason for avoiding seeking primary health care, and was the highest rate in Australia.¹⁴⁷ The rate was almost twice as high in country South Australia (8.0%) than metropolitan Adelaide (4.5%).

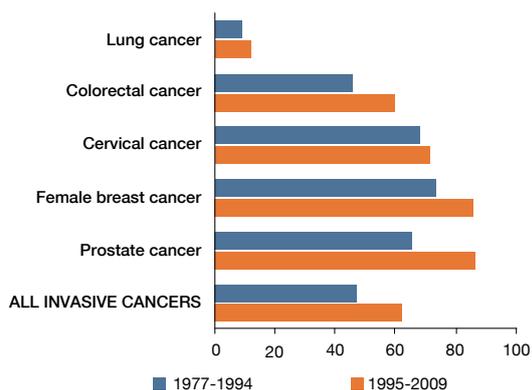
ADVICE: The Minister for Health require SA Health to work with the primary care sector to develop strategies to help people feel supported when they seek primary care.

2.4 Having good outcomes

People have an expectation that modern health care, intervention, or action achieves its desired outcome – namely that they leave the system on a path to better ongoing health. Health services need to provide care that is relevant to the client’s needs and based on established standards. It is critical that a modern healthcare system does everything in its power to reduce actual or potential harm from health care management or the environment in which health care is delivered.

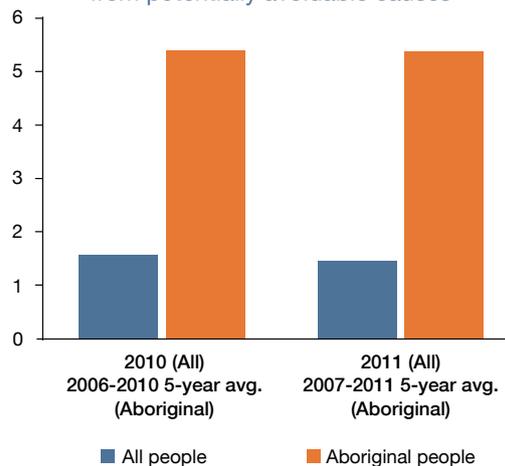
Under this performance domain, we considered a set of key measures including system effectiveness and safety.

Chart 2.7: Cancer survival rates are getting better



Source: SA Health, Customised report, 2014

Chart 2.8: Too many Aboriginal people are dying from potentially avoidable causes



Source: Productivity Commission, Report on government services 2014

Additional <i>Having Good Outcomes</i> measures	Latest SA result (year)	SA trend	Progress	Where should we be?
5-year survival rate after cancer diagnosis ¹⁴⁸	62.1% (1995-2009)		Improved compared to 1977-1994	5-year survival varies from 86.6% for prostate cancer to 12.0% for lung cancer
Number of adverse events per 100 overnight public hospitalisations ¹⁴⁹	11.4 (2012-13)		Adverse increase	Australian avg. (in 2011-12) was 10.7.
Infection of methicillin resistant and sensitive and staphylococcus aureus bacteraemia per 10,000 patient days ¹⁵⁰	0.8% (2012-13)		Positive downward trend	Australian average is 0.9%.
Potentially avoidable deaths per 1,000 people ¹⁵¹	1.5 (2011)		Signs of downward trend emerging	Australian average is 1.5.
People who die at home ¹⁵²	16.5% (2009-10)		Steady	Target is 30%-40%.

What needs attention in South Australia?

The SA Cancer Registry needs to include cancer stage as a core data item

RISK: Lack of information on the extent of the cancer at diagnosis, and an inability to follow the patient care journey through the private hospital system, makes it difficult to evaluate the effectiveness of cancer treatment.

In 2012 cancer was the leading cause of mortality and the largest contributor to total years of potential life lost in this state.¹⁵³ The 5-year unadjusted survival rate for people diagnosed with invasive single cancers during the period 1995-2009 was 62.1%, varying from 61.1% in the Central Adelaide Local Health Network to 63.9% in the Southern Adelaide Local Health Network. The 5-year survival rate for Aboriginal people for invasive single cancers diagnosed in the period 1995-2009 was statistically significantly lower than the overall rate at 42.4%, although up from 39.0% in the period 1977-1994.

ADVICE: The Minister for Health require the SA Cancer Registry to include cancer stage at diagnosis as a core item in its database, and direct SA Health to make private hospital data available to SA-NT DataLink.

Open disclosure and analysis needs to achieve system safety improvements and reductions in adverse events

RISK: Adverse events, some of which may be preventable, have a negative impact on the health of individuals and increase the need for health care service.

During 2012-13, there was an average 11.4 adverse events in public hospitals, in which harm resulted to a person receiving health care – including infections, falls and problems with medication and medical devices – per 100 overnight public hospital separations. The rate ranged from 5.0 in the Women's and Children's Local Health Network up to 15.3 in the Central Adelaide Local Health Network. The rate for Aboriginal people in public hospitals was lower, at 7.6 per 100 overnight hospitalisations.

The Health Performance Council notes that the observed increase in adverse events over the last several years could be due, in part, to initiatives that aim to encourage/improve the recording of adverse events.

ADVICE: The Minister for Health require 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.

The health system needs to maintain its progress in reducing healthcare associated infections

RISK: Failure to consistently apply a relatively small number of healthcare associated infection control and prevention measures increases the risk of longer hospital stay, additional patient suffering, and even death.

The infection rate of methicillin resistant and sensitive and staphylococcus aureus bacteraemia (MRSA & MSSA) in South Australia has seen a decline over the last four years, from 1.2 per 10,000 patient days in 2009-10 to 0.8 in 2012-13.

ADVICE: The Minister for Health require SA Health through its Infection Control Service to continue implementation of quality programs aimed at improving infection control in hospitals, and monitoring the effectiveness of new interventions.

The number of Aboriginal people dying from potentially avoidable deaths needs to be reduced

RISK: Lack of timely and effective interventional health care increases the risk of potentially avoidable death.

There has been a reduction in potentially avoidable deaths, down from 1.6 per 1,000 persons in 2008 to 1.5 in 2011.¹⁵⁴ However, the 5-year average rate for the Aboriginal population over 2007-2011 was almost four times as high at 5.4 per 1,000 population.

ADVICE: The Minister for Health require 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.

People's preferences for place of death need to be supported by the health system

RISK: Lack of support for people's preferences when terminal leads to unnecessary hospital admissions.

Of people who have a preference, 50 to 90% would prefer to die at home, yet in 2009-10 the overall rate of people who died at home was 16.5%, steady compared to the previous two financial years.¹⁵⁵ Rates by Local Health Network varied from 11.5% in the Southern Adelaide Local Health Network up to 20.9% in Country Health SA Local Health Network. Underlying numbers for Aboriginal people are small, but the percentage was much higher, at 29.7% in 2009-10, down from 36.6% in 2007-08.

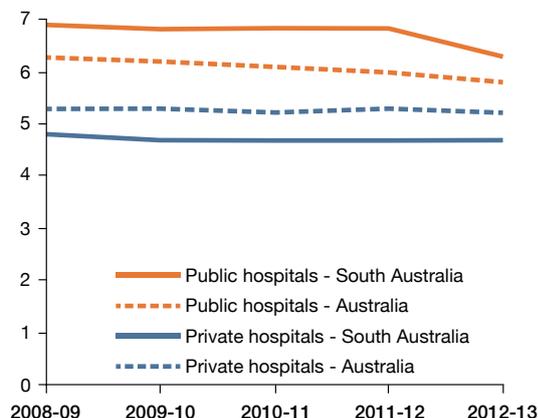
ADVICE: The Minister for Health require SA Health to develop strategies that support the community with the psychosocial and respite supports critical to helping people with a terminal illness remain at home if they wish.

2.5 Working efficiently and remaining sustainable

The community expects the highest quality health system, but one that is sustainable and that achieves its desired results with the most cost effective use of resources. This includes a capacity to sustain workforce and infrastructure, as well as to innovate and respond to emerging needs.

We considered a set of key measures related to efficiency in the short term, and sustainability in the long term.

Chart 2.9: The average length of hospital stay is falling



No data for Australia available for 2013-14.

Source: AIHW, Australian hospital statistics 2007-08

Chart 2.10: Annual growth rate in the cost per casemix adjusted separation is unsustainable



Additional All Done Efficiently and Sustainable measures	Latest SA result (year)	SA trend	Progress	Where should we be?
Total health expenditure per person ¹⁵⁶	\$6,497 (2011-12)		Increase in real terms	Min is \$5,967 (NSW); Australian average is \$6,230.
Average length of an overnight public hospital stay in days ¹⁵⁷	6.3 (2012-13)		Improvement	Min is 5.3 (Qld); Australian average is 5.8.
Average length of an overnight private hospital stay in days ¹⁵⁸	4.7 (2012-13)		Steady	Min is 4.3 (WA); Australian average is 5.2.
Employed medical practitioners per 1,000 people ¹⁵⁹	3.8 (2012)		Increase	Min is 3.3 (WA); Australian average is 3.5.
Employed nurses per 1,000 people ¹⁶⁰	16.7 (2012)	 No data for 2010	Steady	SA has the highest; Min is 11.1 (NSW); Australian average is 12.8.
Registered allied health practitioners ¹⁶¹ and dental practitioners ¹⁶² per 1,000 people.	5.3 1.0 (2012)	No time series data available for this measure		Australian average is 5.6. Australian average is 0.9.
Cost per casemix-adjusted separation per inpatient, including depreciation ¹⁶³	\$5,413 (2011-12)		Increase in real terms	Min is \$4,985 (Vic); Max is \$6,575 (ACT). Australian average is \$5,407.

What needs attention in South Australia?

Growth in health expenditure per person needs to be restrained without compromising quality

RISK: South Australia faces the risk of being unable to meet the challenge of increasing health care requirements of an ageing population.

In 2011-12 the total health expenditure was \$6,497 per person, up 4.0% in real terms from the previous financial year.¹⁶⁴ South Australia ranked third highest in Australia for total health expenditure per person, slightly above the national average of \$6,230. \$4,609 of recurrent health expenditure per person was from government funding, while \$1,647 was from non-government funding.¹⁶⁵

ADVICE: The Minister for Health require SA Health to 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.

Strategies to lower South Australia's high average length of hospital stay need to be examined

RISK: Long hospital stays add unnecessarily to hospital costs.

The average length of stay in public hospitals, excluding same-day separations, was the highest in Australia in 2012-13 at 6.3 days.¹⁶⁶ However, it fell slightly in 2013-14 to 6.0 days.¹⁶⁷ Average length of stay in public hospitals ranged from 7.4 days in the Central Adelaide Local Health Network to 4.3 in the Women's and Children's Local Health Network. Average length of an overnight stay for Aboriginal people in public hospitals was no different from the overall rate at 6.0 days.

Private hospitals recorded a lower average length of overnight stay of 4.6 days.¹⁶⁸ The average length of an overnight stay for Aboriginal people in private hospitals was slightly lower at 4.4 days.

ADVICE: That the Minister for Health require SA Health to develop strategies that will improve length of stay by identifying patients that can be better cared for in non-acute hospital settings.

Health workforce composition needs to match service models and health care needs, and be representative of the population

RISK: A workforce which is not aligned to patient populations risks being unable to provide culturally appropriate care.

In 2012, there were 3.8 employed medical practitioners per 1,000 people, above the national average of 3.5.¹⁶⁹ This compares to 16.7 employed nurses per 1,000 people again above the national average of 12.8.¹⁷⁰

In 2012, 0.2% of employed medical practitioners and 0.7% of employed nurses and midwives were Aboriginal.¹⁷¹

South Australia had 5.3 registered allied health practitioners per 1,000 people – made up largely of physiotherapists (1.2), pharmacists (1.2), psychologists (0.9), occupational therapists (0.7) and medical radiation practitioners (0.6).¹⁷²

In 2012 there were just 0.1 Aboriginal registered allied health practitioners per 100,000 people.¹⁷³

In 2012, South Australia had 1.0 registered dental practitioner per 1,000 people, including the highest per capita number of dental hygienists in Australia.¹⁷⁴

ADVICE: That the Minister for Health require SA Health 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.

Delivery of healthcare needs to be as cost efficient as possible without compromising quality

RISK: Inefficient hospital care puts at risk long term system sustainability.

Cost per casemix-adjusted separation is the average cost of providing care for each admitted patient separation, accounting for the relative complexity of the patient's condition. It is an indicator of the government's objective to deliver services in a cost effective manner. In 2011-12 the total cost was \$5,413, up 6.8% in real terms from the previous financial year and representing a total increase of 22.6% compared to the \$4,415 in 2007-08 (\$4,028 nominal adjusted to 2011-12 real terms).¹⁷⁵

Of the \$5,413 per casemix-adjusted separation, \$2,373 (43.8%) was non-medical labour costs; \$1,237 (22.9%) was medical labour costs; and \$1,642 (30.3%) was other recurrent costs. The Australian averages for non-medical labour, medical labour and other recurrent costs in 2011-12 were \$2,564, \$1,163 and \$1,477 respectively.¹⁷⁶

ADVICE: That the Minister for Health require SA Health to develop strategies and implement efficiencies that will reduce growth in cost per casemix adjusted separation to the national average by 2018.

2.6 Local Health Networks' profiles (measures for which data are available)

Cells highlighted in orange indicate areas that need attention at the Local Health Network level

Building healthy communities

Measure

Five year olds fully immunised (% , 2013).

	NALHN	CALHN	SALHN	CHSALHN	WCHN	SA
Five year olds fully immunised (% , 2013).	92.1	88.7	90.3	91.9		91.3
Hospitalisations of older people for vaccine-preventable conditions (per 1,000 hospitalisations, 2013-14).	3.6	3.6	2.2	2.2		3.0

Getting into the system

Measure

Hospital emergency department patients seen on time (% , 2013-14).

	NALHN	CALHN	SALHN	CHSALHN	WCHN	SA
Hospital emergency department patients seen on time (% , 2013-14).	62.0	66.2	69.6	93.1	89.2	73.4

Being treated well

Measure

Hospital patient days used by those waiting for residential aged care (per 100 patient days, 2013-14).

	NALHN	CALHN	SALHN	CHSALHN	WCHN	SA
Hospital patient days used by those waiting for residential aged care (per 100 patient days, 2013-14).	6.3	1.9	2.9	3.2		2.1
Aboriginal inpatients who discharged themselves against medical advice from public hospitals (% , 2013-14).	2.8	1.8	2.2	4.5	0.4	3.1
Overnight psychiatric hospitalisations with community mental health contact in the seven days following discharge (% , 2013-14)	54.9	50.3	68.7	40.7	62.8	58.6

Having good outcomes

Measure

5-year survival rate after cancer diagnosis (% , 1995-2009).

	NALHN	CALHN	SALHN	CHSALHN	WCHN	SA
5-year survival rate after cancer diagnosis (% , 1995-2009).	61.8	61.1	63.9	62.0		62.1
Number of adverse events (per 100 overnight public hospitalisations, 2012-13).	11.6	15.3	14.3	6.1	5.0	11.4
People who die at home (% , 2009-10)	14.0	11.8	11.5	20.9		16.5

Working efficiently and remaining sustainable

Measure

Average length of an overnight public hospital stay (days, 2013-14).

	NALHN	CALHN	SALHN	CHSALHN	WCHN	SA
Average length of an overnight public hospital stay (days, 2013-14).	5.5	7.4	6.6	4.8	4.3	6.0

Chapter 3: How engaging is the health system?

At a glance

- > There has been significant work to improve engagement capability across SA Health but evidence is lacking of the uptake of engagement tools and a common approach. This unnecessary variation has led to differences in the community's experience engaging with the health system.
- > Central, accessible documentation regarding engagement processes and their impact is lacking. It is therefore difficult to assess the degree to which the system has learned from previous processes or how feedback is used to improve the health system.
- > SA Health has improved its data collection for inbound feedback and begun proactively seeking information about inpatients' experiences. It has also taken the positive step of making some of this information public.
- > Engagement of specific population groups, particularly Aboriginal South Australians, continues to lack the attention and resources it requires.

3.1 Background

Under the *Health Care Act*, we are tasked with advising the Minister for Health about 'the effectiveness of the methods used within the health system to engage communities and individuals in improving their health outcomes.'¹⁷⁷

'When health professionals, managers, patients, families and carers work in partnership, the quality and safety of healthcare rises, costs decrease, provider satisfaction increases and patient care experience improves.'¹⁷⁸

Australian Commission on Safety and Quality in Healthcare

During our 2010 review, we found that although SA Health had made positive steps through developing its Consumer and Community Participation Guideline and Policy, improvements could be made. In particular, we found that

- > engagement as a method of achieving strategic directions had not been robust nor effective
- > stakeholders reported limited access to information on how the system reviews and improves services
- > a strategic approach was lacking to relationships with community organisations and others despite sporadic examples of engagement
- > SA Health had focused on providing training for consumers to participate in committees but engagement was not a core enabler for health systems.

We committed to reviewing the effectiveness of the implementation of the Consumer and Community Participation Policy and Guideline. In particular, we said we would look for evidence of 'a more robust, timely, participative and equitable approach.'¹⁷⁹

For this review, we engaged with stakeholders to understand their perspectives on engaging with the health system. We then looked at SA Health's commitments and other available evidence, like data on feedback received and surveys of hospital inpatients.

3.2 Engagement is happening – but to what effect?

In preparation for our second review of the health system, we consulted in 2011 and 2012 with a diverse range of stakeholders like community groups, clinicians, health system managers, and Health Advisory Councils. From this consultation, it was clear that engagement is an important issue for health consumers and the community.

We spoke to stakeholders in more detail about their engagement with the health system in 2014. We wanted to hear how well they feel they are engaged and their perceptions of engagement processes. We invited comment from Health Advisory Committees and the sixteen bodies prescribed in the Health Care Regulations 2008, which collectively represent the organisations most relevant to the health sector.

We also issued an open invitation for community members who had wanted to give feedback or had actually given feedback to the South Australian health system in the last 12 months to let us know what they thought about health system engagement.

Some stakeholders said they had wanted to provide feedback to the system but did not because they did not know how, they thought their comments would not be taken seriously or they would be treated differently.

‘The community wants to be heard, respected and an integral part of the process.’

Community/volunteer organisation

Of respondents who had provided feedback in the previous year, 70% had participated on a health board or committee. Nearly 50% said they had completed a survey and 2 in 5 said they had given a compliment, complaint or suggestion. Most people (75%) provided their feedback about a public health service or a government department, committee or Minister (50%). Similarly, most people directed their feedback to a public health service (62.5%) or a government department, committee or Minister (62.5%).

Respondents were just as likely to be satisfied that their feedback was respected and taken seriously as they were to be dissatisfied. These responses indicate experiences of giving feedback vary significantly.

An area with more similar perceptions was the impact of feedback. On average, respondents were slightly dissatisfied that they had the impact they wanted. Some respondents expressed frustration that consultation opportunities have not led to outcomes or changes.

Some people who did provide feedback to the health system had concerns that their feedback was dismissed and that responses took too long. Similarly, the lowest level of satisfaction about the engagement process was letting people know how their feedback was used. Twice as many people indicated engagement processes did not satisfactorily let people know how their feedback was used than those who said they were informed about how their feedback was used. Multiple stakeholders commented that people consulted are not told how input is used.

We are often unsure of what elements of our feedback [to SA Health] have been acted upon unless we actively enquire or seek this information... Two things we would greatly appreciate and can be improved upon would be:

- > To be notified of and provided a copy of SA Health’s formal response to such reports out for consultation
- > To receive a response from the relevant area of SA Health indicating what elements of our feedback will be acted upon and other outcomes or information relevant to our comments or concerns.’ –Australian Medical Association (South Australia)

Likewise, many stakeholders complained that if they received a report back, it was not in a reasonable timeframe. Letting consultation participants know their input has been considered is a critical part of engagement; without this step, participants may question the genuineness of engagement.

SA Health invites comment from interested organisations, clinicians and the general public on a variety of reviews and other consultation processes. We asked stakeholders about their awareness of the public consultations SA Health had conducted in the previous 12 months. Generally, respondents said they were aware of the individual consultations or that the consultations were not relevant to them. For four individual consultations, though, 25% or more of respondents said they were not aware that consultation had occurred but that the subject was relevant to them. This suggests SA Health may need to improve its promotion of engagement opportunities. In particular, comment was made that engagement with general practitioners and with mental health services could be improved.

Overall, respondents were satisfied that engagement processes had a clear purpose and adequate resources. There were positive comments regarding the convenience of surveys, but also some concern that feedback processes could be restrictive and not community friendly.

- > 'Feel that the outcome of the process often didn't drill down into "now what" and then what changes can be made and will be made.' –Community member
- > 'Documents are very large, contain acronyms and jargon, and take a lot of time. Some feedback forms restrict feedback.' –Community/volunteer organisation

Despite these frustrations, most respondents stated they were extremely likely to recommend providing feedback about the health system to a friend or colleague.

3.3 SA Health's policies have improved

In August 2009, SA Health released a 'Consumer and Community Participation' policy and guideline. They were superseded in 2013 by the 'Framework for Active Partnership with Consumers and the Community Policy' and accompanying Guideline. The Framework expands on the previous policy, for example, by defining 'consumers' and to whom the Framework applies. The definition of 'consultation' has improved to include early engagement, not only seeking views before making a final decision.

Health should... not mistake information provision as consultation.'
Not for profit organisation

The new Framework includes principles regarding the importance of partnering with consumers and the community. The Framework also states that data from consumer feedback, complaints and consumer experience surveys are to be used to improve health services.

The Framework is accompanied by a guideline. The previous guideline contained little information and practical advice. The revised guideline is based upon the work of the International Association for Public Participation, which is internationally recognised as promoting good engagement practice. The new guideline is a wide-ranging introduction to consumer and community engagement. It includes examples of when and how engagement should be conducted, steps to conduct engagement, checklists, project planning templates, examples of engagement methods, and examples of how to report on National Safety and Quality Health Service Standard 2, 'Partnering with Consumers.'

The Framework has broad coverage. It incorporates the Australian Safety and Quality Framework for Healthcare and also includes engagement of consumers, the broader community and sub-communities. Local Health Networks are required to report annually on implementation of the Framework.

These documents were updated to align SA Health policy with the Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service Standards. The standards aim to create nationally consistent expectations about health services and were developed in consultation with states and territories, technical experts, other organisations, and individuals, including through open public consultation.

National Safety and Quality Health Service Standard 2, 'Partnering with Consumers,' requires systems to support partnering with patients, carers and others to improve the safety and quality of care. It details three main criteria, namely partnership in service planning, in designing care, and in service measurement and evaluation. It has four 'core' actions (which must be met) and eleven 'developmental' actions (which do not need to be fully met but require some activity).

The 2013 National Safety and Quality Health Service accreditation assessments, found SA Health's Local Health Networks had not met many of the developmental actions related to engaging consumers, namely:

- > Standard 1 regarding patient rights and engagement
- > Standard 2 regarding partnering with consumers, and
- > Standard 9 regarding communicating with patients and carers.

While these actions were considered developmental in 2013, they are elements of the national standards and they have been identified as critical to good health care.

SA Health's Framework and Guideline are clear improvements. As tools to improve engagement capability, they are an important element to creating a more robust approach to engagement. Yet there is no evidence of how frequently and how well these documents are being used across SA Health.

In addition, SA Health lacks a centralised way to conduct engagement and does not demonstrate a strategic approach to relationships with community organisations. Stakeholder feedback suggests significant variation in the approach, communications and quality of engagement processes across Local Health Networks.

This decentralised approach also means there are no consolidated, accessible records of previous engagements. The lack of records of previous processes, what was learned from them, and their impacts on the health system is a significant barrier to improving engagement practices.

'Use the networks that exist... Advertise widely... Report back to participants.'
Community/ volunteer organisation

Despite lacking a centralised approach, we were hopeful the SA Health Partnering with Consumers and the Community Advisory Group would drive improvement in engagement. This group has strategic oversight of coordination and monitoring of SA Health's work to partner with consumers.¹⁸⁰ It has representation from the Health Consumers Alliance SA, Health and Community Services Complaints Commissioner, consumers, each Local Health Network and the SA Health Safety and Quality Unit.

We note that the SA Safety and Quality in Health Care Consumer and Community Advisory Committee was abolished in November 2014. This committee provided advice to the SA Health Council on Safety and Quality in Health Care which is also slated to be abolished in 2014¹⁸¹ SA Health has plans to implement a different engagement model in 2015.

Without effective community and consumer oversight, we are not confident SA Health will be able to ensure the robust, timely and participative approach we identified in 2010 was needed. Quality engagement requires design and appropriately-trained staff. Some central coordination, as is done with communications by SA Health's Media and Communications Branch, is necessary to ensuring consistent quality in engagement.

3.4 SA Health receives a lot of feedback

SA Health's Safety Learning System maintains a database of all the feedback including advice, compliments, complaints and suggestions it receives from consumers and the community.

In 2013-14, SA Health recorded 9794 instances of feedback. Central Adelaide and Country Health SA Local Health Networks received the most feedback, with more than half of feedback directed at them.

Over the four years, the three most frequent subjects were access, communication and treatment issues, each which were approximately 15% of all feedback in 2013-14.¹⁸² It is noted that complaints are the only consumer feedback record which require the subject of the feedback to be recorded.

Most feedback is acknowledged within 48 hours



When stakeholders provide feedback, they expect prompt acknowledgment. SA Health has a target of acknowledging 80% of feedback within 48 hours. Although it has consistently met its target over the last four years, its overall rate of acknowledging feedback within 48 hours has reduced slightly from 95.1% in 2010-11 to 92.7% in 2013-14. There was some variation across Local Health Networks in 2013-14, ranging from 90.0% of feedback acknowledged within 48 hours in Country Health to 96.0% in the Southern Adelaide Local Health Network.

The type of feedback least likely to receive prompt acknowledgement in 2013-14 was that provided via SA Health's website, with only 84.8% of website feedback acknowledged within 48 hours. Given the community's expectations of quick responses to online feedback, the 48 hour response rate for this method of feedback should be higher. Across all feedback types, it is unlikely that the target is driving improved customer service, particularly given that SA Health has consistently far exceeded it.

'So far I haven't had any feedback [about my complaint]. Answer letters/emails promptly and let the person providing feedback know how far their complaint has progressed.'

–Community member

'The private hospital replied to my letter immediately. The public hospital took nearly two months to respond to my letter of complaint. Respond quickly and if [you] can't, let people know of the progress.'

–Community member

Most feedback SA Health receives is via the telephone (31.1%) and feedback form (21.8%). It also receives quite a few letters (18.5%) and emails (13.2%), which have more than doubled since 2010-11. Proportionally, the percent of in-person feedback has decreased significantly, from 23.5% of feedback in 2010-11 to only 9.3% in 2013-14. The method of feedback varies across Local Health Networks, with Central Adelaide and Northern Adelaide more likely to receive feedback via telephone, with nearly half of their feedback via phone.

3.5 Satisfaction with hospitals

In addition to the data about inbound feedback captured by the Safety Learning System, SA Health has commissioned the South Australian Consumer Experience Surveillance System since 2010 to survey inpatients regarding their experiences in public hospitals. This system uses standards created by the Picker Institute Europe, a non-profit with expertise in measuring patient experience.¹⁸³ Its protocols allocate scores of between 0 for the least desirable outcomes to 100 for the most desirable.

The survey measures the satisfaction of a sample of approximately 2,000 people annually who are 16 years old or older and who have been inpatients in South Australia.¹⁸⁴ While this survey is a positive move, it excludes anyone who is of Aboriginal or Torres Strait Islander descent or was hospitalised for more than 35 days or admitted for maternity, psychiatric, substance abuse, or chemotherapy or dialysis treatment. Given the high hospital admission rate of Aboriginal South Australians, their exclusion from the survey in particular is a concern.

Overall, most inpatients are satisfied with their experience. In 2010-11 and 2011-12, the survey asked how satisfied people were the overall quality of the hospital service.¹⁸⁵ Both years, more than 84% of people said that they were satisfied or very satisfied. In 2013, this question was changed slightly to ask how people would rate the care they received.

Most inpatients are satisfied overall



8.4/10

Source: Measuring consumer experience:
SA public hospital inpatient annual report 2013

Again, more than eight of every ten patients were satisfied, with 88.2% of patients rating the care good or very good.¹⁸⁶ Similarly, about nine in every ten people surveyed would recommend the hospital where they were treated to a relative or friend across all three years.

South Australian hospitals score well in most areas, with six of the eight domains of care consistently scoring average or better. Being treated with respect and dignity, privacy and pain control consistently scored above average. Three were consistently average: doctors, nursing and cleanliness.

Two areas consistently scored between below average and average: consistent and coordinated care and being involved in decision making. Patients' responses indicate that work and monitoring are needed in these areas. These concerns were also themes from our own consultations with stakeholders in 2011.

Two additional domains were added to the survey 2012: food and discharge information. Both of these areas scored poorly, with former inpatients rating them below average, indicating these areas require immediate action. In particular, patients felt there was not enough help from staff to eat meals and that there was not enough written information provided when leaving hospital.

Overall, while we have noted improvements in engagement practices over the last four years, particularly in engagement policy, we have also identified there continues to be the potential for significant improvement in engagement practices. SA Health could quickly create a more consistent and higher quality system for engagement through a central point of contact for units across the public health system wishing to engage with the community, consumers and stakeholder organisations. This would:

- > provide a central point for providing engagement tools and advice
- > contribute to continuous improvement by documenting engagement processes and outcomes
- > create a strategic approach to relationships with the South Australian community and other related sectors and
- > link SA Health's engagement practice with whole of government efforts to improve community engagement.

Chapter 4: Specific areas of focus during 2011-2014

At a glance

4.1 End of life care in South Australia

In 2013 we found that:

1. People with chronic, terminal conditions are under-recognised by health services as entering the end of life stage. Better identification would improve care and reduce costs.
2. Many people are not confident that clinicians will respect their wishes. Effective promotion of the value of Advanced Care Directives is needed.
3. The capability of the generalist workforce to provide quality end of life care needs enhancement.
4. Partnerships between the health and other sectors are needed to improve access to end of life services including access to equipment, pharmacy and after hour's advice and support.
5. More accessible psychological and respite supports are required. There is a lack of services for culturally diverse populations.

4.2 Aboriginal health in South Australia

In 2014 we found that:

1. Some health service areas are succeeding in reducing the population health status differences between Aboriginal and non-Aboriginal people but the gap remains a significant challenge
2. Concerted system efforts are assisting many Aboriginal people to achieve health gains but significant numbers are still missing out.
3. More Aboriginal people are accessing the right health care but the health system must do more to provide respectful, safe, relevant health services.
4. Aboriginal people are underrepresented in the health sector workforce and this needs to be addressed as a matter of urgency.

4.3 Mental health in rural and remote South Australian communities

In 2012 we found that:

1. 1 in 6 South Australians has a diagnosed mental health condition and there isn't much difference between the city and the country. However mental health risks and poor outcomes are much higher in some country areas, like the Mid North and the Far North and West.
2. Rural and regional South Australians are half as likely to seek help for mental health issues. Promotion and early intervention are critical.
3. People in country South Australia receive less services, like alcohol and drug services, community mental health services, specialised psychiatric care in hospital, and follow-up for mental health in the community. It's no surprise they are admitted to hospital for mental health issues more.
4. Mental health crisis care and infrastructure have improved. Continuity of care and workforce competence and sustainability remain challenges.
5. Actively involving communities will be the foundation of most efficiently meeting these challenges. The valuable knowledge of Health Advisory Councils could be better used.

4.4 Effectiveness of Country Health Advisory Councils

In 2011 we found that:

1. Country Health Advisory Councils were an active and vital link between communities and their health services.
2. Country Health Advisory Councils were promoting the general interests of local communities to the health system, although promotion of the interests of specific population groups was limited.
3. Country Health Advisory Councils had a low profile in the community and their efforts were not well supported or promoted by the health system.
4. Satisfaction with the governance arrangements between country Health Advisory Councils and the local health services from the perspective of community members, Health Advisory Councils and local health service staff was low.
5. The quality of communication and collaboration processes between country Health Advisory Councils and the health system was variable across South Australian country communities.
6. Health Advisory Councils needed additional resources and time to achieve the profile necessary for promoting community interests.
7. Health Advisory Council relationships with the health system worked best where everybody understood and valued the strategic nature and scope of the relationship.

4.1 Improving end of life care in South Australia

Why?

On 2 July 2013, the Minister for Health and Ageing, Hon Jack Snelling MP, asked us to work with the Palliative Care Clinical Network to review the *Palliative Care Service Plan 2009-2016* (the Plan). The terms of reference were to identify areas that have not progressed and why.

The Plan sets out a comprehensive agenda to redesign health system capacity to deliver on end of life care needs for all South Australians. The redesigned services were intended to increase support for people to be cared for in the community and their own homes by generalist and specialist services.

What did we find?

There are several components of good end of life care – meeting the community’s expectations of access to quality end of life care services, providing caring and compassionate experiences for patients and their families, and effectively focusing health system resources. The health system and the community have much to gain by a renewed focus on end of life care, and the opportunity to do so presents itself with the impending implementation of the *Advance Care Directives Act 2013*.

A. Death in South Australia

Cancer and diseases of the circulatory system, like heart attack and stroke, are South Australia’s leading causes of death, followed by respiratory disease, external causes and mental and behavioural disorders.¹⁸⁷ Hospital, aged care facilities, and private homes are the three most common places of death in South Australia.

Over the last several years, there has been a downward trend in deaths in hospital, with a corresponding increase in deaths in aged care.¹⁸⁸ Men are more likely to die in hospital than women, as 50.4% of men who died in 2010-11 died in hospital compared to 42% of women. Men are also more likely to die in a private home, at 21%, compared to 12% for women. Women are more likely to die in an aged care facility, with 37% of women dying in aged care facilities, compared to 21% of men.

There is also a correlation between a person’s residence and the likelihood of dying in hospital. South Australians living in Adelaide are the least likely to die in a hospital, with the likelihood increasing with their residence’s distance from Adelaide.¹⁸⁹

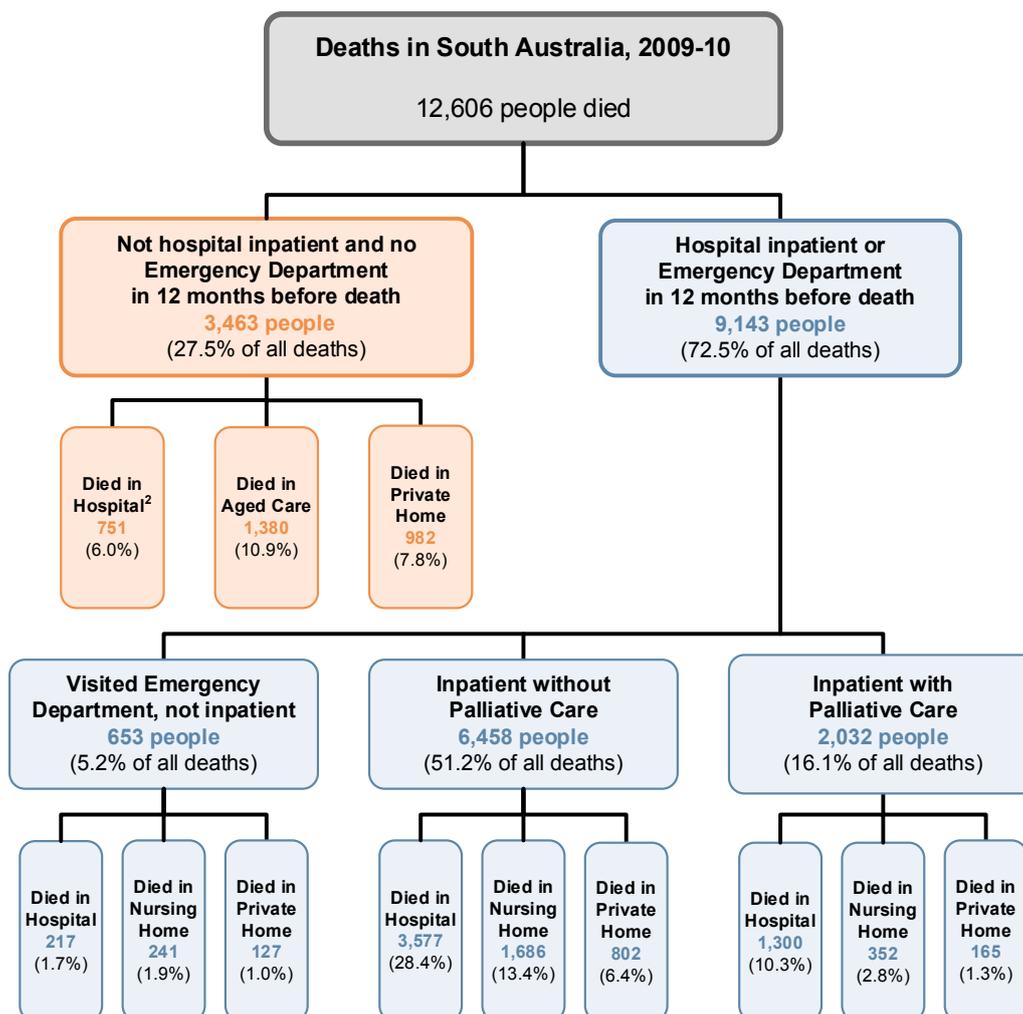
B. End of life care in South Australia

The vast majority of South Australians who die do not receive inpatient palliation in the twelve months before their death.¹⁹⁰ With the prevalence of chronic disease continuing to grow, it is clear that end of life care is core business across the health system. Yet there is a lack of established end of life pathways for most diseases other than cancer. Dementia in particular was frequently mentioned as a terminal illness for which patients do not receive appropriate palliative care.

In South Australia in 2009-10, the vast majority of palliative care separations were for someone who had cancer, higher than the 76% nationally.¹⁹¹ Cancer patients are much less likely to be admitted to intensive care units, and if they are, they stay there for less time.¹⁹² They are also less likely to receive ventilation.

South Australians whose cause of death was respiratory disease are more likely to present to public emergency departments and receive acute care. The data suggest that those with end-stage respiratory disease are either less likely to be identified as being at end of life or that protocols are not in place to support a transition to a palliative approach once it is recognised they are at the end of life.

Chart 4.1: Most South Australians go to hospital before they die but are not identified as palliative



Source: AIHW, Australian hospital statistics 2007-08

C. Palliative care services in South Australia

Despite projections that palliative care service use would soar with the ageing of South Australia's population, it has not. Palliative care-related separations grew on average 1.5% per year between 2005-06 and 2009-10,¹⁹³ less than half of the 4% growth of all hospital separations.¹⁹⁴

Inpatient palliative care in South Australia is also growing slower than Australia-wide, with national average annual growth between 2005-06 and 2009-10 at 6%.¹⁹⁵ Growth across individual Local Health Networks (LHNs) has also remained rather stable since 2001.¹⁹⁶

There have been shifts in palliative care inpatient separations between hospitals, though. Since 2006-07, as planned, there has indeed been a decrease in palliative separations at the Lyell McEwin Hospital, offset by a similar increase at Modbury Hospital.¹⁹⁷

In 2011-12, palliative care bed days accounted for 2% of South Australian hospital bed days.¹⁹⁸ While the average length of stay of a non-same day palliative care hospital separation in 2011-12 was 12.8 days, it is similar to the 2009-10 Australian average of 12.6 days for palliative stays.¹⁹⁹

For the small population of palliative care patients in hospital, the burden of procedures is also small. In 2011-12, inpatient palliative care accounted for 1.5% of all hospital ICU hours and 1.4% of all hospital ventilation hours.²⁰⁰ There has been a shift in the proportion of palliative inpatients receiving allied health interventions as their principal procedure in hospital during the life of the Plan. This increase coincides in a reduction in imaging, such as CT scans, which may indicate a more palliative approach being taken.

Outside of hospital, there were 3,867 Medicare-subsidised palliative medicine specialist services in South Australia in 2010-11.²⁰¹ This equates to a rate of 170.8 per 100,000 people, lower than the national average of 191.0. South Australia has the second highest rate of PBS palliative-related prescriptions, at a rate of 160.5 prescriptions per 100,000 people, much higher than the national average of 128.9.

In 2009, South Australia had 1.0 full-time equivalent of palliative medicine physicians per 100,000 people, slightly above the national rate of 0.8.²⁰² At that time, South Australia's rate of palliative care nurses was also higher than the national average, with 29.7 palliative care nurses per 100,000 people, compared to 20.5 nurses per 100,000 people nationwide. Unlike most other states, South Australia's number of palliative care nurses has decreased since 2007.

It appears that some Local Health Networks are resourced with palliative care staffing below the recommended levels in the Palliative Care Australia's Service Provision Planning Guide.²⁰³ Resources are stretched further as Local Health Networks also support a regional area, each with at least four other services.

D. The Palliative Care Services Plan

We assessed the Plan itself by considering its goals against its initiatives. The Plan was predominately found to be logical, indicating that successful implementation should lead to its stated outcomes. This assessment of the Plan's value was strongly echoed by a range of people throughout the review.

The only frequent concern about the Plan was expressed by clinicians, who were concerned that funding changes may erode the Plan's potential achievements in 2013-2016. Though the Plan is coherent in its goals and initiatives, it lacks clear accountability.

What can be improved? *

Against the Plan's intentions and the service activity associated with end of life care, we assessed areas where the system could be more effective. We found action needs to be taken in the following areas:

A. Increase identification of the end of life stage

Chronic diseases lead to a large proportion of deaths, yet people with chronic, terminal conditions are under-recognised by health services as entering the end of life stage. We advise that SA Health should explore factors which contribute to under-identification of people as being at the end of life and seek to increase recognition of the end of life stage

People who have not been identified as palliative spend significantly more time in the ICU. Better identification of people as being near the end of life would reduce ICU use, saving the public health system up to \$13 million per year. Improved end of life protocols could reduce reliance on intensive care that does not provide quality of life for people with end stage diseases.

A comprehensive strategy to address the end of life needs of people with dementia and their families would reduce unnecessary distress from early diagnosis to the end stages of the disease.

B. Make Advanced Care Directives work

The *Advance Care Directives Act 2013* is a positive move, but not enough to create change on its own. Implementation of the Act requires effective systems and efforts to increase community confidence, such as:

- > Creating public awareness about completing an advanced care directive, partnering across sectors to support South Australians to complete directives, and encouraging people to include it in their Personally Controlled Electronic Health Record.
- > Educating clinicians about the Act and encouraging them to complete a directive themselves.
- > Developing systems to allow clinicians and paramedics to easily access directives.
- > Developing, implementing and resourcing a clinical planning system with decision-making protocols to support clinicians to make good end of life decisions.

C. Do what was intended

Some areas of the Plan have stalled or not commenced; for these areas, renewed effort by the SA Health is required. In particular, governance and accountability for the Plan are generally weak and resources are not clearly allocated. All areas of the Plan should have someone responsible for their progress.

Another part of the Plan that can be quickly improved is the visibility and development of the Palliative Care Services Network. The Network should aim to engage and inform Network members while expanding its reach among clinicians and other clinical networks. In addition, reporting systems for palliative and end of life care are disjointed. The Network should consider the feasibility of statewide palliative care services.

Service delivery arrangements are variable. Coordination of care remains a challenge between primary care, aged care and specialist services. The capability of the generalist workforce to provide end of life care in community, aged care, and hospital settings needs to be enhanced. The structure of specialist palliative care services should be refined and resourced to deliver equitable state-wide services and support to generalist services.

D. Work better together

A renewed focus is required on partnering with the aged care, not-for-profit and private sectors to ensure seamless transitions within and across sectors, maximise personal choice and best use resources.

Improvements in access to equipment, pharmacy and after hours' supports will increase congruence between peoples' desired and actual place of death.

E. Put people first

Psychosocial and respite supports are critical to help people with a terminal illness stay at home if they wish but there is significant confusion about who is to provide this care. We advised SA Health to explore ways to reduce carer fatigue, including by advocating for improved and more flexible respite arrangements.

Improved planning for South Australia's diversity is required, particularly for Aboriginal and culturally and linguistically diverse populations. Firstly, Country Health SA should develop an Aboriginal palliative care service in Port Augusta as committed to in the Plan. Secondly, SA Health and the Palliative Care Services Clinical Network should work with appropriate community organisations to improve end of life responses for diverse populations. We also advised that SA Health should actively recruit staff from diverse populations, train all staff in cultural sensitivities and continue to promote its 'Aboriginal Cultural Respect Framework'.

Want to know more? 

Want to see more data? Keen to read all our recommendations? Check out 'Improving End of Life Care in South Australia' at www.HPCSA.com.au/reports.

4.2 Aboriginal health in South Australia

Why?

In our 2008-2010 review of the health system, we found Aboriginal health outcomes were unacceptable and access was limited to culturally appropriate services.²⁰⁴ Our consultation with community and clinicians in 2011-12 highlighted that there had been very little progress and continuing challenges. We therefore again reviewed the health system's response to Aboriginal health during 2011-2014.

What did we find?

A. Low birth weight and immunisation

Aboriginal women in South Australia are twice as likely to have a low birth weight baby as non-Aboriginal women and are less likely to receive antenatal visits. Yet system efforts have resulted in some improvements, with low birth weight among South Australian Aboriginal babies decreasing and antenatal visits increasing over the last five years. Positive outcomes for mothers and babies are good example that four actions create results for Aboriginal health: setting a target, respectfully engaging Aboriginal people, resourcing initiatives, and monitoring and reporting outcomes.

The South Australian immunisation rate for Aboriginal children is the lowest of all jurisdictions, with nearly one in four Aboriginal five year olds not vaccinated as recommended. SA Health has termed the low rate 'a significant community risk.' Some efforts have been made to improve the rate, but they seem limited compared to the extent of this gap and it is too early to know their impact.

B. System structures

Identifying Aboriginal people is the foundation upon which the health system can measure its achievements, monitor existing need and identify emerging trends. Yet not all Aboriginal people are correctly identified as Aboriginal when they go to hospital, with nearly one in ten Aboriginal people not identified as such in public hospitals. SA Health has made improving Aboriginal identification a priority goal to be achieved by mid-2013. It provided staff training in 2010-11 and 2012-13 as a strategy to meet this goal, but it is unclear the scale of the training or how effective it may have been. There is no evidence of ongoing plans to try to improve identification.

Local implementation plans were supposed to be developed in 2010 to detail how SA Health's Aboriginal Health Care Plan 2010-2016 would be implemented across regions. The local plan created and implemented by the Women's and Children's Local Health Network is comprehensive. Four years into a six year plan, South Australia's other four Local Health Networks have not produced an implementation plan. Although there was activity related to Aboriginal health in these areas, it is difficult to determine what overarching goals these Local Health Networks are trying to achieve for their populations without plans.

C. Respectful, safe, relevant health services

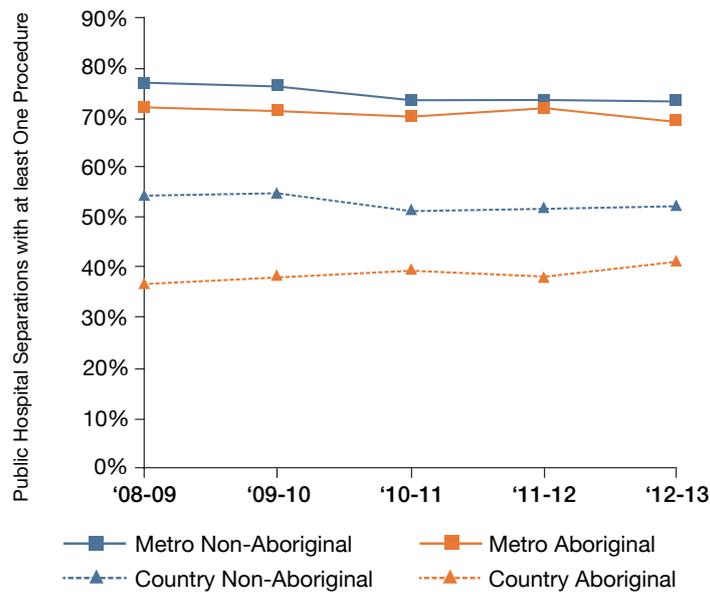
SA Health has clear commitments to provide culturally competent services. Yet there is limited evidence of widespread implementation, monitoring, and evaluation of the degree to which services are culturally competent. For example, SA Health has committed to providing access to a traditional healer for patients who request one. While 1 in 13 Aboriginal South Australians say they have accessed a traditional healer in the last year, there is no evidence of how many people have accessed traditional healers through SA Health.

Effective management of long term illnesses reduces risk of complications. Very few Aboriginal South Australians have chronic disease management plans, despite chronic disease being the major cause of morbidity and mortality for Aboriginal people. The rates are significantly lower than the national average.

When they go to a hospital, Aboriginal people are significantly less likely to receive a medical or surgical procedure. Admissions without appropriate procedures are an inefficient and unfair use of resources.

Patients leaving hospital without being officially discharged by doctors is a clear but indirect measure of whether people's expectations are being met, such as whether they feel they are receiving quality care which will lead to good outcomes. Aboriginal South Australians discharge from hospital against medical advice more than four times more often than non-Aboriginal inpatients and there's been no noticeable change over the last five years.²⁰⁶ The rate is particularly high in country regions.

Chart 4.2: Aboriginal people receive less procedures, particularly in country areas



Source: Integrated South Australian activity collection database, Health information portal, October 1999 - February 2014

D. Drug, alcohol and tobacco use

Cross-departmental efforts to reduce harm to Aboriginal people from drug, alcohol and tobacco use seem to be having some impact but it is not enough.²⁰⁷ Aboriginal South Australians are more likely than non-Aboriginal South Australians to go to emergency departments for alcohol and drug related reasons and this rate has not improved in the last four years. Concerted efforts with Aboriginal communities must continue to reduce the impact of substance use.

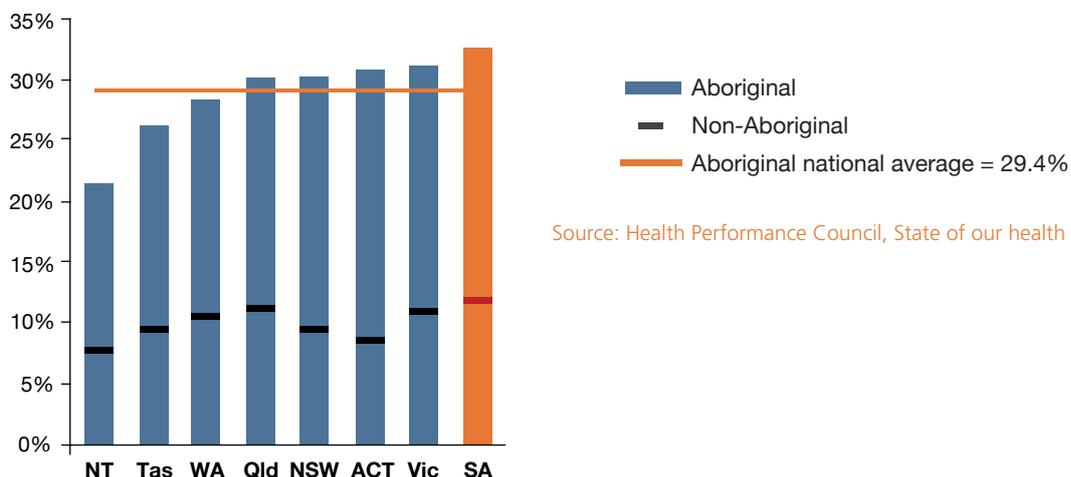
Smoking rates for Aboriginal South Australians have reduced from 47% in 2007-08 to 40% in 2012-13 but remain much higher than rates for non-Aboriginal people. While this reduction is positive, it is unlikely the South Australian’s Strategic Plan target to reduce smoking among Aboriginal people to 23.5% of the population will be met by its deadline of 2018.

E. Mental health

Psychological distress is a major concern for Aboriginal communities. The rate of high to very high psychological distress among Aboriginal South Australians is nearly three times the rate of South Australians overall and the highest of any Australian jurisdiction.²⁰⁸

Although Aboriginal people are accessing mental health services at relatively higher rates than non-Aboriginal people, less than half of Aboriginal people hospitalised for psychiatric reasons receive follow-up in the week after leaving hospital. A concerted effort across the health system is needed to continue to make gains.

Chart 4.3: One in three Aboriginal South Australians are experiencing psychological distress—The highest rate in Australia



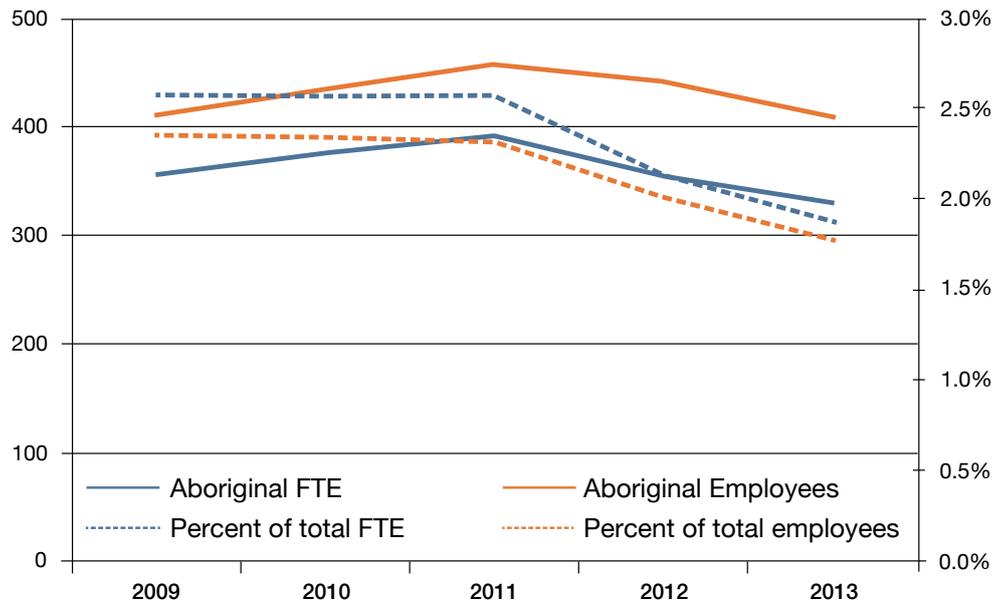
Source: Health Performance Council, State of our health – May 2013

F. Employment

National and international research has shown that Aboriginal employment by health services is a key enabler to improve Aboriginal population health, yet Aboriginal people are underrepresented in the health industry.

Aboriginal employment at SA Health has decreased since 2011. SA Health has not met South Australia’s Strategic Plan target for 2% of its workforce to be Aboriginal across all classification levels by 2014. Aboriginal employees at SA Health are also less likely to work part-time or have an ongoing contract than non-Aboriginal employees.²⁰⁹

Chart 4.4: Aboriginal employment has decreased across SA Health



Source: SA Health, Customised report, 2013

A barrier to monitoring this important contributor to Aboriginal health is accurate and complete recording of employees’ Aboriginal status in the public sector. The Aboriginal status is unknown for nearly half of SA Health employees. There is significant variation between Local Health Networks, ranging from 27% to 80%.

Outside of the public health sector, the Aboriginal community-controlled sector is a very important part of the health care system for Aboriginal people. It provides primary care to more than half of South Australia’s Aboriginal community with a small number of staff. The private health sector employs a very small number of Aboriginal employees but does well identifying its workforce’s Aboriginal status.

A. Provide early intervention

Some health service areas achieve better results than others for Aboriginal people. All health services should first aim to reduce variation between service areas when planning and setting targets for Aboriginal health.

SA Health's efforts to provide culturally-appropriate antenatal supports, like the Aboriginal Family Birthing Program, must continue. This program has demonstrated it contributes to creating a healthier future for Aboriginal South Australians.

The low rate of Aboriginal immunisation is one of the most significant challenges to the South Australian health system. Efforts are required by local governments, Medicare Locals or their successor, community-controlled services and public clinical services to work together to close the gap in immunisation rates.

B. Close the gap in services

Identification rates of Aboriginal people in public hospitals could be improved by re-establishing strategies which have been successful to identify Aboriginal consumers in a culturally appropriate way. SA Health can also improve its responses to Aboriginal South Australians by ensuring all Local Health Networks have quality implementation plans and monitor the implementation of Aboriginal Health Impact statements.

Chronic disease is the biggest cause of sickness, injury and death for Aboriginal people. Better health outcomes could be achieved by raising the rate of Aboriginal South Australians with chronic disease management plans to the national rate.

The high rate of Aboriginal patients discharging themselves from hospital against medical advice requires urgent attention. Local Health Networks should check this rate at each of their hospitals to find problem areas then work with Aboriginal leaders to find solutions.

Psychological distress and its impact on mental health are a major issue for Aboriginal South Australians. Local Health Networks can better address this need by taking the steps recommended in the 'Summary Report: Statewide Aboriginal Mental Health Consultation July 2010' and improving rates of follow-up after people leave hospital for psychiatric treatment. SA Health should also implement strategies to reduce the difference of between the procedures Aboriginal and non-Aboriginal people receive in hospital.

C. Better involve Aboriginal people in health care

Genuine engagement of Aboriginal people across the planning, delivery and evaluation of health services will improve Aboriginal population health. Employment of Aboriginal people by health services must also increase.

The first step is to improve identification of employees, particularly in Local Health Networks with very low levels of identification. SA Health should then take actions to improve representation of Aboriginal people in its services, including by making sure Aboriginal-identified positions are lost and working with universities to make pathways for existing enrolled nurses to become registered nurses.

Want to know more? 

Want to see all our recommendations? Eager to see who we consulted? Check out the full 'Aboriginal Health in South Australia 2011-2014: A Case Study' at www.HPCSA.com.au/reports.

Hungry for more data? See our compilation of what is measured about Aboriginal health status, 'State of Our Health: Aboriginal Population Compendium' at www.HPCSA.com.au/reports.

4.3 Mental health in rural and remote South Australia

Why?

When we asked country Health Advisory Councils what the most important issue was for rural and regional SA, they consistently said mental health. We responded by reviewing mental health outcomes and mental health services in country South Australia.

What did we find?

A. Mental health outcomes

The World Health Organization defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.²¹⁰ Good mental health is important not only to individuals, but also families, communities, the economy and South Australia as a whole.

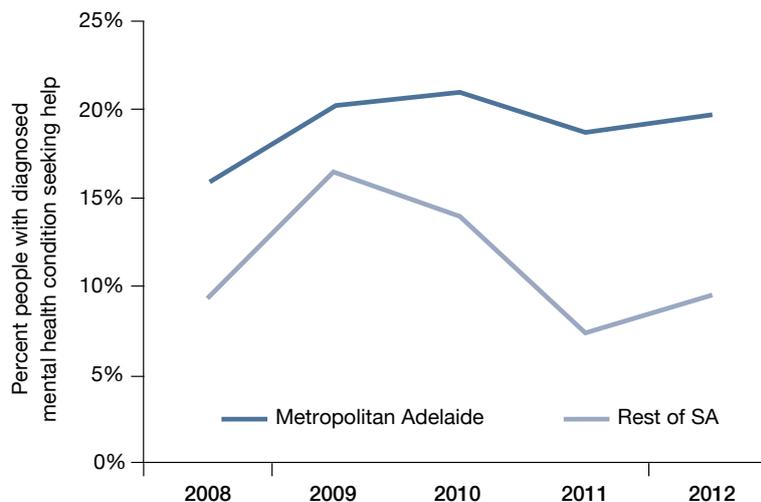
Nearly a third of South Australians live outside the Adelaide area, and the population is growing.²¹¹ A simple comparison between metropolitan and country areas masks the diversity and complexity of country South Australia’s experiences. Although a simple split between metropolitan and country South Australia does not show a large difference in the percentage of people with a mental health condition, on many indicators, mental health indicators in some regions of country South Australia lag behind their metropolitan counterparts. The severity of risk factors and outcomes is particularly evident in some areas, like the Northern and Far Western and the Mid North regions. Both areas have twice the rate of mental health conditions than the rest of the state.²¹²

B. Mental health services

In our 2010 report, *Reflecting on Results*, we noted that SA Health committed to provide appropriate services closer to where people live. It was too early in 2010 to assess service developments in rural and remote communities so we decided to have another look at it. We did just that during this case study. We heard from country residents that investments in infrastructure have improved effectiveness and patient experiences for mental health crisis care.

Yet gaps still exist. Lack of knowledge about what services are available and how to access them is a barrier for some country residents, and this is compounded by stigma and a culture of self-sufficiency. This is even more keenly experienced by specific populations, particularly Aboriginal and culturally and linguistically diverse people.

Chart 4.5: Country South Australians seek help half as often

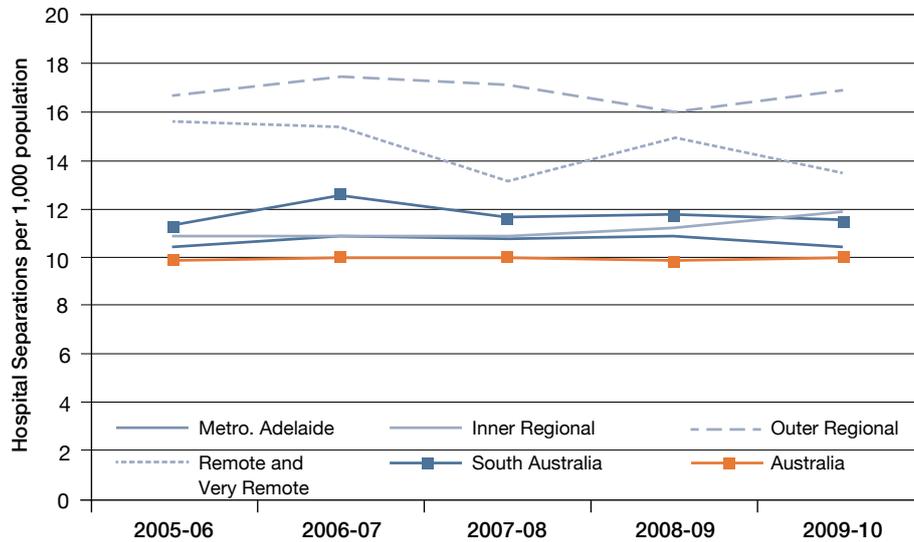


Source: SA Health, Customised report, 2013

Rural and regional South Australians are less likely to get early help for mental health issues due to stigma a culture of self-reliance. They are half as likely to seek help if they know they have a mental health issue.²¹³ They also access community mental health services²¹⁴ and alcohol and drug services less.²¹⁵

Given the relative lack of other mental health services, it is not surprising that rural and regional South Australians are admitted to hospital at higher rates for mental health issues.²¹⁶

Chart 4.6: Rural and regional South Australians are admitted to hospital more for mental health

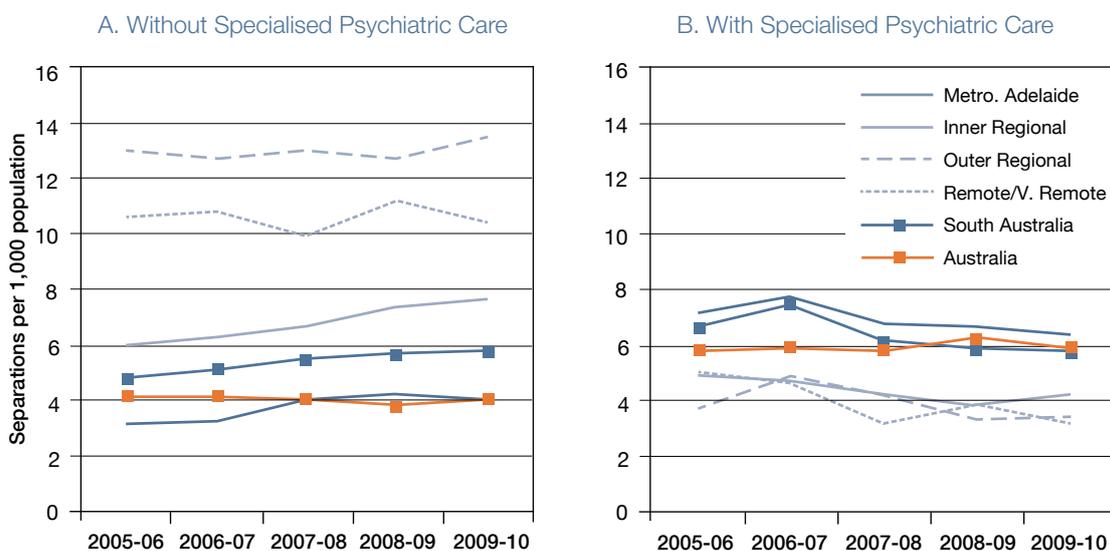


Source: AIHW, Customised report, 2013

Once admitted to hospital, rural and regional South Australians are much less likely to receive specialised psychiatric care.²¹⁷ Nearly 80% of people from outer regional areas who visit hospital due to mental health issues do not receive psychiatric care—twice the percentage of metropolitan Adelaidians and Australians overall who are admitted for mental health reasons.

When released, rural and regional South Australians receive less follow-up. In 2011-2012, country South Australians who were admitted to hospital for mental health reasons were 26% less likely to receive follow-up within a week of being discharged.²¹⁸ Only two in five country residents receive this follow up; the national target is 75%.

Chart 4.7: Rural and regional South Australians receive less psychiatric care in hospital



Source: AIHW, Customised report, 2013

While 26.9% of South Australian inpatient mental health expenditure goes to country residents' health, specialist outpatient services are clearly metropolitan-centric.²¹⁹ Of outpatient psychiatry funding, 99.4% is spent in metropolitan hospitals, with psychology outpatient also metropolitan-centric, with 97.2% going to metropolitan hospitals.

C. Aboriginal mental health

We found in our 2010 report that reducing the gap in health outcomes for Aboriginal people, including for mental health, remained a significant challenge. We said that we would evaluate the effectiveness and cultural responsiveness of health services for Aboriginal people in 2014. Our in-depth look at this issue is in Chapter 4 (4.2), but we also considered culturally responsive services for this case study.

We found Aboriginal South Australians are nearly four times more likely to experience high and very high psychological distress than non-indigenous South Australians. Nearly two in every five (37.1%) of Aboriginal South Australians in the Adelaide area are experiencing psychological distress,²²⁰ compared to only one in every ten of all Adelaidians.²²¹ In regional areas, rates are lower, with only 27.2% of Aboriginal people experiencing high psychological distress,²²² compared to 7.8% of country South Australians overall.²²³ Between 2001 and 2010, Aboriginal South Australians committed suicide twice as often as non-indigenous South Australians.²²⁴ Of the five jurisdictions that reported data, South Australia recorded the second highest Aboriginal suicide rate.

People consulted for this study perceive that the lack of culturally competent services prevents people from accessing the services they need. The South Australian Public Advocate has made similar comments, noting culturally safe and accessible mental health services are needed and that progress in improving Aboriginal mental health outcomes has been "painstakingly slow".²²⁵

What can be improved?

A. Early intervention

There is limited evidence of the health system identifying mental health needs in rural and regional areas before they reach a crisis point. Yet promotion of services available and support of people to access them is critical to the system being responsive to country South Australians. In some cases, we found insufficient early intervention led to preventable mental health deterioration and crises.

General promotion of mental health awareness is necessary to address the stigma in seeking mental health care, even if outcomes may be difficult to measure in the short term.

B. Improved access

In 2010, we found that SA Health committed to reform mental health care but that evidence was lacking of a system-wide approach, improved access and inter-agency coordination.

In this study, we found that the less-tangible elements of the country patient journey need refinement to ensure continuity of care, such as after hospital discharge and transfer between services. Implementation of a system-wide strategy is needed to ensure continuity of care for regional and remote patients and to prevent country patients from falling through the cracks.

C. A sustainable workforce

An adequate and well-supported workforce—both generalist and specialist—is critical to supporting South Australians' mental health as well as the health system's efficiency and sustainability. Limited numbers of general practitioners and allied health professionals, an under-represented number of non-government providers, and an ageing workforce in rural areas create a fragile and unsustainable workforce. In the long-term, recruitment and retention will be key.

In the short term, preparing existing staff who do not specialise in mental health to respond to patients with mental ill health is essential to improving patients' experiences and reducing demand on the system. Country Health SA delivers some training to non-specialist staff to build knowledge to better respond to patients with mental ill health, such as Aboriginal Mental Health First Aid training. It seems many communities would welcome such training to be expanded.

D. Local solutions

Through our review, we found Health Advisory Councils have considerable, valuable knowledge of local communities' perspectives, health outcomes and service needs. Their knowledge was corroborated by academic literature and data about health outcomes and service delivery.

Active contribution of individuals and communities will be the foundation of most efficiently meeting the challenges we have identified. It is not only a question of if communities are consulted, but also the quality of consultation and the depth of its impact on health services.

Want to know more? 

Need more data? Interested in our methods? Want to see who we consulted? Check out the full 'Mental Health in Rural and Remote South Australian Communities' at www.HPCSA.com.au/reports.

4.4 Effectiveness of Country Health Advisory Councils

Why?

Under the *Health Care Act 2008*, the South Australian Government abolished all hospital boards and established 41 Country Health Advisory Councils 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 Health Advisory Councils 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 Health Advisory Councils and relevant hospital/s from the perspective of the members of the Health Advisory Councils, the local community, and the hospital
- > 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.

What did we find?

A. Effectiveness of Health Advisory Councils in promoting the interests of local communities

The Health Advisory Councils were established to discuss health issues, priorities and needs within their communities and advocate on behalf of the community with Country Health SA.

Since 2008, Health Advisory Councils and local health services had been working together on the development of local health services plans. These draft plans were completed in mid-2010 and submitted to Country Health SA.

The review identified examples of sound working relationships between some Health Advisory Councils, local communities and local health services. Within these relationships local health needs were identified, advice provided by Health Advisory Councils to the health services, and relevant collaborative projects undertaken to improve the health system infrastructure and health care processes. These outcomes were considered by all parties to indicate the Health Advisory Councils were successful in promoting local interests of the community.

However within a significant number of the relationships between other Health Advisory Councils, local communities and health services, the review found that successful engagement was not evident despite these relationships operating for three years. In these instances the effectiveness of Health Advisory Councils in promoting community interests was considered by all parties to be inadequate.

B. Satisfaction with the governance arrangements

The country health governance arrangements were set up to maintain a strong link between Health Advisory Councils and local health services so that each Health Advisory Council can advocate on behalf of their communities and provide advice to the Minister for Health and the Chief Executive of SA Health through Country Health SA. Health Advisory Councils also had the right to go directly to the Minister for Health if they wished.

We surveyed how satisfied Health Advisory Councils and local community members and local health services were with these arrangements. Survey responses from community, Health Advisory Councils members and local health service staff indicated low satisfaction levels. In particular, there were significant negative responses about the communication and decision-making processes of Country Health SA.

C. Health Advisory Councils contributions to local health services

Review of Health Advisory Council annual reports and draft local health service plans supported the conclusion that Health Advisory Councils are an active and important link between local communities and health services.

We discovered that several Health Advisory Councils successfully engaged in targeted fundraising activity to provide their local health services with additional resources. This was a major workload undertaken within limited resources by volunteer Health Advisory Council members. In this way Health Advisory Councils have continued the long history of country community support and advocacy for local health services despite their actions being largely unnoticed by the community.

We concluded that there was considerable variety in the capacity of the 41 Health Advisory Councils when it came to participating in the improvement of local health services, for example, providing advice, fundraising, participating in senior workforce recruitment processes, health and health literacy promotional events, and advocacy for general and specific population health needs.

Where Health Advisory Councils responded strongly to participation opportunities and their value to the health system was affirmed locally, they appeared to be more positive about their role into the future, despite frustrations with the limitations of bureaucratic processes.

What can be improved? *

Our report concluded with the following suggestions for strengthening country Health Advisory Councils as a critical and significant community engagement mechanism of the health system with local country communities:

1. Health Advisory Councils and local health services to develop joint local community engagement action plans inclusive of strategies for specific population groups, with Health Advisory Councils undertaking annual monitoring of implementation outcomes.
2. Country Health SA Local Health Network Health Advisory Council Inc to clarify its ongoing relationship with Health Advisory Councils.
3. For Country Health SA to consider:
 - a. Regularly promoting to the wider country communities the value of Health Advisory Councils to the health system including members' contributions during 'Volunteer Week'
 - b. Equipping Health Advisory Councils to participate in the monitoring of impacts of implemented local action and state-wide clinical network plans
 - c. Increasing the transparency of decision-making to country communities and the contribution of Health Advisory Councils to these processes
 - d. Clarifying its ongoing relationship with Aboriginal Health Advisory Committees.

Want to know more?

Want to see all the survey results? Eager to see who we consulted? Check out the full 'Review of Country Health Advisory Councils' Governance Arrangements' at www.HPCSA.com.au/reports.

Appendices

1. Review process

How the Health Performance Council selected its evaluation measures

A thorough understanding of what the current South Australian population looks like, its health status, and emerging trends in these areas was the evidence base we used in our evaluation of the health system's performance.

Part I: The evaluation framework

In considering how to evaluate South Australian health system performance, we built our assessment on the five pillars below, which were adapted from the National Health Performance Framework.

“Building Healthy Communities”

The performance of the health system is founded on the resilience of the community to meet health challenges through protective and preventative measures such as health checks and immunisation.

“Getting Into the System”

Access is key to the performance of the health system. People need to be able to obtain appropriate health care at the right place and right time irrespective of income, location and cultural background.

“Being Treated Well”

A high-performing health system is client-oriented. People must be treated with dignity, confidentiality, and encouraged to participate in informed choices about their care.

“Having Good Outcomes”

People have an expectation that their health care, intervention, or action achieves its desired outcome – that is, they leave the system on a path to better ongoing health.

“All Done Efficiently and Sustainable”

The community expects the highest-quality health system, but one that is sustainable and that achieves its desired results with the most cost effective use of resources.

We recognised early on in its 2011-2014 review process that it wouldn't be possible to evaluate and report on every single quantitative measure relating to the health system performance, and still provide a coherent story for decision-makers.

Part II: Consultation

So we embarked on a consultation process, engaging with SA Health, Aboriginal leaders, clinicians, health system managers, community representatives – including culturally and linguistically diverse community leaders, Medicare Locals, the Health Advisory Councils, and other expert stakeholders. We wanted to understand the issues of concern to key interested parties about the South Australian health system's performance, and base our advice to the Minister for Health in a way that is reflective of the views of people right at the coalface of healthcare.

Stakeholders were invited to provide their views via surveys, specific consultation forums hosted by us, meetings, and phone interviews. These consultations proved invaluable in highlighting a common set of concerns and revealed broad agreement that we cover in our review:

- > System monitoring of health outcomes, patient experiences, and system outcomes
- > Effectiveness of services across the care continuum for all
- > Safety and quality impacts of service gaps and access delays on clients, carers, and vulnerable population groups
- > Barriers for specific vulnerable population groups resulting in needs not being adequately met within a culturally safe care environment

- > Quality of continuity and continuum of care relationships and structural linkages between health sectors and other agencies
- > The impact of socio-economic, geographic and systemic barriers on access to the health system
- > Resource allocation between preventative and treatment services and more focus on involving community stakeholders in efficiency / sustainability discussions.

Part III: Data audit and shortlisting of priority measures

We then conducted a thorough investigation of a wide range of nationally reported system performance data containing South Australian context and comparison that described trends over time, differences between geographical areas, and a focus on specific population groups wherever possible. It was then out of this larger dataset, and in ongoing engagement with stakeholders including SA Health, that we were able to shortlist a relatively small set of key representative health system performance measures to report on as priorities. These included areas identified in our inaugural 2010 review for follow-up, especially around disparities in Aboriginal health service outcomes. From this priority list, one improvement and one challenge has been highlighted as a focus under each domain.

A focussed evaluation of these key priority measures, improvements, and challenges formed the basis for our advice to the Minister for Health for improving the performance of the South Australian health system.

Part IV: Strengths and limitations in the Health Performance Council's system performance measures

We used only high quality data sources and every effort has been made to ensure that data used reflects source material. However, data custodians referenced throughout the report are primarily responsible for the quality, accuracy, validity, and consistency of their own information.

In addition, all data have limitations – in their collection, definitions and assumptions. Even the most comprehensive data collection will still be unavoidably more simplistic than the complexity of the South Australian health system. While the measures throughout Chapter 2 are intended to reflect the system performance, this collection of indicators is by necessity limited in scope.

2. Health Performance Council Members and Secretariat

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End notes

- 1 ABS, 'Table B04: Age by sex, ', Census of population and housing, Basic community profile, South Australia, cat no. 2001.0, ABS, Canberra, 2012, viewed 10 July 2012, <[http://www.censusdata.abs.gov.au/CensusOutput/copsub.NSF/All%20docs%20by%20catNo/2011~Community%20Profile~4/\\$File/BCP_4.zip?OpenElement](http://www.censusdata.abs.gov.au/CensusOutput/copsub.NSF/All%20docs%20by%20catNo/2011~Community%20Profile~4/$File/BCP_4.zip?OpenElement)>.
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