Southern Adelaide-Fleurieu-Kangaroo Island (SAFKI) Medicare Local

Comprehensive Needs Assessment

2014 Report

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Executive Summary

This Comprehensive Needs Assessment (CNA) has been developed to support the development of a clear picture of key population health issues and needs that prevent our communities from achieving optimal physical, mental and social wellbeing. The information collated as part of the CNA forms the foundation for determining priorities for action in the SAFKI Medicare Local region.

Building on the population health planning foundation established at SAFKI Medicare Local to date our needs assessment approach has been developed utilising the principles from:

» *the 'Medicare Locals Comprehensive Needs Assessment' Framework (DoHA, Sept 2013)*

» *IAP2 Public Participation Spectrum; and*

» *'Developing Healthy Communities' process.*

Detailed information regarding the CNA process can be sound in Section 1 of this report.

The specific techniques to collate relevant information to inform the 2014 CNA has included:

1. Examination and synthesis of a range of existing population, health status and service data as well as any other relevant published information
2. Invited opportunities to comment through the your health your voice your choice community awareness and marketing campaign (incorporating southern metro bus backs 10/2/14-6/3/14, promotional material in targeted locations, local media, paid advertising, twitter and website) promoting:
   - 'Have Your Say' Postcard
   - 'Have Your Say' survey form
   - 'Have Your Say' e-survey via www.yourhealthvoicechoice.com.au
   - 'Feedback, compliments & complaints' via our Anonymous Feedback | Medicare Local
3. Conducting a range of small (Focus) Group Discussions regarding patient experiences
4. Encouraging direct contact via local Community Events (Marion Shopping Centre, Kangaroo Island Field Days, Flinders Uni O'Week, Flourishing on the Fleurieu)
5. Facilitating proactive input through our SAFKI Medicare Local Community Connections Events (Kangaroo Island, Hackham & Strathalbyn)
6. 'Connecting with Primary Health Care Practice' 2014 eSurvey and follow-up General Practice themed visits
7. Targeted ConnectIN (individual PHC provider membership) invitation for participation
8. Linking in with the Southern Adelaide Health Alliance (SAHA) projects
9. Building proactive partnerships through Public Health Planning Activities with Local Government
10. Priority setting and response activity Think Tanks.

Executive Summary cont.

Building on the 2012 Needs Assessment Report, the following themes have been identified as areas of need, key issues and gaps in the SAFKI Medicare Local region (presented in alphabetical order and detailed in 'Our Health' profile documentation (available upon request), as well as *Tables 3 and 4* in Section 2 of this report):

- Aboriginal Health and Wellbeing
- Aged Care
- Allied Health
- Chronic Disease
- Community Development
- Cultural and Linguistically Diverse Health Services
- Dental Services
- Disability
- Funding
- General Practice
- Health Literacy
- Health Services Information
- Mental Health
- Obesity
- Palliative Care
- Pharmacy
- Primary Care Workforce
- Service Coordination and Communication
- Sexual Health
- Tourists
- Transport

No key issues/needs were excluded in the shortlist for *Table 4* (as stated above presented in Section 2 of this report) with the view that a facilitated Think Tank process would provide identification of criteria for decision making and prioritised needs and activities for 2014-15.

Key to our CNA approach were 'Think Tanks' for setting priorities for the work of SAFKI Medicare Local in 2014-15 based on consideration of the results of the CNA were developed to facilitate internal staff and external ConnectIN member's participation (details are presented in Section 3 of this report).

Unfortunately, due to a lack of registrations from the 161 ConnectIN members invited, the second Think Tank session was cancelled. Nonetheless, our focus shifted to input from our Leadership and Advisory Group (LAG) that comprises up to 15 members including GPs, Practice Nurses, Pharmacists, Allied Health Professionals, and Consumers to provide a regular, independent, focus group and advisory group function to SAFKI Medicare Local.

The 'internal' staff Think Tank was conducted on Friday 2 May 2014. Thirteen (13) staff covering all areas of the organisation at a range of levels participated in the 3 hour workshop that resulted in the identification of eight (8) potential priority issue/need areas for the organisation to target and a range of relevant strategic activities for 2014-15.

The revised 'external' LAG Think Tank to comment on priority recommendations was held Tuesday 6 May 2014.

The outcomes from these Think Tanks (and appropriate CNA documentation) were presented to our Clinical and Community Governance Committee for consideration, comment and documentation endorsement (7 May 2014). This included identification of the most important issues/gaps/areas of need for targeting to

Executive Summary cont.

improve health and reduce inequalities in the SAFKI Medicare Local region for 2014-15 as being (in alphabetical order):

1. Aboriginal and Torres Strait Islander (ATSI) Health and Wellbeing
2. Ageing Population
3. Cultural & Linguistically Diverse (CALD) Population
4. Disability Services Support
5. Mental Health
6. Obesity
7. Palliative Care
8. Primary Health Care Workforce Support & Wellbeing

Response themes across these areas above encompass:

- Health Information & Health Literacy
- PHC Service Information, Coordination & Delivery
- Quality and Safety in PHC
- Early Intervention & Disease Prevention
- PHC Strategy & Development

Please refer to *Table 6* (in Section 3 of this report) for further information regarding issues/needs and strategies to address them.

Section 4 of this report describes our approach in the 2014 CNA to confirm the priorities for action in 2014-15.

In addition to Clinical and Community Governance consideration and comment on the above priority areas and responses, a validation process was conducted via Survey Monkey for key members of SAFKI Medicare Local (Board, LAG and Staff) to indicate their support or otherwise of the eight (8) proposed priority areas and responses in 2014-15.

The results have confirmed the following priority issues/needs as:

- Aboriginal and Torres Strait Islander (ATSI) Health and Wellbeing
- Ageing Population
- Mental Health
- Primary Health Care Workforce Support & Wellbeing

with strategic activities for these areas involving:

1. Support services for keeping people well and out of hospital
2. Leading better primary health care through service information, coordination, integration and delivery
3. Driving better quality and safety within primary health care services
4. Delivering better health information and improved health literacy
5. Advancing frontline primary health care support services

A follow-up Senior Management session was held.

Where possible and appropriate, responses to shortlisted needs/issues (from Table 4 in Section 2) are aligned to the activities in the 2014-15 Annual Plan where we are able to build upon existing achievements and partnerships in recognition of the transition of Medicare Locals to Primary Health Networks (PHNs) in the near future.

Executive Summary cont.

Overall, the 2014 CNA process concludes with the critical next steps including:

- Delivery of a comprehensive communication strategy in partnership with key messages to community members, GPs, primary health care providers and other key stakeholders regarding outcomes from the Medicare Local Review and Federal Budget announcements (13 May 2014).
- Process evaluation that results in population health planning submission/s to our Quality Committee and relevant documentation review and updates to inform any future PHN.

Further, measuring success of the implanted strategies involves:

1. Formal monthly reporting and quarterly review of performance information.
2. Outcome reporting (generating where possible evidence based health outcome indicators).

Section 1 – Planning (Phase 1)

Table 1 - Phase 1 Selected Gate Review Items

Item Title	Complete?
Phase 1	
Governance established (Strategic Leadership Group (or similar) appointed).	☑
Stakeholder mapping has been completed and analysed – appropriate partnering and engagement plans developed.	☑
Data sources (secondary and primary) identified (including existing reports and relevant background information from partners).	☑
Resourcing (with appropriate capacity and capability either internal or external) has been acquired, and are aware of their involvement and commitment.	☑
Project Plan (including schedule, resourcing capacity and capability, methodology, measures of success and a risk management strategy) completed & approved.	☑
Project Plan is in alignment with the CNA Reporting Template and describes how final outputs are expected to be published and distributed.	☑

Section 2 – Assessing Needs (Phase 2)

Table 2 - Phase 2 Selected Gate Review Items

Item Title	Complete?
Phase 2	
Part A – Compiled and reviewed data on health inequity, key demographic trends and decided on special needs groups (or sub-regions) where issues/needs may exist based on evidence.	☑
Part B - Compiled and reviewed data on health outcomes, health status and health utilisation as well as considered available information on patient experience or consumer satisfaction.	☑
Part C - Compiled and reviewed data/information on service provision including mapping service capacity and considering gaps in access for vulnerable and marginalised populations.	☑
Part D - Findings from the community profile completed in A, B and C informed the scope of and approach to community engagement and health professional and service provider consultations.	☑
Part D1 **-** The community has been appropriately consulted (considering the most appropriate engagement methods) including consultations with special needs groups where identified and deemed important.	☑
Part D2 **-** Health professionals and service providers have been appropriately consulted (considering the most appropriate engagement methods) including consultations with special needs groups where identified and deemed important.	☑
Part E **-** Data and information from Parts A, B, C and D has been compiled and a final population health profile has been completed, including consideration of normative, comparative, expressed and felt needs. The Strategic Leadership Group (or similar) has approved the final population profile.	☑
Part E **-** A shortlist of needs, using that profile as a key input, has been generated. The Strategic Leadership Group (or similar) has approved the final shortlist of issues/ needs.	☑

Please refer to Appendix 1: '*Table 3*: Population Profile'

A comprehensive overview of the demographic, health status and health service characteristics that are relevant to identifying health needs.

Please refer to Appendix 2: '*Table 4*: Shortlist of issues/needs based on evidence'

Discussion Box 2 -

Shortlisting Identified Issues/Needs

In-line with the CNA Framework, the process used to triangulate and develop a shortlist of identified issues/needs encompassed:

- Systematic review of the population profile documentation to determine a thematic shortlist of issues/needs for the region
- Review and transfer/merging of relevant qualitative information into the population profile and shortlist of issues/needs
- Additional data sourcing and analysis undertaken as required and where possible to develop the description of issues/needs, identification of affected population groups and details for key evidence summaries.

The process was undertaken by the Health Information and Data Analyst and Qualitative Data Analyst with support and checking by the Senior Primary Health Care Development Manager (Planning, Information & Connection).

Both the population profile and needs/issue shortlist were made available and distributed to targeted staff and Clinical and Community Governance Committee members for consideration and comment.

No key issues/needs were excluded in the shortlist for Table 4 with the view that the facilitated Think Tank process would provide identification of criteria for decision making and prioritised needs and activities for 2014-15.

The Think Tank process aims were:

- To consider the results of SAFKI Medicare Locals 2014 CNA
- To identify of a range of potential priorities and activities for 2014-15 in line with this information.

The internal (staff) Think tank process (conducted on Friday 2 May 2014) was facilitated by the Senior Primary Health Care Development Manager (Planning, Information & Connection) and encompassed:

- Consideration of the current content and political environment in which Medicare Locals are undertaking population health planning activities
- Putting ‘first thoughts’ on the table regarding priorities/activities for 2014-15 that could ‘improve health and reduce inequalities’ in the SAFKI Medicare Local region
- Developing a ‘decision making criteria’ to decide on ‘locally effective and efficient services strategies/activities’ and ranking the defined criterion
- Presentation of 2014 CNA results in partnership with the provision and discussion of supporting documentation – ‘Our Health: An Overview’, Table 3: Population Profile and Table 4: Shortlist of issues/needs
- Small group workshop activities (documented on worksheets) that resulted in the identification of:
  - Prioritised Issues/Needs
  - Strategy/ies to respond to those needs
  - Key activities to perform as part of strategy responses (including expected outcome(s) and justification where possible/appropriate)
- Group work outcome sharing and ‘mind-mapping’ of key themes and approaches to establish a set of agreed priority areas, strategies and key activities
- Review and checking in line with ‘first thoughts’ and checklist for decision making
- An opportunity for any other comments regarding potential gaps, outcomes achieved, the session process
- Advice regarding next steps.

As stated previously, unfortunately our ConnectIN Think Tank for external stakeholders was cancelled due to lack of registrations and interest from the 161 ConnectIN members invited. Whilst disappointing, it is

acknowledged that the timing (immediately after public and school holidays) and political review context in which Medicare Locals are operating (on a number of fronts) were key factors that contributed to this outcome. As a result, however, our focus shifted to input from our Leadership Advisory Group (LAG) which comprises a broad mix of Consumers and PHC professionals (including GPs, Practice Nurses, Pharmacists, Allied Health Professionals) and have the role to provide a regular, independent, focus group and advisory group function to SAFKI Medicare Local.

Prior to the LAG meeting, a Senior Management Team planning session was conducted in the morning of Tuesday 6 May 2014. This session provided a brief of the internal Think Tank outcomes and presented a framework for understanding the priority issues/needs and proposed activities to be included in our Annual Plan. Debate and further analysis resulted in support for all of the proposed responses to be presented to the Clinical and Community Governance (Board sub) Committee.

On the evening of Tuesday 6 May 2014, SAFKI Medicare Local's LAG conducted a Think Tank to consider and provide comment on the decision making criteria and priority issues/needs to lead the work of our organisation in 2014-15. Again themes reinforcing and supporting the priority issues/needs and proposed activities to be included in our Annual Plan were put forward.

Section 3 – Establish priorities (Phase 3)

Table 5 - Phase 3 Selected Gate Review Items

Item Title	Complete?
Phase 3	
Assessed the impact, evidence, changeability, acceptability and resource feasibility of each issue/need.	☑
Considered and assessed strategies to address issues/needs and documented an indicative Scoping Paper for discussion in selecting priorities.	☑
Engaged with relevant stakeholders to ensure they have bought into the set of prioritised problems or factors.	☑
Validated priority setting criteria and ratings and rankings of each strategy/proposal/initiative.	☑
Prepared recommendations and received formal comment from the Strategic Leadership Group (or similar) and other stakeholders identified in *Phase 1* through stakeholder mapping.	☑
Validated and agreed the final list of priorities including those that will be progressed by the ML and those that will be progressed by other stakeholders (if applicable).	☑

Please refer to Appendix 3: '*Table 6:* Summary of issues/needs and strategies to address'

Discussion Box 3 -

Rationale for key shortlisted issues/needs which will not be addressed in 2014-15

The principles underpinning our criteria for decision making in the 2014-15 Plan has been defined as:

- Clearly identified need
  - supportive data/evidence (broad range, valid)
  - cross sector implications
- Proactively developing our business to improve PHC and not ignoring what we have done before nor the successes/lessons from the past
- Achievable activities/targets within our 12 month timeframe contributing to longer term goals
- Driven by our strategic directions/core business and purpose
- Maximising our funding and resources.

As identified in Table 4 a broad range of needs/issues were shortlisted through the CNA process. Overall, not addressing shortlisted identified needs/issues is in line with inability to meet the above criteria. Improving population health outcomes and the PHC sector is, however, more complex than this and more detailed rationales are presented below:

- *Accessing Dentists and Allied Health professionals (Optometrists, Pharmacists, Physiotherapists, Podiatrists)*

  Significant concern has been raised regarding limited resources to improve access in a timely manner. These are 'new' areas of direct health care for SAFKI Medicare Local and responses have cross sectoral implications. It is acknowledged a successful, multi-pronged response requires partnership approaches with LHNs, NGOs, the private sector (General Practitioners, Allied Health Providers, Private Health Insurers) and Universities. Regional purchasing of primary health care services is also recognised as a potential response to these issues for a future PHN.

- *Affordable health care – general and dental*

  Whilst not established as a priority need in its own right it is recognised that Affordable Health Care is important (please note Accessing Dentists response above). It is also intended this issue will inform the work of SAHA and relevant local government public health planning now and into the future.

- *Being overweight/obese*

  Significant concern has been raised regarding limited evidence based practice to improve population health outcomes and reduce obesity in a timely manner. Responses have cross sectoral implications and it is acknowledged a successful, multi-pronged response requires partnership approaches with LHNs, Local Government, NGOs and the private sector (General Practitioners, Gyms, Mental Health Clinicians, Private Health Insurers). In recognising, ASTI Health and Wellbeing as a priority, it is intended that obesity will be a focus of Community Education in 2014-15.

- *Culturally and Linguistically Diverse (CALD) – professional list and access to interpreters*

  It is intended that responding to these issues will occur as part SAFKI Medicare Local's commitment to Resource review and General Practice support services as requested/required. It is acknowledged this is best done in partnership with SA Migrant Health Service.

- *Carers – support*

  Whilst not established as a priority need in its own right it is recognised that support for Carers (all ages) is important and some issues will be addressed through responding to the needs of an Ageing Population, ASTI Health and Wellbeing and Mental Health. Complimenting direct care services/programs such as

headspace may also contribute to issues related to young people. It is appropriate that a partnership approach with relevant peak bodies and NGOs should be further developed as a priority for a future Primary Health Network.

- *Disability – service demand and respite care*

  SAFKI Medicare Local acknowledges further research is required regarding a productive and supportive response within the Disability Services sector for a future PHN. Some components of Disability Service Support needs will be addressed through Resource review and General Practice support services as requested/required. A commitment to better understanding of patient experiences for people with a disability will also form part of consolidating SAFKI Medicare Local's 'My Care, Better Care' work (Phase 2).

- *Geographical Location*

  The key issues regarding Geographical location have been noted and will influence strategy and activity targeting in 2014-15. It is also intended this issue will inform the work of SAHA and relevant local government public health planning now and into the future.

- *Homelessness*

  There are strong linkages and opportunities to respond to homelessness issues via the PIR program in which SAFKI Medicare Local is currently the consortium lead. Complimenting this direct care service/program is considered to be an appropriate target in 2014-15.

- *Multiple Health Risks*

  Like Geographical Location (above) the issues related to Multiple Health Risks will continue to influence strategy and targeting processes in the SAFKI Medicare Local region now and into the future.

- *Oral Health*

  Whilst not established as a priority need in its own right it is recognised that Oral Health is important and some issues will be addressed through responding to the needs of an Ageing Population via investment in piloting a Comprehensive Health Assessment for 75+ General Practice consumers in the South Coast area of the SAFKI Medicare Local region and ATSI Health and Wellbeing through Community Education as achievable targets for 2014-15.

- *Palliative Care*

  Similar to Oral Health (above), whilst not established as a priority need in its own right it is intended that Palliative Care issues will be addressed through responding to the needs of an Ageing Population via investment in activities related to Community Education and CPD on 'Dying with Dignity', Advance Care Directives, Resource review and development. Responses regarding the development and implementation of community based palliative care in the south is resource intensive, potentially competitive, has cross sectoral implications and requires a partnership approach with LHNs, NGOs and Palliative Care Council of SA to be successful.

- *Sexual Health*

  Some components of sexual health needs, particularly in relation to young people, will be addressed through complimenting direct care services/programs such as headspace.

- *Transport*

  Similar to the disability sector further research is required regarding a productive and supportive response for a future PHN. Some components of transport needs will be addressed through complimenting direct care services/programs such as Closing the Gap, Care Coordination Supplementary Services (CCSS) and Partners in Recovery (PIR).

Section 4 – Confirm priorities for action (Phase 4)

Table 7 - Phase 4 Selected Gate Review Items

Item Title	Complete?
Phase 4	
Presented the recommendation to the ML Board and gained endorsement.	☑
Developed action plans for each initiative and implemented a stakeholder communication. strategy	☑
Set up the post-CNA evaluation review process.	☑

Discussion Box 4 –

Priority Confirmation and Next Steps

Confirmation of the priorities to be funded has involved:

- Clinical and Community Governance Committee consideration and comment
- Priority validation exercise via survey monkey
- Consultation with and support from Executive and Senior Management

SAFKI Medicare Local's Clinical and Community Governance (Board sub) Committee met on Wednesday 7 May 2014 to:

- Discuss the outcomes of SAFKI Medicare Local's 2014 CNA
- Consider and comment on the range of shortlisted priorities and the strategy approach proposed for 2014-15
- Endorse the Population Profiling and Shortlisted Needs/Issues documentation (as per Department of Health requirements).

The following eight proposed Priorities for Action were presented (in alphabetical order):

1. Aboriginal and Torres Strait Islander (ATSI) Health and Wellbeing
2. Ageing Population
3. Cultural& Linguistically Diverse (CALD population)
4. Disability Services support
5. Mental Health
6. Obesity
7. Palliative Care
8. PHC Workforce Support and Wellbeing

With response themes across these areas above encompassing:

- Early Intervention & Disease Prevention
- Health Information & Health Literacy
- PHC Service Information, Coordination & Delivery
- PHC Strategy & Development
- Quality and Safety in PHC

The Committee discussed the rationale for selection of these priorities and sought clarification around what sits under these areas and the achievability of outcome in the reporting period. The Committee endorsed the CNA Population Profiling and Shortlisted Needs/Issues documentation supplied.

A validation process was later conducted via Survey Monkey for key members of SAFKI Medicare Local (Board, LAG and Staff) to indicate their support or otherwise of the eight (8) proposed priority areas and responses in 2014-15. By midday Tuesday 13 May 2014, five (5) Board members, six (6) LAG members and twenty (20) staff had completed the survey. The results (in rank order) are as follows:

Do you believe:	**Should be a priority (Yes):**
Primary Health Care Workforce Support & Wellbeing…	100%
Mental Health…	96.8%
Ageing Population…	96.8%
Aboriginal and Torres Strait Islander Health and Wellbeing…..	93.6%
Palliative Care…	80.7%
Disability Support Services…	77.4%
Obesity…	70.9%
Culturally & Linguistically Diverse (CALD) Population…	54.8%

A follow up Senior Management Team Planning Session occurred on Tuesday 13 May 2014 to present and discuss the results of this priority validation exercise and principles for annual planning completion.

As this session the Team confirmed the following priority issues/needs for 2014-15 as:

- Aboriginal and Torres Strait Islander (ATSI) Health and Wellbeing
- Ageing Population
- Mental Health
- Primary Health Care Workforce Support & Wellbeing

With strategic activities for these areas involving:

1. Support services for keeping people well and out of hospital
2. Leading better primary health care through service information, coordination, integration and delivery
3. Driving better quality and safety within primary health care services
4. Delivering better health information and improved health literacy
5. Advancing frontline primary health care support services

Further consultation with Executive and Senior Management has resulted in, the concept of where possible and appropriate, responses to shortlisted needs/issues (from Table 4 in Section 2) will aligned to the activities in the 2014-15 Annual Plan. That is, where we are able to build upon existing achievements and partnerships - in recognition of the transition of Medicare Locals to Primary Health Networks (PHNs) in the near future.

Overall, the 2014 CNA process continues to be wound up with critical next steps including:

- Delivery of a comprehensive communication strategy in partnership with key messages to community members, primary health care providers and other key stakeholders regarding outcomes from the Medicare Local Review and Federal Budget announcements (13 May 2014). This will involve Communiques to ConnectIN and other key stakeholders, Twitter feeds, website updates and press releases communicating results in the local media.
- LAG will receive a follow-up CNA update brief at its next meeting scheduled for 24 June 2014 and the opportunity to 'Think Tank' feedback regarding the CNA process.
- Finalisation of a process evaluation that encompasses:
  - Internal peer review (including anecdotal feedback collated throughout the CNA journey)
  - External peer review (focus groups and Community Connections Events have formal evaluation components in-built to their implementation, anecdotal feedback is collated throughout the CNA journey)
  - Marketing evaluation (as affordable and appropriate)
  - Post CNA Evaluation outputs of:
    - SMARTer Tools completion and submission to Quality Committee by July 2014*
    - Relevant Policy/Procedure/Plan documentation review and updates scheduled for June/July 2014.

Lastly, measuring success of the implemented strategies is anticipated to involve:

1. Formal monthly reporting and quarterly review of performance information (as per 2014-15 Annual Plan)
2. Health Outcomes Workshop attendance late May with the view to improve outcome reporting through the generation, where possible of evidence based health outcome indicators)
3. Performance and Outcome reporting as required.

** SMART-ER Planning & Evaluation Tools ensures that all projects, programs and services (both clinical and non-clinical) developed under the auspices of SAFKI Medicare Local are evaluated in a consistent manner to ensure goals are achieved efficiently, effectively and within budget constraints; and that learning from each project is disseminated and made available for use throughout the organisation. SMART-ER is designed to create a culture and environment of continuous quality improvement and knowledge management within the organisation and ensures that management, stakeholders and funders are informed of the effectiveness of the organisation's projects, programs and initiatives.*

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Appendix 1 - Table 3: Population Profile

Demographic Trends & health inequities	***The situation for Australia***	*Overall, Australia is a healthy nation*	*• Australians enjoy one of the highest life expectancies in the world—79.5 years for males and 84.0 years for females, both 25 years longer than a century ago.* *• Most Australians feel positive about their quality of life. In 2007, 82% said they were delighted, pleased or mostly satisfi ed, 14% said they had mixed feelings, while only 4% felt mostly dissatisfi ed, unhappy or terrible.* *• Australia's level of smoking continues to fall and is among the lowest of Organisation for Economic Cooperation and Development (OECD) countries, with 1 in 7 people aged 14 and older smoking daily in 2010.* *• In June 2011, most children were fully immunised—92% of 1 year olds, 93% of 2 year olds, and 90% of 5 year olds. This is an improvement for 5 year olds over the past few years, but there has been little change for the younger ages.*	*Life expectancy in South Australia follows a similar pattern with females having a higher life expectancy than males.* *While life expectancy for females living in country SA is very similar to that for females living in metropolitan Adelaide, life expectancy for males in Country SA is lower than their metropolitan Adelaide counterparts*	*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)* *SA Health Performance Council - State of Our Health (unpublished report May 2103)*
		However, some groups experience poorer health	*• Aboriginal and Torres Strait Islander people generally fare worse on a number of health measures—for example, life expectancy is about 12 years shorter than for other Australians. And access to and use of health services is often lower—for example, in 2009–10, 36% of Indigenous women were screened for breast cancer, compared with 55% of non-Indigenous women.* *• Many aspects of health are related to how well-off people are financially: generally, with increasing social disadvantage comes less healthy lifestyles and poorer health. For example, in 2010, 25% of people living in the lowest socioeconomic areas smoked tobacco, twice the rate of people living in the highest socioeconomic areas.* *• The further people live away from major cities, the less healthy they are likely to be. For example, in 2009–10, the rate of hospitalised injury cases for residents of Very remoteareas (4,299 per 100,000 population) was more than twice that for people in Major cities(1,728 per 100,000).* *• Severe or profound disability often carries an extra health burden: in 2007–08, 46% of people aged 15–64 with severe or profound disability reported poor or fair health, compared with 5% for those without disability.*		*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
		There is room for improvement	*• In 2007–08, almost all Australians aged 15 and over (99%) had at least one risk factor for poorer health (such as high blood pressure or not eating enough vegetables), and about 1 in 7 people had 5 or more risk factors.* *• Comparisons among OECD countries show that Australia has one of the highest rates of obesity. In 2007–08, 1 in 4 Australian adults and 1 in 12 children were obese.* *• Although most babies (96%) in Australia in 2010 were initially breastfed, only 39% of infants were exclusively breastfed to around 4 months, and 15% to around 6 months, the recommended period.* *• The prevalence of diabetes more than doubled between 1989–90 and 2007–08. An estimated 898,800 people have been diagnosed at some time in their lives.* *• The number of people on the organ transplant waiting list continues to exceed the number of available organs. In 2010, there were about 1,770 Australians on the list.*		*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
		The health sector is busy	*A typical day in the health sector includes: 342,000 people visiting a GP, 742,000 medicines being dispensed by community pharmacies, 23,000 people being admitted to hospital, and 17,000 people presenting to an emergency department at larger public hospitals, and that's only part of the story.* *• There was a 51% increase in the number of palliative care hospitalisations between 2000–01 and 2009–10.* *• The most commonly used medicines in Australia in 2010–11 were for reducing blood cholesterol, lowering stomach acid, lowering blood pressure, and antibiotics.*		*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
		A good health system is expensive and requires a large and diverse workforce	*Australia spent $121.4 billion on health in 2009–10, which accounted for 9.4% of total spending on all goods and services—similar to the average for all OECD countries.* *• Hospitals were by far the biggest area of health spending, consuming $4 in every $10 of recurrent health spending.* *• Cardiovascular diseases accounted for the greatest spending ($7.9 billion or 11%) followed by oral health ($7.1 billion, or 10%) and mental disorders ($6.1 billion or 8%).* *• In 2010 there were more than three-quarters of a million workers in health occupations. This is an increase of 26% since 2005—more than double that of the overall workforce (12%).* *• Employers of health workers across Australia report workforce shortages or recruitment difficulties for many health professions, particularly midwives and physiotherapists.*		*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
		A good health system requires ongoing research and information	*Health and medical research spending comprises 14% of all research and development spending in Australia, and this fi gure has been climbing over the past two decades.* *• The AIHW contributes to the health and medical research eff ort by analysing and reporting on data, making data holdings available to other researchers, and developing and promoting information standards for the health sector.* *• Along with other stakeholders, the AIHW continues to develop health data and information, leading to new collections, and expanded and higher quality data collections, which in turn lead to better information on Australia's health.*		*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
	Key demographic drivers	*There are a number of population drivers:* *The ageing population leadng to disability and health conditions becoming more prevant with age* *Changes in the patterns of family formation* *Women havig children at older ages* *Many mothers of yound children remaining in the workforce* *The population becoming increasingly diverse in terms of cultural and language backgrounds*	*Australia has undergone considerable change in population size and composition over the course of two generations. Long-standing demographic trends of an ageing population and lower birth rates, which are mirrored in many other developed countries, mean that the mix of services required by* *society, and the ways in which they are funded and delivered, will not be the same in the future as in the past. This is equally true in the health sector as in the broad range of services that come under the umbrella of welfare.* *Population ageing is a major driver of anticipated demand for both health and welfare services and associated expenditure. Australia's ageing population is expected to increase the number of people requiring specialist disability services, aged care and/or high-end health care at a rate outstripping population growth. Ageing and population growth account for 23% and 21%, respectively, of the projected increase in total expenditure on health and residential aged care over the period 2003–2033.* *As disability and health conditions tend to become more prevalent and complex with age, the need to provide services to an ageing population highlights the interrelationship between the health and welfare sectors. For example, discharge from hospital of an older person whose health has declined* *depends on the availability of appropriate support services in the community or residential care.* *Another notable demographic change in recent decades has been in patterns of family formation, particularly an increase in the average age of child bearing. Fertility rates among women in their 30s and 40s have risen since the late 1970s while rates for younger women have fallen. In the welfare* *sector, this shift has occurred alongside a greater likelihood for mothers of young children to remain in the workforce, leading to growth in demand for child care services. In the health sector, use of assisted reproductive technology has become increasingly common, with women in their late* *30s and 40s comprising a disproportionately large share of those undergoing treatment.* *Demographic factors other than age also have considerable impact on the provision of health and welfare services. For example, the population is becoming increasingly diverse in terms of cultural and language backgrounds, with more than one-quarter of Australians born overseas. There is strong regional growth in some areas and population decline in others, and the emergence of considerable numbers of temporary residents in some locations associated with employment patterns. Each of these factors can aff ect demand for health and welfare services as well as models of* *service delivery, so lessons learned in one sector may well be applicable to another.*		
	The situation for SAFKI ML:				
	Geography	*SAFKI region is a mix of metopolitan, rural and remote areas*	*Total area of the SAFKI ML region is 8027 km$^{2.}$ Of this, more than 90% is classified as 'rural' and/or 'remote'.* *87.1% of the region's population live in remoteness category 'RA1' (major cities of Australia)* *11.7% live in remoteness category 'RA2' (inner regional)* *1.2% live in remoteness category 'RA24 (remote)*		*ABS Census* *ABS Census*

			For population health purposes, the region can be divided in to several sub-regionswhich form communities with common features. These districts overlap local government (LGA) boundaries and comprise the following statistical areas (SLAs): *Inner Southern (Metropolitan) Adelaide:* *This district comprises the LGAs of Holdfast Bay (C), Marion (C), Mitcham (C) and the SLAs of Onkaparinga Rservoir and Onkaparinga Hills. It contains around 225,000 people living in a variety of urban, rural and semi-rural communities, ranging from high density and fully developed communities of flats and apartments; older traditional family homes and established commercial areas; low density communities of larger family homes; and small-holdings centred around smaller commercial areas. The District has a large proportion of people born in non-English speaking countries and has a similar age profile to the Region overall. Economically, it includes areas across the range of advantage and disadvantage, from a SEIFA Disadvantage score of 975 for Marion North (higher disadvantage) to 1087 for Mitcham Hills (lower disadvantage). The District has the lowest proportion of Indigenous persons within the Region.* *Outer Southern (Metropolitan) Adelaide:* *This district comprises the SLAs of Onkaparinga Hackham, Onkaparinga Morphett, Onkaparinga North Coast, Onkaparinga South Coast and Onkaparinga Woodcroft. It contains around 125,000 people living in urban, medium to high density communities of relatively new family homes. The population is primarily made up of families in the process of buying their home or renting. It is primarily an English-speaking district and contains a relatively high proportion of single parent families. The District is overrepresented with children and has a smaller proportion of older persons compared to the Region as a whole. Economically, it includes areas of the greatest disadvantage within the Region (902 for Onkaparinga North Coast, 921 for Onkaparinga Hackham, and 944 for Onkaparinga Morphett), has a relatively high rate of unemployment, and a larger proportion of welfare-dependent and low income families with children. The District has the highest proportion of Indigenous persons within the SAFKI Region.*	*Further details are available at aa LGA level via the individual LGA profiles on the SAFKI website.*	*ABS Census etc*
			Southern Fleurieu: *This District ccomprises the LGAs of Yankalilla (DC), Victor Harbor (C) and the SLA of Alexandrina Coastal. It contains around 31,500 people living in rural and semi-rural communities, ranging from fully developed communities of family and holiday homes to low density communities and small-holdings centred around smaller commercial areas and villages. It is principally an English-speaking District, and is overrepresented with older persons, couples without children, and single person households. It also has the highest level of home ownership in the Region. Economically, it is more disadvantaged than the Region as a whole (968 for Victor Harbor, 972 for Yankalilla and 974 for Alexandrina Coastal compared with 1009 for the Region), has a relatively high level of unemployment, and has a high proportion of disability support pensioners, and persons holding pensioner concession and health card holders* *Starthalbyn:* *This District ccomprises the SLA of Alexandrina Strathalbyn. It contains around 10,600 living in a rural communities and smaller holdings surrounding small villages. It is principally an English-speaking District with an age profile broadly similar to that for the Region overall. The District has a low proportion of rented dwellings, and a low proportion of lone person households. Economically, it has a similar level of disadvantage to the Region as a whole (1004 compared with 1009 for the Region), and has a relatively low level of unemployment* *Kangaroo Island:* *Kangaroo Island is Australia's third largest island and contains around 4,500 people living in rural and semi-rural communities, ranging from small developed and undeveloped communities of family and holiday homes, through to small holdings surrounding smaller villages and remote isolation. It is primarily an English-speaking District and overrepresented by males, lone person households, and couples without children. Despite a quarter of its dwellings being rented, it also has a relatively high level of home ownership. Economically, it is more disadvantaged than the Region as a whole (983 compared with 1009 for the Region), but has the least proportion of persons unemployed across the Region.*		*ABS Census etc*
SEIFA Index of Relative Socio-economic Disadvantage (IRSD)	*SAFKI region a mix of high and low areas of Relative Socio-economic Disadvantage*	*Based on 2011, SAFKI ML scored 1009 on the SEIFA Index of Relative Socio-economic Disadvantage (IRSD) indicating that it was less disadvantaged than both the state and national averages.* *Note this index is derived from various attributes that reflect disadvantage (for eg low income, low educational attaiment, high unemployment, etc)*	*At smaller ABS statistical areas within SAFKI ML, IRSD ranges from 902 though 1087 indicating quite a range in disadvantage across the region - for eg parts of Onkaparinga have veryu high disadvantage while parts of Mitcham have very low disadvantage - cf full IRSD table in SAFKI profile.*	*ABS Census - SEIFA Indexes*
Estimated resident population	*SAFKI resident population almost 400,000 in 2011 (24.2% of SA population)*	*At June 2011, SAFKI population was 397,100 (24.2% of the total SA population), an increase of 0.7% from the previous year and 5.2% since June 2006.* *(note ERP for June 2012 is 401,460)* *Largest population growth (in terms of %) during 5 years 2006 to 2011 was in Victor Harbor council (13.0%) and Alexandrina (11.9%)*	*163,485 (41.2%) live in the Onkaparinga council, 85,400 (21.5%) inlive in Maron, and 65,050 (16.4) live in Mitcha. Just 4,430 (1.1%) liv ein Yankalilla and 4,510 live on KI (1.1%)*	*ABS ERPs by Age, Sex and Region*
Age profile	*Higher proportion of older persons (in SAFKI vs SA)*	*The median age of SAFKI Medicare Local residents is 41. This compares with a median age of 39 for South Australia and 37 for Australia.* *In terms of life-stage groups, 52.9% of SAFKI Medicare Local residents are aged 25 years to 64 years, 17.1% are aged 14 years or less, 17.0% are aged 65 years and older and 13.0% are aged 15 years to 24 years. While 17% of SAFKI resident population aged 65+ (June 2011),16% for SA (and 14% for Australia) are aged 65+*	*The rural LGAs of Victor Harbor, Yankalilla and Strathalbyn have a much higher proportion of older citizens than their metropolitan counterparts.*	*ABS ERPs by Age, Sex and Region*
Sex profile	*Higher proportion of females (in SAFKI vs SA) - particularly in older age groups(as seen in age sex pyramid)*	*51.2% of the region's resident population are female and 48.8% male. This profile indicates a slightly higher female proportion than for SA (50.5% female and 49.5% male)*	*All LGAs have a higher proportion of females than males with the exception of Yankalilla (50% for each) and Kangaroo Island (51.6% males)*	*ABS ERPs by Age, Sex and Region*
Australian indigenous	*Lower proportion of persons of Aboriginal and/or Torres Strait Islander origin (in SAFKI vs SA)*	*At June 2011, 1.0% in SAFKI compared with 1.9% for SA*	*More than half (53%) of SAFKI's Australian Indigenous population live in the LGA of Onkaparinga with another 22% living in the Marion LGA.*	*ABS Census SEIFA Indexes*
Projected population growth	*Population expected to increase by around 15% by 2025 -*	*According to PHIDU estimates, the region's population is expected to grow to around 456,000 by 2015, an increase of 14.8% from 2011.*	*The largest growth in terms of population is expected in Onkaparinga, followed by Marion and Mitcham, while the largest percentage increases are expected in the rural LGAs of Alexandrina, Yankalilla and Victor Harbor. Kangaroo Island is exected to grow by the least amount, both in population size and in percentageterms.*	*Estimates compiled by PHIDU from ABS Population Projections, 2025; Customised population projections for Statistical Local Areas prepared for the Australian Government Department of Health and Ageing by the Australian Bureau of Statistics. The projections were prepared by the ABS at the SLA level for the Australian Government Department of Health and Ageing. They are Customised projections prepared for the Australian Government Department of Health and Ageing by the Australian Bureau of Statistics, and not official ABS data. Accordingly, specific Conditions of Use apply in respect of the use of the data. Accordingly, terms and conditions must be acknowledged, understood and accepted before the projections are used. Further information can be found at http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-stats-lapp.htm*
	Population expected to 'age' by 2025 with the proportion of older persons iexpected to rise from 18% in 2011 to around 23% in 2025	*PHIDU also predicts the population profile will age with an expected 57.4% increase in older persons aged 65 to 84 years and 42.5% increase in senior citizens aged 85 years and older* *According to previous PHIDU forecasts, proportion of older persons in SAFKI expected to rise from 17.6% in 2011 to around 23% in 2025*	*While all LGAs are expected to age, the largest percenatge increases in older persons is expected in the rural LGAs of Yankalilla (143% for 85+ and 80% for 65-84) & Alexandrina (126% for 85+ & 72% for 65-84), while Holdfast Bay is LGA expected to have lowest growth in older persons (51% for 65-84 and -9% for 85+)*	*Estimates compiled by PHIDU from ABS Population Projections, 2025 - see above*
	Proportion of SAFKI population being of Aboriginal and/or Torres Strait Islander origin (Australian Indigenous) increased from 2006 to 2011	*Proportion of SAFKI population reporting to be of Aboriginal and/or Torres Strait Islander origin was 1% in 2011, compared with 0.8% in 2006*		*ABS Census*
Migration	*Population growth in South Australia is spawned by net overseas migration and natural increases from births and deaths.*	*Migration, or residential mobility, together with births and deaths are significant components of population change in Australia. The movement of people into, and out of an area directly influences the characteristics of the population and the demand for services and facilities.* *In the 2011 calendar year, net overseas migration formed the main component of South Australia's growth, accounting for 64.7% of total growth. Natural increases (due to births/deaths) accounted for 52.1% of total growth, while net interstate migration accounted for -16.8% of total growth).*		*ABS Census*
		Just under 75% of persons living in SAFKI ML in June 2011 had been living within SAFKI 5 years earlier, 7.4% had been living somewhere else in South Australia, 3.1% had been living interstate, 4.4% had been living outside of Australia, and almost 6% were new births.	*n/a*	*ABS Census*
Country of birth	*Similar proportion of SAFKI population born overseas (in SAFKI vs SA)*	*At June 2011, 22.2% in SAFKI born overseas compared with 22.1% for SA*		*ABS Census*
	The proportion of persons born overseas increased from 2006 to 2011	*The proportion of persons in SAFKI Medicare Local born overseas rose from 20.6% in 2006 to 22.2% in 2011*		*ABS Census*
	SAFKI has a slightly lower proprion of person born in a non-English- speaking country compared with SA	*At June 2011, 8.1% of SAFKI residents were born in a non-English- speaking country. This compares with 10.7% for SA.*	*Higher proportions of persons born in a non-English-speaking country in metro areas than rural areas. LGAs with largest proprtions of their residents born in a non-English-speaking country are Marion (11.4%) and Mitcham (11.3%). Lowest proportions are in rural LGAs and KI.*	*ABS Census*

Language spoken at home	*Lower proportion of population speaking non-English at home (in SAFKI vs SA)*	*At June 2011, 9.1% indicated they spoke a language other than English at home in SAFKI compared with 14.4% for SA*	*Languages spoken at home follows a similar sub-regional pattern to that of persons born in non-English-speaking countries (cf above)*	*ABS Census*
	The most prevalent non-English languages spoken at home in SAFKI region at June 2011 were Greek, Mandarin, Italian, German and Arabic	*Top non-English languages at June 2011:* *Greek (0.99% of resident population), Mandarin (0.71%), Italian (0.68%), German (0.56%) and Arabic (0.47%)*		*ABS Census*
Profiency in English	*Overall, better proficiency in English for overseas born persons within SAFKI compared with SA*	*In 2011, People born overseas reporting poor proficiency in English:* *SAFKI: 0.9%* *SA: 2.1%*	*Poor proficiency in English follows a similar sub-regional pattern to that of persons born in non-English-speaking countries (cf above)*	*Estimates compiled by PHIDU from ABS Census*
Education and qualifications	*Slightly higher proportion of Year 12 completions within SAFKI compared with SA*	*At June 2011,for persons aged 15+ (and no longer at school):* *Year 12 completions: 47.4% for SAFKI and 44.8% for SA;* *Year 9 or below completions: 9.8% for SAFKI and 12.1% for SA*	*Year 12 completions highest in Mitcham (62%), Holdfast bay (54%) and Marion (50%), and lowest in rural LGAs : Victor Harbor (32%), Yankalilla (35%) , Alexandrina (37%) and Kangaroo Island (38%).*	*ABS Census*
Education and qualifications	*Slightly higher proportion of persons holding formal qualifications for SAFKI compared with SA*	*At June 2011,for persons aged 15+ ; Formal qualifications: 45.7% for SAFKI and 42.0% for SA;*	*LGAs with highest proportions of formal qualifications are Mitcham (55%) and Holdfast Bay (49%). LGAs with lowest proportions are Victor Harbor (38%), Kangaroo Island (39%) and Yankalilla (40%).*	*ABS Census*
Household composition	*Similar household composition profile for SAFKI as for SA*	*Households at June 2011:* *Couples without children: 29.0% for SAFKI and 27.7% for SA* *Couples with children: 29.0% for SAFKI and 28.7% for SA* *One parent families: 10.7% for SAFKI and 11.0% for SA* *Lone person households: 27.0% for SAFKI and 27.9% for SA* *Group households: 3.3% for SAFKI and 3.6% for SA*	*Couples without children:* *Highest in Victor Harbor (42.3%), Yankalilla (39.1%) and Alexandrina (37.9%) and lowest in Marion (26.0%), Holdfast Bay (27.7%), Mitcham (28.1%) and Onkaparinga (28.2%)* *Couples with children:* *Highest in Mitcham (33.9%) and Onkaparinga (31.8%) and lowest in Victor Harbor (17.1%) and Yankalilla (20.6%)* *One parent families:* *highest in Onkaparinga (12.7%) and Marion (11.1%).* *Lowest on Kangaroo Island (6.7%).* *Lone person households:* *Highest in Holdfast Bay (36.4%), Kangaroo Island (31.3%), Victor Harbor (30.2%) and Yankalilla (29.6%) and lowest in Onkaparinga (23.7%) and Mitcham (24.8%)* *Group households:* *Highest in Holdfast Bay (4.5%), Marion (4.3%) and Mitcham (3.4%) and lowest in (Victor Harbor (1.8%), Yankalilla (2.1%) and Alexandrina (2.2%)*	*ABS Census*
Housing tenure	*Slightly higher proportion of SAFKI households own/purchasing their dwelling compared with SA implying slightly lower prortion renting*	*Households at June 2011:* *Dwelling owned outright: 33.5% for SAFKI and 32.8% for SA* *Dwelling being purchased: 38.2% for SAFKI and 35.3% for SA* *Renting: 24.3% for SAFKI and 27.9% for SA*	*Owned outright:* *Highest in rural LGAs; Victor Harbor (46.8%), Yankalilla (42.2%), Kangaroo Island (41.0%) and Alexandrina (40.3%).* *Lowest in Onkarparinga (29.0%) and Marion (31.1%)* *Being purchased:* *Highest in Onkaparinga (44.4%), Mitcham (38.1%) and Marion (36.1%) and lowest in Victor Harbor (24.6%) and Holdfast Bay (27.2%).* *Rented:* *Highest in Holdfast bay (31.0%) and Marion (29.2%) and lowest in Mitcham (18.2%) Alexandrina (21.2%) and Yankalilla (21.3%)*	*ABS Census*
Internet connection	*Access to internet slightly higher in SAFKI households compared with SA*	*At June 2011:* *76.3% of SAFKI households had access to the internet, compared with 73.2% for SA*	*Highest proportion in Mitcham (80.4%) and Onkaparinga (78.0%). Lowest in Victor Harbor (68.9%), Yankalilla (70.4%) and Kangaroo Island (70.7%)*	*ABS Census*
Labour force	*SAFKI has a marginally higher proportion in employment and a marginally lower proportion unemployed compared with SA*	*In 2011, 60.7% of SAFKI Medicare Local's population aged 15 years and above were in the labour force (ie employed or unemployed and actively looking for work) This compares 59.9% for South Australia* *94.6% of those in the labour force in SAFKI were employed and 5.4% unemployed. This compares with 94.3% and 5.7% for SA at the same time*	*In Labour force:* *Highest proportion in Kangaroo Island (63.4%), Mitcham (62.9%), Onkaparinga (62.8%) and Marion (61.2%).Lowest in Victor Harbor (41.5%), Yankalilla (51.7%) and Alexandrina (53.4%)* *Unemployed (as % of labour force)* *Highest in Victor Harbor (6.7%), Yankalilla (5.9%) and Onkaparinga (5.7%). Lowest in Mitcham (4.4%), Kangaroo Island (4.4%) and Holdfast Bay (4.6%)*	*ABS Census*
	Most popular industry sectors in SAFKI: *Health care and social assistance, retail trade, manufacturing, education and training and construction.*	*The five most popular industry sectors in the SAFKI Medicare Local region were health care and social assistance, retail trade, manufacturing, education and training and construction. In combination, these five industries employed 53.2% of the region's residential population aged 15 years and above*		*ABS Census*
Income	*Personal income higher in SAFKI than SA*	*In 2011, Median (personal) weekly income for SAFKI residents was $551 compared with $534 for South Australia*	*Highest "median" personal incomes in Holdfast Bay ($646) and Mitcham ($637). Lowest in Yankalilla ($437) and Victor Harbor ($408).*	*ABS Census*
	Household income higher in SAFKI than SA	*In 2011, Median (household) weekly income for SAFKI households was $1076 compared with $1044 for South Australia*	*Highest "median" household incomes in Mitcham ($1,387) and Holdfast Bay ($1,159). Lowest in Yankalilla ($778) and Victor Harbor ($751).*	*ABS Census*
Unpaid work	*Marginally higher levels of unpaid work in SAFKI than for SA*	*In 2011 (% of persons aged 15+):* *Undertaking voluntary work: 16.8% for SAFKI and 16.2% for SA* *At least 15 hours of unpaid domestic work in a week: 19.9% for SAFKI and 19.0% for SA* *Providing unpaid assistance for a person with a disability: 10.1% for SAFKI and 9.7% for SA*	*Voluntary work:* *Highest in rural LGAs ; Kangaroo island (31.5%), Yankalilla (24.3%), Victor Harbor (23.2%) and Alexandrina (22.2%).* *Lowest in metro LGAs: Onkaparinga (14.3), Marion (14.7%) and Holdfast Bay (17.9%)* *At least 15 hours of unpaid domestic work in a week:* *Generally hher in Rural LGAs than Metro LGAs:* *Highest in Yankalilla (27.0%) and Victor Harbor (26.2%).* *Lowest in Holdfast Bay (17.5%) and Marion (18.0%).* *Providing unpaid assistance for a person with a disability:* *Highest in Victor harbor (11.8%), Yankalilla (11.1%) and Alexandrina (11.0%). Lowest in Kangaroo Island (9.6%), Marion (9.7%) and Onkaparinga (9.7%).*	*ABS Census*

Health Inequities	**Private health insurance**	*Age standardised rate is **slightly higher** in SAFKI compared with SA*	*Age standardised rate per 100 persons: SAFKI: 51.8 SA: 47.4*	*Rates are much higher in least disadvantaged LGAs (ie Mitcham and Holdfast Bay), and are higehr in metro compard with rural/remote*	*Data compiled by PHIDU (2013) based on data from the 2007-08 National Health Survey (NHS), ABS (unpublished); and ABS Estimated Resident Population, average of 30 June 2007 and 30 June 2008*
	Income support	*SAFKI Medicare Local has **lower** proportions of all (major) income support types than SA*	*Pensioner concession card: 23.0% for SAFKI and 23.2% for SA Health care card: 8.2% for SAFKI and 8.7% for SA Disability support: 6.4% for SAFKI and 7.0% for SA Receiving unemployment benefit: 4.0% for SAFKI and 4.6% for SA Welfare and other low income families: 8.0% for SAFKI and 9.5% for SA*	*Pension card holders: Rates are much higher in rural LGAs (apart from Kangaroo Island) than metro LGAs. Highest is Victor Harbor (37.7%), Yankalilla (29.2% andf Alexandrina (29.2%). Lowest in Mitcham (17.2%), Kangaroo Island (17.8%) and Holdfast Bay (20.5%). Health Care card: Again, higher in rural than metro LGAs. Highest in Victor Harbor (11.0%) and Kangaroo Island (10.1%). Lowest in Mitcham (5.5%) and Holdfast Bay (6.2%). Disability Support: Rates are much higher in rural LGAs (apart from Kangaroo Island) than metro LGAs. Highest in Yankalilla (10.4%) and Victor Harbor (9.5%). Lowest in Mitcham (3.8%) and Holdfast Bay (5.2%). Welfare & other low income families with children: Highest in Onkaparinga (10.4%), Yankalilla (9.9%) and Alexandrina (9.3%). Lowest for Mitcham (4.0%) and Holdfast Bay (4.8%).*	*Based on data compiled by PHIDU using data from Centrelink as agent for the Department of Families, Housing, Community Services and Indigenous Affairs, June 2009; Department of Veteran Affairs, 1 July 2009; and ABS ERP, 30 June 2009*
	Life expectancy	*Life expectancy in South Australia follows a similar pattern to that of Australia, with **females having a higher life expectancy than males**.*	*While life expectancy for females living in country SA is very similar to that for females living in metropolitan Adelaide, life expectancy for males in Country SA is lower than their metropolitan Adelaide counterparts.*	*n.a.*	*SA Health Performance Council - State of Our Health (unpublished report May 2103)*
	Difficulty accessing services	*The age-standardised rates (ASR) for persons aged 18+ having difficulty accessing services is **essentially the same** within SAFKI as for SA as a whole*	*According to mdelled estimates produced by PHIDU: Within SAFKI: around 27 persons aged 18+ in 100 have difficulty accessing services - compared with 28.5 within SA (not significantly different) Within SAFKI: around 2.9 persons aged 18+ in 100 often have difficulty/can't get to places needed with transport - compared with 3.0 within SA (not significantly different)*	*Not surprisingly, ASRs tend to be higher in rural areas than metro for difficulty accessing services*	*Data compiled by PHIDU (2013) based on data from the 2010 General Social Survey and ABS Estimated Resident Population, 30 June 2010*
	People with profound or severe disability	*The proportion of SAFKI residents with with a profound or severe disability is the same as for SA. Theis proportion is much higher within older residents (65+)*	*In 2011, 5.4% of SAFKI's resident population has a profound or severe disability (those who often or always require help or assistance with core activity of daily living). This is the same proportion as SA (5.4%) This proportion is much higher for older persons; 17% of SAFKI's resident population aged 65 years and above (compares with 18.3% for SA)*	*The proportion of persons with a profound or severe disability is higher in rural regions (with the exception of Kangaroo Island) which directly reflects the older age profiles within these rural areas*	*Data compiled by PHIDU (2013) based on Census 2011 data*
			Recent evidence shows that people with disability experience significantly worse health outcomes than the general population (WHO 2011). Data from ABS National Health Surveys show a much higher proportion of people aged 15-64 with a severe or profound disability report poor or fair health compared with those without disability. Persons with a profound or severe disability can be extensive users of health services, a result of the high prevalence of multiple long-term conditions, and comorbidity of mental disorders and physical conditions.		*WHO (World Health Organisation) 2011. World report on disability. Geneva: WHO.*
Special Needs Populations	**Aboriginal and Torres Strait Islander people**	*Aboriginal and Torrest Strait islander people are generally less healthy than other Australians, die at much younger ages, and have more disability and a lower quality of life*	*Accordng to the AIHW, Aboriginal and Torres Strait Islander people (Indigenous Australians) generally have significantly more ill health than other Australians. They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health. One of the reasons for this poorer health is that Indigenous Australians are socioeconomically disadvantaged compared with other Australians. On average, they report having lower incomes than other Australians, higher rates of unemployment, lower educational attainment, and more overcrowded households). This socioeconomic disadvantage also places Aboriginal and Torres Strait Islander people at greater risk of unhealthy factors such as smoking and alcohol misuse, as well as overweight and obesity.*		*Life Tables for Aboriginal and Torres Strait Islander Australians, 2010–2012.*
		*Aboriginal and Torrest Strait islander people have a **much lower** life expectancy*	*Life expectancy is much lower for Aboriginal and Torrest Strait islander people than for non-Indigenous Australians (around 11 years for males and 10 years for females)*		*Life Tables for Aboriginal and Torres Strait Islander Australians, 2010–2012.*
		Greater proportion of Aboriginal and Torrest Strait islander people are aged less than 25 compared to non-Indigenous population	*57.1% of SAFKI Indigenous population are aged less than 25 compared to 29.9% for non-Indigenous*		*ABS Census*
		Predominantly reside in SAFKI's rural and most disadvantaged (metropolitan) areas	*Proportions higher in region's disadvantaged councils: Onkaparinga, Alexandrina, Kangaroo Island, Marion and Victor Harbor*		*ABS Census*
		Higher rate of unemployment	*Unemployment rate for Indigneous population markedly higher than non-Indgenous population within SAFKI region - 18% compared with 5.6% for non-Indigenous*		*ABS Census*
		Generally less healthy than other Australians	*According to AIHW, Indigenous Australians generally have significantly more ill health than other Australia, typically die at a younger ages and are more likely to experience disability and reduced quality of lide because of ill health*		*AIHW Australi's Health 2010; AIHW 2009 Aboriginal and Torres Strait Islander Health performance Framework 2008 report*
		Higher perinantal death rates	*According to AIHW, the perinatal dealth rate of babies born to Indigenous mothers in 2007 was twice that of other babies (20.1 compared with 9.8 per 1,000 births)*		*AIHW Australi's Health 2010;*
		Immunisation rates lower than non-Indigenous	*(see Immunisation rates in Disease prevention - under Utilisation of Health Services section below)*		
		No Aboriginal Community Controlled Health Service(ACCHS) within SAFKI region	*Closest ACCHS is in the Adelaide CBD*		*SAFKI Needs Assessment 2012-13 - Closing the Gap*
		A numbr of factors contribute to Indigenous ill-health	*Contributing factors: Nutrition, Physical activity, Immunisation, Alocohol use, Tobacco smoking, Body Weight, Drug use, Unemployment, Poor housing, Poverty, Poor health in youth, Mental health*		*SAFKI Needs Assessment 2012-13 - Closing the Gap*
		Barriers to health services	*Through direct community consultaion: Lack of tranport, particularly for rural and remote areas; Venue of health service isn't always appropriate for Aboriginal perons which leads to feeling uncomfortable and not attending; Lack of cultural competency and relationship building of health professionals*		*SAFKI Needs Assessment 2012-13 - Closing the Gap*
		Areas of need	*Through direct community consultaion: Youth servcies and mental health; young people not attending school due to social and emotional issues/health; lack of services & programs for Aboriginal youth; lack of housing options in rural regions; lack of accommodation for patients and families when relocating to access hospitals and other medical care.*		*SAFKI Needs Assessment 2012-13 - Closing the Gap*
	Rural and remote areas	*Higher levels of disease risk facors and illness*	*According to AIHW, people living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities.*		*AIHW Australi's Health 2010;*
		Generally poorer health	*Generally higher level of disadvantage in rural/remote areas, higher levels of tobacco smoking and less access to health services*		*AIHW Australi's Health 2010;*
		Major barriers to health services	*Larger distances to major cities and available health services*		*AIHW Australi's Health 2010;*
	Older residents	*As people age, their health-care needs tend to become more complex*	*Among older Australians living in the community in 2009, almost half (49%) aged 65–74 had five or more long-term conditions; this rate increased to 70% of those aged 85 or over. In government-subsidised residential aged care settings, 48% of permanent residents in June 2010 had medium or high needs for complex health-care services as appraised by the Aged Care Funding Instrument. In addition, it is estimated that half of all permanent residents in Australian Government-subsidised aged care facilities have a diagnosis of dementia—the large majority of whom have high-care needs.*		*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
		Poorer health and risk of hospitalisation due to falls	*In general, health outcomes and burden of disease highly correlated with age as does the risk of hospitalisation due to falls. The main causes of burden of disease and injury are Ischaemic heart disease, dementia, stroke, cancer and diabetes . According to the AIHW, major risk factors for older perons include being overweight, inadequate intake of fruit and vegetables, and being sedentary*		*Burden of Disease statistics from SA Health (2005-07) and AIHW AIHW Australi's Health 2010*
		Impact of dementia	*In 2011, there was an estimated 298,000 people living with dementia in Australia. Among Australians aged 65 and over, almost 1 in 10 (9%) had dementia. And among those aged 85 and over, 3 in 10 (30%) had dementia. As Australia's population ages, more people will be affected by dementia.With the projected rise of Australia's aged population, it is estimated the number of people living with dementia is projected to triple to around 900,000 by 2050. Dementia is one of the major reasons why older people enter residential aged care or seek assistance from community care programs. Dementia was the third leading cause of death in 2010, with 9,003 deaths recorded across Australia. For people aged 65 and over, dementia was the second leading cause of burden of disease and the leading cause of disability burden*		https://www.health.gov.au/dementia
		Access to Aged Care facilities	*At June 2013, there were 50 RACFs in SAFKI with an estimated 63.7 beds per 1,000 population aged 65+ (ie around 4,030 beds) Further, there were: 39 RACFs with secure dementia facilities 28 RACFs with respite facilities 36 RACFS with 'Ageing in Place'*		*SAFKI Aged Persons profile*

	Home support and care	*At June 2103, there were 17 Community Aged Care providers opering in the SAFKI region, offering a combined total or around 1,030 Community Aged Care Packages (CACP), 134 Extended Aged Care at Home packages - non-dementia specific (EACH)) and 52 Extended Aged Care at Home packages - dementia specific (ECAHD).*	*Largest proportion of CACPS existswithin the Holdfast Bay council, followied by Onkaparinga and Marion - there are none on Kangaroo Island* *Again, Holdfast Bay council has the largest proportion of EACH and EACHD and again, there are none on KI*	*Seniors Information Service (SIS) , Aged Care Guide, REACH phone survey, and ABS regional estimates of population by age and sex.*
	Supported Residential Facilities	*At June 2013, there were 7 such facilities operating in the SAFKI region, 6 are located in the Cities of Holdfast Bay, Marion and Mitcham and the other at Victor Harbor, with 3 of these having specialised care servcies for older persons with dementia and the frail aged.*		*SIS & Aged Care Guide*
	Barriers to health services	*Older persons generally suffer more ill health, disability and home or aged care confirment. Further, frailty of aged care residents, declinging GP aavailabilty and changing worforce patterns in RACFS mean residents of RACFs are sometimes transferred to hospital when they could have been cared for in their facility. In response, SAFKI ML established REACH.*		*SAFKI Aged Persons profile*
	Concern with health related costs - particularly foreign students.	*A number of responses to YHYVYC survey: "How can health services be better?" related to free access to exercise-related programs (eg gyms) and lower or no cost services/health food.*	*n.a.*	*Your health, your voice, your choice*
People with profound or severe disability	*People with disabilities aged under 65 are much more likely than people without disabilities to report having long-term physical and mental health conditions, and to rate their overall health as fair or poor.* *A number of health risk factors are also more common among people with severe or profound limitations than those without disability, including being overweight or obese, engaging in low levels of exercise, and smoking daily*	*An estimated 5.4% of SAFKI's residential population has a severe or profound disabaility.* *Recent evidence (both Internaltionally and in Australia) shows that people with disability experience significantly worse health outcomes than the general population (WHO 2011).* *Data from ABS National Health Surveys show a much higher proportion of people aged 15-64 with a severe or profound disability report poor or fair health compared with those without disability.* *People with disability often have high and complex needs for health care. In 2003, half of all Australians with disability (about 2 million people) had multiple types of disability. In addition, the average person with disability had 3.1 long-term health conditions, which are not always directly associated with their disability (AIHW 2009). People with severe or profound limitations, in particular, are extensive users of health services, and are more likely than those without disability to consult general practitioners, specialist doctors and other health-care professionals, as well as social workers and welfare workers. Despite this, people with disability may have unmet or under-met need for health care. For example, in 2009, 59% of people aged 5–64 with severe or profound core activity limitations needed personal help with their health care, but almost 1 in 10 (34,200 people) eported that they did not receive any assistance . Research suggests that people with disabilities may be especially susceptible to inadequate or inappropriate health care if their interactions with services are additionally complicated by communication or behavioural difficulties.* *Persons with a profound or severe disability can be extensive users of health services, a result of the high prevalence of multiple long-term conditions, and comorbidity of mental disorders and physical conditions.*		*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)* *WHO (World Health Organisation) 2011. World report on disability. Geneva: WHO.*
Mental Health	*In a 2007 survey, 1 in 5 Australians aged 16–85 experienced a mental disorders in the previous 12 months, and a further 25% had done so at some time in the past.*	*Mental illness comprises a wide spectrum of disorders and varies in its severity. Its effect on individuals and families can be severe, and its influence is far-reaching for society as a whole. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity, and homelessness. Those with mental illness often experience problems such as isolation, discrimination and stigma.* *There is a high prevalence of mental disorders in the Australian population. The 2007 National Survey of Mental Health and Wellbeing estimated that 1 in 5 Australians aged 16–85 experienced one or more of the common mental disorders in the 12 months before the survey. These were affective disorders (such as depression), anxiety disorders and substance use disorders. An additional one-quarter of the population, while not experiencing one of these disorders in the 12 months beforehand, had done so at some time in the past. Altogether, 45% of Australians aged 16–85, that is, 7.3 million people, had experienced a mental disorder in their lifetime.* *Comorbidity—defined as involving more than one mental disorder, or at least one mental disorder and one or more physical conditions—is common among those with mental illness, and people with multiple disorders are more disabled and consume more health resources than those with only one disorder.* *In general, comorbidity increases with increasing disadvantage.* *Health risk factors, for example, smoking, are generally more prevalent among people who had a mental disorder and highest among those suffering comorbidity, although it is important to note that there are no causal pathways implied by this finding. Further, people with a comorbidity of any mental disorder and physical condition have higher rates of hospitalisation than the comparison groups considered in the study.*		
Areas of 'higher socioeconomic disadvantage'		*Health status within a population typically follows a gradient, with overall health tending to improve with each step up the socioeconomic ladder. This is commonly known as the socioeconomic gradient of health, or the social gradient of health, and is a global phenomenon seen in low, middle and high income countries.* *An example of a health behaviour with a strong social gradient is tobacco smoking: in 2010 its prevalence among people living in the lowest socioeconomic areas was 25%, twice the rate among people living in the highest socioeconomic areas. This gradient has persisted since 2007, even though overall prevalence declined over that period.* *Other social gradients are presented throughout Australia's health 2012, for example:* *• risk factors such as physical inactivity and obesity, as well as the prevalence of multiple risk factors in an individual* *• adverse outcomes such as lower cancer survival, poor oral health and incidence of end-stage kidney disease* *• summary measures such as life expectancy and self-assessed health status* *• the ability to find, understand and apply information about health—that is, health literacy.* *Social gradients also exist in the access to, and use of, health-care services and resources in Australia, with the strength and direction of the relationship varying between service groups. For example, people living in the most disadvantaged areas have relatively high rates of general practitioner (GP) consultation. On the other hand, they are less likely to receive preventive dental care and more likely to be hospitalised for potentially preventable conditions.* *The precise cause of social gradients in health is not fully understood—it is thought to be a complex set of relationships between education, attitudes and behaviours, economic resources, and the ability to exercise choice. Insofar as the welfare system has the capacity to modify socioeconomic factors, such as education and access to economic resources, it may aff ect individuals' health outcomes as well as the extent and manner in which they interact with the health system.*		
Palliative Care	*A number of issues connected with pailliative care exist*	*A range of issues and areas of concern relate to palliative care and end of life care in South Australia. The Palliative Care Council South Australia (PCCS) has identified the following themes:* *1. Lack of understanding about palliative care, difficulty obtaining information about services and the timing of referrals for palliative care* *2. Provision of palliative care and services to care for the dying - Access to community services and to specialist palliative care; Access to specialist palliative care for GPs; Co-ordination of services; After hours and weekend availability (24/7 services); Financial and cost implications of end of life care* *3. Support for dying at home - End of life packages; Respite care; Place of death and experience of end of life care* *4. Quality, accountability and funding - Qualifications, training and experience; Attitude, dignity and respect; Cultural competence, culturally appropriate care service providers; GP involvement in providing end-of-life care;* *5. Attitudes to death and dying - need to normalise death and increase public awareness of palliative care ; advanced care planning; voluntary euthanasia*	*n.a.*	*The Palliative Care Council South Australia (PCCS) - Report of End of life case study South Australia 2013*
Homelessness	*Homeless people tend to have high and complex health-care needs, and may under-use health services relative to their needs*	*Despite a lack of comprehensive national data about the health needs of people experiencing homelessness, Australian and international research demonstrates disproportionate rates of mental illness among people who are homeless or marginally housed, as well as a high prevalence of substance use disorders. In particular, primary homelessness—that is, living on the streets or in public places—is associated with risk of chronic disease of increased severity and complexity than the general population, as well as infectious diseases associated with poor living conditions. However, homeless people also report unmet need for general and specialised health care, including medicines and dental treatment.* *The Specialist Accommodation Assistance Program (SAAP) National Data Collection shows that 7–9% of support periods provided by these services were for people primarily seeking assistance because of a health issue (including substance use and mental health/psychiatric illness); this figure was up to 16% for lone men aged 25 or over (AIHW 2011d). Specialist homelessness services provided, or referred people to, a range of specialist health-care services, including psychological and psychiatric services, alcohol and other drug treatment, pregnancy/family planning support as well as general health/medical services.*	*n.a.*	*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
	On Census night 2006, there were 848 people in South Australia who were sleeping rough, a rate of 5 per 10,000 population	*Homelessness can be the result of a number of issues, such as poverty, unemployment, unaffordable housing, domestic violence, relationship breakdown, mental illness, substance abuse,gambling and social isolation. "Rough sleepers" are defined here as people sleeping on park benches or in other "rough" accommodation (the traditional definition of homeless people). The ABS develops a homeless enumeration strategy for each Census, and works with homeless service providers to maximise the enumeration of these groups on Census night.* *On Census night 2006, there were 848 people in South Australia who were sleeping rough, a rate of 5 per 10,000 population. This included 251 (30%) rough sleepers in metropolitan Adelaide,16 (2%) in regional centres (including Whyalla and Pt Pirie), and 581 (68%) in rural and remote parts of the Country SA.* *The South Australian rate was lower than the national average of 8 rough sleepers per 10,000 population, and ranked it third lowest amongst the states and territories.*	*n.a.*	*SA Health Performance Council - State of Our Health (unpublished report May 2103)*
Carers	*Informal carers of people with disability are more likely than non-carers to report having a long-term health condition, especially psychological and physical conditions*	*According to the 2009 Survey of Disability, Ageing and Carers, 10% of primary carers reported having been diagnosed with a stress-related disorder, and 29% said that their overall physical and emotional wellbeing had been aff ected by the caring role (AIHW 2011a). However, it is difficult to identify patterns of health service usage by this group, as information systems tend to capture statistics oriented around the service needs of care recipients to a greater extent than care providers*	*n.a.*	*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*

	Refugees/CALD persons	*A major barrier to accessing primary health care and understanding both GPs and pharmacists is not being able to speak or comprehend English*	*A major challenge facing many countries today is the protection of refugees who have been forced to leave their home.* *Australia has a commitment to protecting refugees and resolving refugee situations which is strongly expressed through the Humanitarian Program (Department of Immigration and Citizenship, 2011).* *The SA community is becoming increasingly diverse as more migrants, asylum-seekers and people from refugee backgrounds settle in South Australia.A recent study of refugee women living in SA indicated the the main barrier to accessing primary health care and understanding both GPs and pharmacists was not being able to speak or comprehend English. Refugees, support organisations, GPs, pharmacists and their staff require more education, training and support.*	*n.a.*	*PHCRIS eBulletin - 6 March 2014 - Reference to a paper by Clark A, Gilbert A, Rao D, Kerr L. (2014). Australian Journal of Primary Health, 20(1), 92-97*
			In 2010-11, a total of 1,144 permanent additions were accepted under the Offshore component of the Humanitarian Program in South Australia. Of these, 881 were made under the Refugee category and 263 under the Special Humanitarian Program.	*n.a.*	*SA Health Performance Council - State of Our Health (unpublished report May 2103)*
	Students	*Concern with health related costs - particularly foreign students.*	*A number of responses to YHYVYC survey: "How can health services be better?" related to free access to exercise-related programs (eg gyms) and lower or no cost services/health food.*	*n.a.*	*Your health, your voice, your choice*
Health Status & Health Outcomes	**The Australian situation**	*Overall - Australia is a health country but there is room for improvement* *Australia currently has 9 National Health Priority Areas*	*See Demographic Trends & health inequitiessection above* *The National Health Priority Areas (NHPAs) are diseases and conditions that Australian governments have chosen for focused attention because they contribute significantly to the burden of illness and injury in the Australian community:* *Cancer control* *Cardiovascular health* *Injury prevention and control* *Mental health* *Diabetes mellitus* *Asthma* *Arthritis and musculoskeletal conditions* *Obesity* *Dementia* *The National Health Priority Areas (NHPA) initiative was Australia's response to the World Health Organisation's global strategy Health for All by the year 2000 and its subsequent revision.The initiative recognises that the strategies for reducing the burden of illness should be pluralistic, encompassing the continuum of care from prevention through to treatment, management and maintenance, and based on appropriate research and data sources. By targeting specific areas that impose high social and financial costs on Australian society, collaborative action can achieve significant and cost-effective advances in improving the health status of Australians. The diseases and conditions targeted under the NHPA initiative were chosen because through appropriate and focused attention on them, significant gains in the health of Australia's population can be achieved.*		*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
	Health literacy	*Australians In 2006:* *41% of Australians aged 15–74 had at least an adequate level of health literacy* *83% of older Australians (aged 65–74) did not have an adequate level of health literacy* *Lower health literacy is associated with living outside Major cities and with lower SES* *Lower levels of health literacy are associated with poorer self-assessed health status* *South Australians in 2008:* *South Australians with lower health literacy were more likely to have chronic conditions such as diabetes, heart disease and stroke, and less likely to have recently visited a doctor;* *Further, those aged over 64 with inadequate health literacy were more likely to have been admitted to hospital than those with adequate health literacy.*	*Health literacy is a measure of a person's ability to find, understand and apply health information. It involves knowledge of bodily functions, signs of poor health, and how and where to seek more information. The concept of health literacy is broader than the ability to read labels, fill in forms and follow instructions. It also encompasses the ability to access health information and interpret conflicting advice critically, navigate the health-care system, and communicate eff ectively on health-related matters. Health literacy can have a direct impact on an individual's health. A person with low health literacy may not be able to eff ectively manage their health, placing them at greater risk of adverse health outcomes. This can be detrimental to the individual and the broader community. High health literacy among the population may reduce costs in the health-care system by preventing illness and chronic disease, and reducing rates of injury and death.* *The latest national information on health literacy in Australia comes from the ABS Adult Literacy and Life Skills Survey (ALLS), conducted in Australia in 2006 (ABS 2008a). The ALLS was also conducted in a number of other countries in successive survey waves. For the purposes of the ALLS, health literacy is defi ned as the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, fi rst aid, emergencies and staying healthy. The survey collected information from a sample of 15–74 year olds living in private dwellings in all but Very remoteregions of Australia. The level of health literacy of an individual was derived from their responses to 191 health-related questions across four domains: prose literacy, document literacy, numeracy and problem solving. Based on this information, respondents were categorised into one of fi ve levels of health literacy, with 1 being the lowest and 5 the highest. Level 3 is regarded as adequate health literacy.* *Based on data from the 2006 ALLS, 41% of Australians aged 15–74 had at least an adequate level of health literacy (defined as level 3 health literacy or above). This was similar for males and females (40% and 41% respectively).* *Results from the ALLS show that about 83% of older Australians (aged 65–74) did not have an adequate level of health literacy in 2006.* *Results from the ALLS also show that lower health literacy is associated with living outside Major cities and with lower SES. Among those aged 15–74, 42% of people living in Major cities had at least an adequate level of health literacy compared with 37% of those living in other areas. Similarly, 55% of the population in the highest SES group had at least an adequate level of health literacy compared with 26% of those in the lowest group.* *The ALLS also found that health literacy was higher among people who were employed, had higher levels of formal education, who participated in social groups and organisations, or who spoke English as a first language.* *Lower levels of health literacy are associated with poorer self-assessed health status. From the ALLS, 48% of Australians aged 15–74 who assessed their own health as 'excellent' or 'very good' had at least adequate health literacy. In comparison, only 25% of those with fair or poor health status had at least adequate health literacy.*	*not available*	*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW), 2006 Adult Lieracy and Life Skills Survey (ABS)*
			The South Australian Health Omnibus Survey, conducted in September and October 2008, surveyed more than 2,800 people aged 15 and over.In this survey, a screening tool called the Newest Vital Sign was used to identify people at risk of limited functional health literacy. *The survey found that people with lower health literacy were more likely to have chronic conditions such as diabetes, heart disease and stroke, and less likely to have recently visited a doctor. People aged over 64 with inadequate health literacy were more likely to have been admitted to hospital than those with adequate health literacy.*	*not available*	*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW), South Australian Health Omnibus Survey, September and October 2008*
	Self-assesed health	*Self assessed health is* ***similar*** *in SAFKI ML to that of SA (and Australia) as a whole with more than 80% stating their health to be 'good', 'very good' or 'excellent".*	*The age standardised rate per 100 persons stating their health to be poor or fair in 2010 was 16.7 for SAFKI and 17.9 for SA (nor significantly different). Thus, more than 80 persons in every 100 state their health to be good, very good or excellent.* *In 2011-12, around 85% of SAFKI adults reported excellent, very good or good health - this is identical to the 85% nationally.*	*only minor differences across the LGAs (no significant differences in age standardised rate per 100 persons)*	*Data compiled by PHIDU (2013) based on data from the 2010 ABS General Social Survey and ABS Estimated Resident Population, 30 June 2010* *National Health performance Authority (NHPA)*
	Chronic disease	*No 'major' differences' in rates of (selected) chronic disease between SAFKI and SA*	*Based on 2007-08 data, age-standardised rates (per 100 persons) for some chronic conditions were as follows:* *Type 2 diabetes: SAFKI 3.4 , SA 3.5* *High cholesterol: SAFKI 7.3 , SA 7.4* *Circulatory system diseases: SAFKI 18.2 , SA 18.6* *Respiratory system diseases: SAFKI 29.3 , SA 27.9* *Musculoskeletal system diseases: SAFKI 32.1 , SA 31.5*	*Some slight differences exist across SAFKI Council regions:* *Type 2 diabetes:* *Highest in Victor Harbor (3.6), Alexandrina (3.5), Yankalilla (3.5), Marion (3.5) and Onkaparinga (3.5). Lowest in Mitcham (3.1), Holdfast Bay (3.2) and Kangaroo Island (3.3).* *High cholesterol:* *Highest in Marion (7.5), Victor Harbor(7.3) and Onkaparinga (7.3). Lowest in Mitcham (6.9) and Yankalilla (7.0)* *Circulatory system diseases:* *Highest in Marion (18.8) and lowest in Mitcham (17.1). All the others are either 18.3 or 18.4.* *Respiratory system diseases:* *Highest in Holdfast Bay (31.0), Marion (30.9) and Onkaparinga (30.4). Lowest in Alexandrina (20.3), Yankalilla (20.7) and Victor Harbor (21.5).* *Musculoskeletal system diseases:* *highest in Marion (33.0), Onkaparinga (32.8) and Holdfast Bay (32.3). Lowest in Kangaroo Island (27.9), Alexandrina (28.5) and Yankalilla (28.7)*	*Based on modelled (synthetic) estimates compiled by PHIDU from ABS National Health Survey 2007-08*

	Oral health	*Australia's oral health is suboptimal, particularly among disadvantaged people* *There is room for improvement in Australian oral health particularly among disadvantaged groups. There are major problems in accessibility of dental services, including a maldistribution of dentists, and the lack of universal government-funded coverage*	*One quarter of Australian adults have untreated decay and 23% have moderate or severe gum disease. Poor oral health is not only a source of pain, embarrassment, discrimination, and financial pressure for individuals, but also contributes to significant medical problems that impose a substantial burden on the community, the health system, and the economy. Expenditure on dental health accounts for more than 6% of total health funding.* *Although most dentists are primary health care practitioners, they generally work in private practice, in isolation from the rest of primary health care. Their services are less affordable than most primary health care services because they are often not subsidised. Dental care has been largely excluded from Medicare, the universal healthcare insurance system that funds much primary health care, particularly medical services provided by general practitioners. Most dental care is provided by private dentists on a user-pays basis, albeit often subsidised by private health cover.* *Aboriginal & Torres Strait Islander people have substantially worse oral health than other Australians, particularly in terms of tooth loss, untreated decay, and tooth wear. They report higher rates of toothache and difficulty eating because of dental problems. Their poor oral health status is compounded by lack of access to dental care.* *Poor oral health is common in elderly Australians. Root decay and periodontitis are three times more prevalent in people aged over 75 than in the population at large. In 2010, approximately 21% of Australians aged 65-plus were edentulous, which is a risk factor for poor nutrition, weight loss, and impaired communication.*	*n.a.*	*Oral Health, Dental Care and Primary Health Care - PHCRIS Research Roundup May 2013*
	Mental health	*Age standardised rates of high/very high psychological distress are slightly lower (not statistically significant) in SAFKI than for SA* *Age standardised rates of mental and behavioural problems are essentially the same for males and for females in SAFKI and SA - (Rates for females appears slightly higher than for males however the difference is not statistically significant)*	*In 2007/08, the indirectly age standardised rate (ASR) for high or very high psychological distress per 100 persons (adults 18 years and above) was:* *SAFKI: 11.6* *SA: 12.1* *In 2007/08, the indirectly age standardised rate (ASR) for males and females with mental and behavioural problems (including moof (affective) problems) per 100 persons (adults 18 years and above) was:* *Males: SAFKI: 10.7 ; SA: 10.8* *Females: SAFKI: 12.0 ; SA: 12.1*	*n.a.* *n.a.*	*Data compiled by PHIDU (2013) based on ABS National Health survey (2007-08)* *Data compiled by PHIDU (2013) based on ABS National Health survey (2007-08)*
	Sexually transmitted infections (STIs) and blood borne viruses (BBVs)	*A total of 5795 new notifications of sexually transmitted infections (STIs) and blood borne viruses (BBVs) were collected in South Australia in 2012. This is comparable to the number of notifications received in 2011.*	*Chlamydia remains the most frequently reported STI in South Australia with 5061 cases in 2012. An increasing trend is observed over the past five years predominantly involving young people aged 15 to 29 years. The number of notifications amongst females exceeds that of males by 43%. Aboriginal peoples are 3.7 times more likely to be diagnosed with chlamydia compared to the non-Aboriginal population. The vast majority of cases occurred in heterosexual individuals (89%). Similar to 2011, only 30% of cases reported symptoms of infection. The large proportion of asymptomatic infections reinforces the importance of routine screening for chlamydia particularly amongst priority groups.* *There were 542 notifications of gonorrhoea in 2012. This is the highest recorded number of annual notifications during the five-year period (2008-2012). In contrast to chlamydia, gonorrhoea affects more males than females. The age-specific diagnosis rate was highest amongst males 20 to 29 years and females aged 15 to 19 years. Aboriginal peoples are disproportionately affected by gonorrhoea and are 33.7 times more likely to be diagnosed with gonorrhoea compared with their non-Aboriginal counterparts. Men who have sex with men (MSM) represent 31% of all reported cases.* *There were 43 cases of infectious syphilis reported in 2012, over twice the number reported in 2011. Cases were predominantly males (84%). Similar to previous years, Aboriginal peoples experience a higher burden of infectious syphilis compared to non-Aboriginal people. In 2012, the rate of diagnosis of infectious syphilis in Aboriginal peoples was 13 times that of non-Aboriginal people. MSM accounted for 67% of male cases.* *Forty-three new diagnoses of human immunodeficiency virus (HIV) infection were reported in 2012 compared with 68 in 2011. Males are more than three times more likely to be diagnosed with HIV compared with females in 2012. Those aged 20 to 29 years recorded the highest infection rate of 7.0 cases per 100,000 population. Fifty-one per cent of cases were born overseas. Twenty-five cases (58%) reported overseas acquired infection. The majority of cases (79%) reported sexual contact as the most likely route of transmission. Twenty cases identified as MSM and of this subgroup 60% acquired the infection in Australia.* *There were 17 cases of newly acquired hepatitis B virus infections notified in 2012 compared with nine cases in 2011 and an increasing trend is observed since 2008. The number of male cases was more than twice the number of female cases. The diagnosis rate was highest in the 30 to 39 year age group at 2.9 cases per 100,000 population. Newly acquired hepatitis B cases were more likely to be born in Australia (71%) and the modal exposure factor cited was injecting drug use.* *Seventy-eight cases of newly acquired hepatitis C infection were notified in 2012. A large increase in case numbers is attributed to the adoption of the national case definition for newly acquired hepatitisC. The timeframe for a previous negative anti-hepatitis C antibody test has been increased from 12 months to 24 months. The majority of cases occurred in males. The highest age-specific incidence rate was observed in people aged 20 to 29 years with a rate of 12.6 cases per 100,000 population. Similar to 2011 data, Australia was the most frequent country of birth identified for newly acquired hepatitis C cases (87%).* *Injecting drug use continues to be the primary risk factor for acquisition of hepatitis C.* *Hepatitis D occurred as a co-infection in 11 cases of hepatitis B in 2012. There were six males and five females reported and the median age was 44 yea rs. One case identified as Aboriginal. Eight cases were born oversea.*	*n.a.* *n.a.* *n.a.* *n.a.* *n.a.* *n.a.* *n.a.*	*Communicable Disease Control Branch SA Health(2012)* *Communicable Disease Control Branch SA Health(2012)* *Communicable Disease Control Branch SA Health(2012)* *Communicable Disease Control Branch SA Health(2012)* *Communicable Disease Control Branch SA Health(2012)* *Communicable Disease Control Branch SA Health(2012)* *Communicable Disease Control Branch SA Health(2012)*
	Risk factors	*Over one half (58%) of South Australians are living with at least one risk factor while more than a quarter (27%) are living with two or more risk factors.*	*In 2011, for the following risk factors:* *- High blood pressure* *- High cholesterol* *- Not enough physical activity* *- Obesity* *- Smoking* *- High long-term risk of harm from alcohol* *- Poor diet (lack of sufficient fruit & vegetables);* *41.7% of South Australias were living with no risk factors;* *31.3% were living with one risk factor;* *16.7% were living with two risk factors;* *10.3% were living with 3 or more risk factors* *Furher, prevalence of persons living with multiple risk factors was statistically significantly higher in Country SA than metropolitan Adelaide in 2011.* *Trend data also indicates that the gap between Country SA and metropolitan Adelaide is widening* *Not surprisingly, the prevalence of the population living with multiple risk factors increases with age* *Prevalence rates are similar between males and female*	*n.a. for 2011 data* *n.a.*	*National Health performance Authority (NHPA) based on unpublished data from the ABS 2011-12 National Health Survey* *National Health performance Authority (NHPA) based on unpublished data from the ABS 2011-12 National Health Survey*
	Tobacco smoking	*The proportion of adults smoking daily is* ***slightly lower*** *in SAFKI comapred with SA and its peer ML group*	*In 2011-12, 13% of SAFKI adults aged 18 years and over smoked daily. This compares with 16% for SA and 16% for the Metro 2 peer group at the same time.* *Tobacco smoking is the single most preventable cause of ill health and death in Australia. It contributes to more hospitalisations and deaths each year than alcohol and illicit drug use combined.* *Rates of smoking have been dropping in Australia for many years. In 2012, 16.7% of South Australians aged 15 years and over smoked (either daily, weekly or less than weekly), compared with 23.6% a decade earlier. This figure is expected to further decrease with time, given the decreasing proportion of younger people smoking and the increasing proportion who have never smoked.* *However, certain population groups are greater at risk. Those more likely to smoke than the average population include people who are unable to work or unemployed, people living in remote areas, those identifying as Aboriginal and Torres Strait Islander people, and people suffering from mental illness and disorders*	*n.a.*	*Based on data published by and Drug and Alcohol Services SA (DASSA)*
	Alcohol consumption	*In 2010, 1 in 5 Australians aged 14 or older were at risk of lifetime harm and round 2 in 5 put themselves at risk of short term harm.*	*Healthy guidelines recommend drinking no more than 2 standard drinks a day to reduce the lifetime risk of harm from alcohol-related disease or injury. Drinking no more than 4 standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.* *According to the AIHW, In 2010, 1 in 5 Australians aged 14 or older were at risk of lifetime harm and around 2 in 5 put themselves at risk of an alcohol-related injury during a single occasion at least one in the previous year, with males and younger Australians more at risk. Levels of risky alcohol use have generally remained stable over the past decade.*	*n.a.*	*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
		In 2011, 3.6% of South Australians aged over 16 years were at risk of long term harm from alcohol with the Country SA rate higher than the metropolitan Adelaide rate. Further, around 27% of were at risk of short term harm from alcohol consumption *The age-standardised rate of risky drinking levels are similar in SAFKI ML to that of SA*	*According to SA Health, in 2011, 3.6% of South Australians (or 1 in 28) aged over 16 years were at risk of long term harm from alcohol, with the Country SA rate (5.3%) statistically higher than the metropolitan Adelaide rate (2.9%). Further, in 2011, around 27% of all South Australians were at risk of short term harm from alcohol consumption.* *The latest available data on risky drinking for the SAFKI MI region (2007-08) shows an age-standardised rate of 4.7 persons per 100 aged 18 years and above consumed alcohol at levels considered to be a high risk to health.At this time, the age-standardised rate for all of SA was 4.9 persons per 100.*	*n.a.* *n.a.*	*SA Health Performance Council (HPC) (unpublished) based on South Australia Monitoring and Surveillance System (SAMSS) data* *Based on modelled (synthetic) estimates compiled by PHIDU from ABS National Health Survey 2007-08*
	Being overwieght and Obesity	*The proportion of adults who are obese is slightly higher in SAFKI compared with SA* *The proportion of adults who are overweight or obese is slightly higher in SAFKI comapred with its peer ML group* *Overweight and obesity weights are increasing across Australia* *The percentage of adults who are overweight or obese increases with geographical remoteness and lower socio-economic status*	*In 2011-12, 26% of SAFKI adults aged 18 years and over were obese. This compares with 25% for SA in 2011.* *In 2011-12, 66% of SAFKI adults aged 18 years and over were overweight or obese. This compares with 62% for the ML Metro 2 peer group at the same time.* *In 1989, 44% of adults were overweight or obese. The percentage has increased to to 63% in 2011-12*	*n.a.* *n.a.* *n.a.* *n.a.*	*National Health performance Authority (NHPA) based on unpublished data from the ABS 2011-12 National Health Survey* *State of our Health - SA Health Performance Council (draft)* *National Health performance Authority (NHPA) based on unpublished data from the ABS 2011-12 National Health Survey* *National Health performance Authority (NHPA) based on unpublished data from the ABS 2011-12 National Health Survey* *National Health performance Authority (NHPA)* *National Health performance Authority (NHPA)*

		Health problems related to excess body weight have a major impact on the health care system *Obesity rates are higher in Aboriginal and TSI population*	*Obesity imposed an estimated $2 billion in direct costs on Australia's herlath system in 2008* *In 2004-05 (latest available data), more than one-third of SA Aboriginal and TSI adults were classified as obese.This compares with 25%*	*n.a.*	*SA Health Performance Council (HPC) (unpublished) based on South Australia Monitoring and Surveillance System (SAMSS) data*
	Low birth weight babies	*The proportion of births resulting in low birth weight babies is similar in SAFKI compared with SA*	*The proportion of births resulting in low birth weight babies (2008-10):* *SAFKI: 6.9%* *SA: 7.0%*	*Proportions appear correlated with Index of Relative Socio-economic Disadvantage: in general, the more disadvantaged the area, the higher the proportion of low-weight babies*	*Data compiled by PHIDU (2013) based on data from SA Health, 2008-2010*
	Smoking during pregnancy	*The proportion of persons smoking during their pregnancy is slightly lower in SAFKI compared with SA*	*The proportion of persons smoking during their pregnancy (2008-10):* *SAFKI: 12.3%* *SA: 15.0%*	*Proportions appear correlated with Index of Relative Socio-economic Disadvantage: in general, the more disadvantaged the area, the higher the proportion of persons smoking during their pregnancy*	
	Death rates	*Deaths rates across SAFKI council region are the same or lower than SA*	*In 2011, standardised death rates for council regions within the SAFKI MIL region range from 4.6 deaths per 1,000 population (Mitcham) to 5.9 deaths per 1,000 population (Onkaparinga). The corresponding standardised death rate for SA was 5.9 deaths per 1,000 population*	*n.a.*	*Based on data produced by PHIDU based on deaths data supplied by ABS on behalf of State and Territory Registrars of deaths for 2006 to 2010; and ABS Estimated Resident Population, 30 June 2006 to 2010*
	Premature mortality	*Age standardised rates of premature mortality are lower in SAFKI than for SA (for males, females and persons)*	*From 2006 to 2010, the average annual age standardised rate (ASR) of premature mortality (defined as dealths before the age of 75) per 100,000 population was:* *Males: SAFKI: 266.2 ; SA: 312.7* *Feales: SAFKI: 164.4 ; SA: 189.4* *Persons: SAFKI: 214.3 ; SA 250.6*	*Average annual ASRs vary across the 8 council regions however none are higher than SA. The 'worst' is Marion Council (301.0 for males, 184.9 for females & 240.0 for persons) while the 'best' is Mitcham (203.4 for males, 137.3 for females & 169.8 for persons)*	
	Causes of death	*Leading causes of death vary across SAFKI life style groups:* *Cancers, cardiovascular disease, nervous system & sense disorders and chronic respiratory disease are the leading causes amongst older persons;* *Cancers, cardiovasular disease, intentional and unintentional injuries are the leading causes amongst adults and young people; Cancers and unintentional injuries are the leading causes amongst children*	*Leading causes of death by age (life style) groups across SAFKI:* *Infants (0-4 yrs): Neonatal causes (50%) and congenital anomalies (23%)* *Children (5-14 yrs): Unintentional injuries (50%) and cancers (50%)* *Young people (15-24 yrs): Unintentional injuries (41%), intentional injuries (27%), cancers (7%) and nervous system & sense disorders (7%)* *Adults (25-64 yrs): Cancers (47%), cadiovasular disease (21%), intentional injuries (8%) and unintentional injuries (8%)* *Older people (65-84 yrs): Cancers (36%), cardiovascular disease (34%), nervous system & sense disorders (8%) and chronic respiratory disease (7%)* *Senior citizens (85yrs+): Cardiovasular disease (47%), cancers (28%), nervous system & sense disorders (8%) and chronic respiratory disease (6%)*	*n.a.*	*Department for Health and Ageing (South Australia). South Australian Burden of Disease website Adelaide, SA: SA Health; 2010 - 3 yearly annual average 2005-07*
	Burden of disease and injury	*Leading causes of burden of disease and injury vary across SAFKI life style groups:* *Ischaemic heart disease, dementia and stroke are the leading causes amongst older persons;* *Anxiety and depression is the leading cause among adults and young people;* *Asthma and anxiety & depression are the leading causes amongst children*	*Leading causes of burden of disease and injury by age (life style) groups across SAFKI:* *Infants (0-4 yrs): Low birth weight (15%), asthma (9%) and other chromosomal disorders (9%)* *Children (5-14 yrs): Asthma (34%), anxiety and depression (23%) and attention-deficit hyperactivity disorder (6%)* *Young people (15-24 yrs): Anxiety and depression (21%), schizophenia (9%), migraine (7%) and road traffic accidents (6%)* *Adults (25-64 yrs): Anxiety and depression (9%), Type 2 diabetes (8%) and ischaemic heart disease (6%)* *Older people (65-84 yrs): Ischaemic heart disease (14%), dementia (10%) and stroke (6%)* *Senior citizens (85 yrs+): Ischaemic heart disease (20%), dementia (15%) and stroke (11%)*	*n.a.*	
	Quality of Life	*Respondents to the 2007 National Survey of Mental Health who rated their physical health as good, very good or excellent were satisfied with their quality of life, whereas those rating their health as fair or poor were more likely to report mixed feelings*	*Quality of life is increasingly recognised as an important concept in health and other contexts. There is a growing awareness that health is not merely the absence of disease, but a combination of factors related to physical, mental and social wellbeing. Further, the health and wellbeing of individuals is infl uenced by conditions in the society around them. Single measures, such as life expectancy or the prevalence of disease and risk factors, do not always capture this complexity.* *When asked in the 2007 National Survey of Mental Health and Wellbeing about their quality of life over the previous year and how they felt about the future, most respondents said they were mostly satisfied, pleased or delighted. About 14% said they had mixed feelings about their life, while 4% felt mostly dissatisfi ed, unhappy or terrible.* *Most respondents who rated their physical health as good, very good or excellent were satisfied with their quality of life, whereas those rating their health as fair or poor were more likely to report mixed feelings*	*n.a.*	*Australia's Health 2012, Australian Institute of Health and Welfare Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
		In 2011, the ABS reported that improvments have generally been made on 'health'	*Measures of Australia's progress:* *In 2011, the ABS reported that of the 17 headline indicators in Measures of Australia's Progress, improvements have generally been made on six indicators: health, education and training, work, national income, national wealth, and household economic wellbeing. For example:* *• male life expectancy increased slightly more than female life expectancy (3.1 years compared with 2.1), which resulted in the gap between male and females decreasing by 1 year to 4.6* *• between 1998 and 2008, the male infant mortality rate decreased from 5.5 to 4.6 deaths per 1,000 live births, while the female rate declined from 4.5 to 3.6* *• the proportion of 25–64 year olds with a vocational or higher education qualifi cation rose from 50% in 2000 to 63% in 2010* *• from 1999–00 to 2009–10, Australia's real net national disposable income per capita grew from $37,400 to $45,600, in 2008–09 dollars (ABS 2011a).* *However, Australia has generally regressed compared with 10 years ago on two indicators: biodiversity and atmosphere.* *• There was an increase in the number of threatened fauna species from 312 in 2000 to 427 in 2009.* *• Australia's greenhouse gas emissions increased by 16% from 473 million tonnes of carbon dioxide equivalent gases in 1998 to 550 million tonnes in 2008*	*n.a.*	*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
		Based on the OECD Better Life Index, Australia ranks in the top two countries in the category of 'health'	*OECD Better Life Index:* *Australia performs very well and ranks among the top OECD countries for many of the 11 categories of the OECD's Better Life Index). Based on the information in the index, Australia ranks in the top two countries in the categories of health, housing and governance.*	*n.a.*	*Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)*
			The Human Development Index: *The 2011 Human development report presents 2011 HDI values and ranks for 187 countries and territories based on a summary measure of life expectancy, literacy, education and standards of living. Australia's HDI value for 2011 is 0.929—in the very high human development category.* *This positioned it second of all countries globally, behind Norway, and ahead of the Netherlands, the United States and New Zealand (UNDP 2011).* *Between 1980 and 2011, Australia's HDI value increased from 0.850 to 0.929, an increase of 9.3%. There have also been increases in the global average, suggesting improvements in the key indicators that comprise the HDI*	*n.a.*	
	Oral health	*Australia's oral health is suboptimal, particularly among disadvantaged people.* *One quarter of Australian adults have untreated decay and 23% have moderate or severe gum disease.*	*Oral health, including dental health, is fundamental to overall health and wellbeing.* *The 2004-06 National Survey of Adult Oral Health found that experience of dental decay was universal, 25.5% of adults had untreated decay, 22.9% had moderate or severe gum disease and 6.4% had no natural teeth.* *As with many health indicators, poor oral health is more prevalent among disadvantaged groups, including Aboriginal and Torres Strait Islander people, and people with physical disabilities or serious mental illnesses. People in rural and remote areas tend to have worse oral health than those from the cityand older cohorts have worse oral health on some but not all measures.* *As with health more generally, the inverse care law is apparent: people with worse oral health tend to have less access to dental/oral treatment. There is evidence of growing inequalities. For example, concession cardholders (who are generally on low incomes) are consistently less likely than non-cardholders to report a dental visit at least once a year, but the gap increased from 5.4 to 15.3 percentage points between 1994 and 2008. Also the proportion of people reporting that dental visits are a large financial burden increased for rural/remote dwellers but not for urban dwellers. In addition, there is a maldistribution of dentists in Australia, with inadequate numbers in non-urban areas.* *Poor oral health imposes substantial demands on the healthcare system, beyond the direct effects of oral disease. Untreated or poorly managed oral disease is implicated in the development of systemic diseases, including cardiovascular disorders and respiratory diseases. It is a significant cause of preventable hospitalisations. In addition, the quality of life of people with chronic health problems isoften reduced by poor oral health (eg. 18% of people with heart disease reported having toothache often or very often in the last year). Oral health has significant economic consequences. Expenditure on dental health accounts for more than 6% of total health funding.Dental problems can reduce employment capacity,both by causing pain and ill-health and by causing stigma-triggering disfigurement.* *In summary, here is room for improvement in Australian oral health particularly among disadvantaged groups. There are major problems in accessibility of dental services, including a maldistribution of dentists, and the lack of universal government-funded coverage. However, some promising interventions have been trialled or are currently being investigated.*	*n.a.*	*PHCRIS Research Roundup Issue 28, June 2013*
Utilisation of Health Services	***Types of Health services***	*There are a large variety of health services across the region:*	*In summary there are:*		*National Health services Directory (NHSD) and SAFKI's internal organisational database*

		Hospitals:	*6 publicly funded hospitals and 3 emergency departments* *Note: SAFKI ML region is serviced by 2 major hospitals; Flinders Medical Centre (FMC) and Noarlunga Health Service (NHS) with FMC being the major referral centre for acute care and emergency services within the region.In addition, the Repatriation General Hospital (RGH) is located in Daw park and is an acute care public hospital specialising in care for older people and veterans* *The total number of beds available in public hospitals is in the order of 1070, which equates to around 2.7 beds per 1000 population in the SAFKI region. More than half of these (around 590) are at FMC. RGH has around 300 beds and NHS 95 beds.* *6 private hospitals*	*These are managed by various Local Health Networks (LHNs) - covered in more detail below* *The 3 rural hospitals: SouthCoast has 50 beds, Strathalbyn 20 and Kangaroo Isalnd 15* *5 in the metro region and 1 in the rural region*	*National Health services Directory (NHSD) and SAFKI's internal organisational database* *SAFKI ML internal organisation database*
		General practice:	*According to SAFKI ML internal database, there are currently* *103 general practice sites* *with 475 paracticing GPs and 217 practice nurses (note this implies a GP to Population ratio of 1 GP per 842 residents)* *Further, based on the age profile of GPs, it is anticipated as much as half of the GP workforce in the SAFKI ML region will retire in the next 5 to 10 years.*	*89 in metro region* *14 (9 practices) in rural regions* *1 on Kangaroo Island (remote)*	*DOHA's Medicare Local GP Statistsics, National Health services Directory (NHSD) and SAFKI's internal organisational database*
		Other health services:	*105 pharmacies* *15 ambulance stations* *2 medical deputising services* *96 mental health services* *50 aged care facilities* *250+ allied health service 'sites' covering a wide range of additional primary care services offered by more than 9,000 primary health care professionals including:* *Audiology - 29* *Chiropractic - 48* *Dieteticss - 14* *Exercise Physiology - 6* *Occupational Therapy - 19* *Physiotherapy - 66* *Podiatry - 53* *Speech pathology - 13* *Social work - 3* *Diabetes educator - 2* *22 disability support services* *34 specialist services* *85 dental services*		*National Health services Directory (NHSD) and SAFKI's internal organisational database* *National Health services Directory (NHSD) and SAFKI's internal organisational database* *National Health services Directory (NHSD) and SAFKI's internal organisational database* *National Health services Directory (NHSD) and SAFKI's internal organisational database* *National Health services Directory (NHSD) and SAFKI's internal organisational database* *National Health services Directory (NHSD) and SAFKI's internal organisational database* *National Health services Directory (NHSD) and SAFKI's internal organisational database* *National Health services Directory (NHSD) and SAFKI's internal organisational database* *National Health services Directory (NHSD) and SAFKI's internal organisational database*
		Other key care services within the SAFKI region:	*Reach Aged Care in the South* *Noarlunga Headspace* *GP Plus Marion* *GP Plus Super Clinic Noarlunga*		
	Local Health Networks (LHNs)	*SAFKI ML has dealings with 3 LHNs:* *Southern Adelaide LHN* *Country Health SA LHN* *Women's and Children's Health Network*	*LHNs manage the delivery of public hospital services and other community based services as determined by the State Government.They comprise single or groups of public hospitals and have a geographical or functional connection.. They are accountable to the state government for performance management and planning.*		
	Local Government	*There are also a number of community based services delivered by local government organisations*	*Immunisation clinics* *HACC* *Social support services* *Home help services* *Transport services*		
	Allied health providers in public hospitals	*There are also a number of allied health providers working in public hospitals*	*Additional information collated to date has identified:* *. 110 allied health providers working at the Repat GH, 120 at FMC, 80 FTE within southern metro health services and 220 within southern metromental health services* *. In the country LHN, there are known to 17 FTE allied health providers working across the Fleurieu region including 2 FTE on Kangaroo Island*		*various health websites*
	Use of primary health care services:				*Department of Human Services Medicare Benefits Statistics, 2013*
	GPs	*1,775,133 GP consultations in a year*	*In 2012, 1,775,133 GP consultations at consulting rooms across SAFKI.* *This represents 23.6% of all SA GP consultations at consulting rooms* *The vast majority of the GP consultations during 2012 were standard consultations (83.1%), long consultations accounted for 11.7%, brief consultations accounted for 4.5% and prolonged consultations 0.7%.*	*n.a.*	
		148,300 GP 'after hours' conultations in a year	*In 2012, there were 148,300 GP 'after-hours' consultations across SAFKI (of which 85.2% within surgery)* *This represents 24.4% of all SA GP 'after hours' consultations*	*n.a.*	*Department of Human Services Medicare Benefits Statistics, 2014*
		57,967 GP RACF consultations in a year	*In 2012, GPs held 57,967 consultaions at RACFs within SAFKI (of which 88.2% were during 'usual' hours)* *This represents 22.4% of all GP RACF consultatations in SA*	*n.a.*	*Department of Human Services Medicare Benefits Statistics, 2015* *National Health performance Authority (NHPA)*
		83% of SAFKI residents see a GP	*In 2011/12, 83% of SAFKI residents saw a GP within last 12 months (83% in 2010/11)* *This compares with 81% for all Australians*	*n.a.*	*National Health performance Authority (NHPA)*
		5.8 GP attendenaces per person in SAFKI (non-age-standardised average)	*In 2011/12, Average number of GP attendances per person was 5.8 for SAFKI residents (5.6 in 2010/11)* *(NOTE: based on Medicare statistics, the rate is lower, at just over 4.4 in 2012)*	*n.a.*	*National Health performance Authority (NHPA)*
		$261.46 spent per person on GP attendances in SAFKI	*In 2011/12, Average expenditiure on GP attendances per person was $261.46 in SAFKI ($246.91 in 2010/11)*	*n.a.*	*National Health performance Authority (NHPA)*
		12% of adults visited a GP more than 12 times in a year	*In 2010/11, 12% of SAFKI adults visited a GP more than 12 times in the last 12 months* *(12% for all Australians)*	*n.a.*	*National Health performance Authority (NHPA)*
		20% of adults visited a GP for uregnt care	*In 2010/11, 20% of SAFKI adults visited a GP for urgent care* *(16% for all Australians)*	*n.a.*	*National Health performance Authority (NHPA)*
		80.8% of GP attendances bulk-billed	*In 2011/12, 80.8% of GP attendances were bulk-billed*	*n.a.*	
	Practice nurse and Aboriginal health workers		*In 2012, there were 22,630 services administered by practice nurses and Aboriginal health workers in SAFKI* *(This represents 28.3% of all such services in SA)*		
	After hours GP Helpline	*In 2012, almost 5,300 persons were assisted by the after hours GP helpline*	*In 2012, healthdirect Australia received 21,610 calls originating from the SAFKI Medicare Local region during the after hours GP helpline operating hours. Of these, 16,314 (75.5%) were managed by a triage nurse and 5,296 (24.5%) were transferred to the after hours GP helpline*	*n.a.*	
		A greater proprtion of SAFKI persons assisted by after hour GP helpline were females	*A greater proportion of after hours GP helpline calls during 2012 were from or on behalf of female patients (64.4% compared with 35.6% for males)*	*n.a.*	

	Almost 1/4 of SAFKI calls to after hours GP helpline were made on belaf of infants aged 0 to 4 years	*In terms of life-stage groups, 41.2% of calls to the after hours GP helpline calls during 2012 were from or on behalf of patients aged 25 years to 64 years, 24.9% were on behalf of infants aged 0 to 4 years, 12.8% were from or on behalf of young adults aged 15 to 24 years, 10.1% were from or on behalf of children aged 5 to 14 years, 9.3% were from or on behalf of older persons aged 65 to 84 and 1.8% were from or on behalf of senior citizens aged 85 years and older*	*n.a.*	
	Weekends are the busiest times for calls to the after-hours GP helpline	*Sunday was the busiest day (24.1% of calls during 2012), followed by Saturday (17.4%) and Monday (13.1%). Thursday had the lowest volume of calls (10.8%).*	*n.a.*	
	Almost half of SAFKI calls to after hours GP helpline resulted in self care advice or a recommendation to see GP in normal business hours. 13% resulted in advice to visit an ED immediately and 17% in see a GP immediatwely.	*The most frequent types of advice given by GPs on the after hours GP helpline during 2012 were; Self care and see a doctor or health provider within normal operating hours (49.1%), See a GP immediately (16.6%) and Visit a hospital emergency department immediately (12.9%)*	*n.a.*	
				National Health performance Authority (NHPA)
Dental	*51% of SAFKI adults visit a dentist (inlcuding speciailst dentist and hygienists)*	*In 2011/12 ,51% of adults saw a dentist, hygienist or dental specialist in the preceding 12 months*	*n.a.*	*National Health performance Authority (NHPA)*
Medical Specialist	*51% of SAFKI adults visit a medcial specialist*	*In 2011/12 ,36% of adults saw a medical specialist in the preceding 12 months*	*n.a.*	
				National Health performance Authority (NHPA)
Hospitals	*The number of beds available in public hospitals equates to around 2.7 beds per 1000 population in SAFKI*	*The total number of available beds in SAFKI public hospitals is in the order of 1,070, which equates to about 2.7 beds per 1,000 population*		
		In 2011/12, 15% of SAFKI adults were admitted to any hospital in preceding 12 months	*n.a.*	*National Health performance Authority (NHPA)*
		In 2011/12, 14% of SAFKI adults went to a hospital ED in preceding 12 months	*n.a.*	
				SA Health hospital and other health care statistics, 2013
Public hospital activity	*25% of all public hospital separations were in SAFKI hospitals*	*In 2012, there were 100,680 public hospital separations across SAFKI's 6 public hospitals (25% of all SA public hospital separations)* *Of these, 86,940 (82%) were persons residing within the SAFKI region.*	*FMC makes up 57% of all SAFKI separations*	*SA Health hospital and other health care statistics, 2013*
	The hospitalisation rate (separations per 1,000 people) is similar in SAFKI to that of SA	*In 2012, there were 105,578 public hospital separations by residents of the SAFKI ML region with 86,940 being in SAFKI's 6 public hospitals.*		
		This means the hospitalisation rate per 1,000 people was similar in SAFKI compared with SA		
	The average length of stay per person in a public hospital is the same in SAFKI as SA	*In 2012, ave. length of stay in SAFKI ML public hospitals was 3.9 days per person. This is the same as for all SA public hospitals*	*In 2012, Ave. length of stay highest in KI hospital (7.3 days) followed by RGH (5.7). The lowest was in South Coast (1.8) and Noarlunga (2.6). The largest hospital,FMC, was 3.8.*	*SA Health hospital and other health care statistics, 2013*
	26% of all SA public hospital outpatient occasions of service were in SAFKI's public hospitals	*In 2012, 350,000 public hospital outpatient occasions of service for SAFKI's 6 public hospitals (26% of all outpatient occasions of service in SA)*		*SA Health hospital and other health care statistics, 2013*
	Emergency Department presentations across the SAFKI ML region increased by around 5.1% in 2012	*In 2012, 126,430 ED presentations in SAFKI (increase of 5.1% from 120,320 in 2011)*	*FMC just behind RAH in terms of ED presentations (FMC: 68000 in 2102; RAH 71,700) however FMC largest % increase from 2011 to 2012 (12%) - LMH (4.4%), RAH (2.4%), QEH (2.1%) Modbury (0.6%)*	
	More than half of all ED presentations within the SAFKI region in 2012 were classified as 'semi- or non-urgent'	*In 2012, 1 in 8 (12.3%) of ED presentations were Triage 1 or 2 (Resusitation or Emergency => immediate or seen within 10 mins), 36.2% were triage 3 (Urgent - seen within 30 mins) and more than half (51.4%) were triage 4 or 5 (semi-urgent or non-urgent)*		*SA Health hospital and other health care statistics, 2013*
	Patient admissions from ED presentations	*In 2012, 32,250 patients were subsequently admitted to hospital after presnting to a public hospital ED in SAFKI region* *This represents around 1/4 of all ED presentations.*	*In 2101, 82.2% of these are from FMC, 9.1% from Noralunga, 5% from South Coast, 2% from Strathalbyna nd 1.6% from KI*	*National Health performance Authority (NHPA)*
	Use of hospital EDs instead of GPs	*Number of subsequent hospitalisatios from ED presntations increased by 12.6% in 2012 (due to a 14.7% increase at FMC)* *In 2010-11, Among all adults who visited a hospital emergency department (ED) for care in the preceding 12 months, the percentage of adults who thought their care could have been provided by a GP instead of an ED:* *SAFKI: "not available"* *Australia: 21%* *Medicare Local Peer Group 2: 17% (Ranges from 10% to 23% for MLs published)*	*FMC*	
Ambulance services	*In 2011/12, SA Ambulance respondedn to 255,560 incidents in SA (55% were emergency cases and 22% were urgent cases),*	*For the 12 months ending June 2012, SA Ambulance responded to 255,563 incidents. Of these, 140,930 (55.1%) were emergency cases, 57,091 (22.3%) were urgent cases and 57,542 (22.5%) were non-urgent cases.*	*n.a.*	
		There are 108 ambulance stations across South Australia. Of these, 15 are located within the SAFKI Medicare Local region, 6 in southern metropolitan Adelaide, 5 across the Fleurieu Peninsula and 4 on Kangaroo Island.	*n.a.*	
Patient experiences with primary health care				*National Health performance Authority (NHPA)*
GPs	*The proportion of adults feeling they wait longer than acceptable to get a GP appointment is **higher** for SAFKI than for Australia and SAFKI's Medicare Local (ML) 'peer' group.*	*In 2010-11, the percentage of adults who felt they waited longer than acceptable to get a GP appointment:* *SAFKI: 19%* *Australia: 15%* *Medicare Local Peer Group 2: 13%*	*n.a*	*National Health performance Authority (NHPA)*
	*Waiting times for urgent appointments with a GP **appear to be longer** in SAFKI when compared to Australia and SAFKI's ML 'peer' group*	*In 2010-11, the percentage of adults who waited >4 hours from making an appointment to seeing GP for urgent GP appointments:* *SAFKI: 47%* *Australia: 40%* *Medicare Local Peer Group 2: 42%*	*n.a*	*National Health performance Authority (NHPA)*
	*The proportion of adults delaying or not seeing their GP due to cost is **very similar** in SAFKI to that for Australia and SAFKI's ML 'peer' group*	*In 2011-12, among all adults who saw, or needed to see, a GP for their own health in the preceding 12 months: the percentage who said they did not see, or who delayed seeing, a GP due to cost in the preceding 12 months:* *SAFKI: 6% (down from 10% in 2010-11)* *Australia: 7% (down from 8% in 2010-11)* *Medicare Local Peer Group 2: 7% (down from 9% in 2010-11)*	*n.a*	*National Health performance Authority (NHPA)*
	*The proportion of adults feeling their GP always or often listened carefully to them is **very similar** in SAFKI to that for Australia and SAFKI's ML 'peer' group*	*In 2010-11, among all adults who saw a GP for their own health in the preceding 12 months: In 2010–11, the percentage who felt that their GP always or often listened carefully to them in the preceding 12 months:* *SAFKI: 88%* *Australia: 89%* *Medicare Local Peer Group 2: 89%*	*n.a*	*National Health performance Authority (NHPA)*
	*The proportion of adults feeling their GP always or often showed respect for what they have to say is the **same** in SAFKI as that for Australia and SAFKI's ML 'peer' group*	*In 2010-11, among all adults who saw a GP for their own health in the preceding 12 months: In 2010–11, the percentage who felt that their GP always or often showed respect for what they had to say in the preceding 12 months:* *SAFKI: 92%* *Australia: 92%* *Medicare Local Peer Group 2: 92%*	*n.a*	*National Health performance Authority (NHPA)*
	*The proportion of adults feeling their GP always or often spent enough time with them is **very similar** to that for Australia and SAFKI's ML 'peer' group*	*In 2010-11, among all adults who saw a GP for their own health in the preceding 12 months: In 2010–11, the percentage who felt that their GP always or often spent enough time with them in the preceding 12 months:* *SAFKI: 86%* *Australia: 87%* *Medicare Local Peer Group 2: 88%*	*n.a*	*National Health performance Authority (NHPA)*
	*The proportion of adults saying they could not access their preferred GP (of those who had a preferred GP) is **slightly higher** in SAFKI compared with its ML 'peer' group*	*In 2010-11, among all adults who saw, or needed to see, a GP for their own health in the preceding 12 months and had a preferred GP: the percentage who said they could not access their preferred GP at any time in the preceding 12 months:* *SAFKI: 40%* *Medicare Local Peer Group 2: 37%*	*n.a*	*National Health performance Authority (NHPA)*
	*The proportion of adults saying they delayed filling or did not fill a prescription due to cost is **similar (albeit slightly less)** to that for Australia and SAFKI's ML 'peer' group*	*In 2011-12, among all adults who were written a prescription for medication by a GP for their own health in the preceding 12 months, the percentage of adults who delayed filling or did not fill a prescription due to cost:* *SAFKI: 8%* *Australia: 9%* *Medicare Local Peer Group 2: 10%*	*n.a*	*National Health performance Authority (NHPA)*

Medical specialists	*The proportion of adults saying they waited longer than acceptable to get an appointment with a medical specialist is **similar (albeit slightly less)** to that for Australia and SAFKI's ML 'peer' group*	*In 2011-12, among all adults who received a referral to a medical specialist for their own health in the preceding 12 months, the percentage who felt they waited longer than acceptable to get an appointment with a medical specialist:* *SAFKI: 22%* *Australia: 25%* *Medicare Local Peer Group 2: 24%*	*n.a*	*National Health performance Authority (NHPA)*
	*The proportion of adults delaying seeing or did not see a medical specialist due to cost is **similar** to that for Australia and SAFKI's ML 'peer' group*	*In 2011-12, among all adults who saw or needed to see a medical specialist for their own health in the preceding 12 months, the percentage of adults who delayed seeing or did not see a medical specialist due to cost:* *SAFKI: 6%* *Australia: 8%* *Medicare Local Peer Group 2: 7%*	*n.a*	*National Health performance Authority (NHPA)*
Dental professionals	*The proportion of adults delaying seeing or did not see a dentist or hygienist due to cost is **similar** to that for Australia and SAFKI's ML 'peer' group*	*In 2011-12, among all adults who saw or needed to see a dentist, dental hygienist or dental specialist for their own health in the preceding 12 months, the percentage of adults who delayed seeing or did not see a dentist or hygienist due to cost:* *SAFKI: 19%* *Australia: 21%* *Medicare Local Peer Group 2: 20%*	*n.a*	
Disease prevention and management				*National Health performance Authority (NHPA)*
Immunisation	*Immunisation rates (2011-12) in SAFKI **similar** to that for all SA*	*According to The Australian Childhood Immunisation Register (ACIR):* *92.8% of all SAFKI children aged 1 year (12-15 months) were immunised (2011/12) - SA 92.3%* *92.2% of all SAFKI children aged 2 years (24-27 months) were immunised (2011/12) - SA 92.6%* *86.5% of all SAFKI children aged 5 years (60-63 months) were immunised (2011/12) - SA 87.7%*	*n.a.*	*National Health performance Authority (NHPA)*
	*Immunisation rates (2011-12) are **lower** for Aboriginal and Torres Strait Islander children*	*Immunisation rates are lower for Aboriginal & Torres Strait Islander (Indigenous) children however, viz:* *89.0% of SAFKI Indigenous children aged 1 year (12-15 months) were immunised (2011/12) - SA 79.6%* *91.4% of SAFKI Indigenous children aged 2 years (24-27 months) were immunised (2011/12) - SA 87.4%* *75.8% of SAFKI Indigenous children aged 5 years (60-63 months) were immunised (2011/12) - SA 79.2%*	*n.a.*	
Cancer screening	*Rates for cancer screening in SAFKI ML are similer to those for SA*	*There are national screening programs for breast, cervical and bowel cancer in Australia, and each has its own target group based on age and sex. The latest data shows that:* *• 57% of SAFKI Medicare Local women aged 50-69 took part in Breastscreen Australia programs in 2009-2010. (57% for SA).* *• 63% of SAFKI Medicare Local women aged 20-69 took part in the National Cervical Screening Program in 2008-2009. (61% for SA)* *• 42% of SAFKI Medicare Local men and women invited to participate in 2010 took part in the National Bowel Cancer Screening Program. (45% for SA)*	*n.a.*	*Data compiled by PHIDU based on data from variety of sources including the ABS, BreastScreen SA, the Department of Health and Ageing from the National Bowel Cancer Screening Program and the SA Cervix Screening Program.*
Health assessments	*In 2012, a total of 14,221 health assessments were undertaken across SAFKI Medicare Local by GPs and Practice Nurses, representing 25% of all South Australian health assessments.* *On a weighted per capita basis, SAFKI Medicare Local GPs conducted a higher rate of 'brief' and 'prolonged' health assessments 2012 than their state counterparts in 2012, but a lower rate of 'standard' and 'long' health assessments.*	*Medicare Benefits Scheme (MBS) Health Assessment items are aimed at the early detection of health risk factors and chronic disease, and are part of the increasing focus on the promotion of good health and the prevention of chronic disease. From 1 May 2010, health assessment items were consolidated into four time-based items as follows:* *• Brief Health Assessments (GPs) lasting less than 30 minutes (Item 701)* *• Standard Health Assessments (GPs) lasting 30 to 45 minutes (Item 703)* *• Long Health Assessments (GPs) lasting 45 to 60 minutes (Item 705)* *• Prolonged Health Assessments (GPs) lasting more than 60 minutes (Item 707)* *and* *• Indigenous Health Assessments (non-time based) (Item 715)* *• 4 year old check by a Practice Nurse or Aboriginal Health Worker (Item 10986)* *In 2012, a total of 14,221 health assessments were undertaken across SAFKI Medicare Local by GPs and Practice Nurses (including 453 Healthy Kids Checks). This represents 25% of all South Australian health assessments during 2012.* *During 2012, health assessments undertaken by GPs consituted 96% of all health assessments within the SAFKI Medicare Local region. Of these, 8.9% were brief health assessments (Item 701), 18.6% were standard (Item 703), 16.0% were long (Item 705) and 56.5% were prolonged health assessments (Item 707)* *On a weighted per capita basis, SAFKI Medicare Local GPs conducted a higher rate of 'brief' and 'prolonged' health assessments 2012 than their state counterparts in 2012, but a lower rate of 'standard' and 'long' health assessments.*	*n.a.*	*Medicare Statistics Australia, 2013; Regional Population Growth 2011-12, Australia, ABS Cat. 3218.0*
Chronic disease management		*MBS chronic disease management items enable GPs to manage the health care of patients with chronic medical conditions, including patients who need multidisciplinary care. Medicare rebates are available to GPs for preparing and reviewing GP Management Plans for patients with chronic medical conditions. For patients requiring multidisciplinary care, GPs can claim from Medicare for coordinating team care planning and review services. These items apply for treatment of persons with asthma, arthritis, diabetes, heart disease and other chronic medical conditions.* *The item numbers included are:* *• Item 721 GP Management Plan (GPMP)* *• Item 723 Team care Arrangements (TCA)* *• Item 729 Contribution to a Multidisciplinary Care Plan (MCP)* *• Item 731 Contribution to a MCP for an aged care facility resident* *• Item 732 Review of a GPMP or TCA* *During 2012, around 86,750 chronic disease management (CDM) services were provided across the SAFKI Medical Local region, representing around one-quater all South Australian CDM services in 2012.* *GPMP/TCA reviews accounted for just over half (50.5%) of CDM services in 2012, the preparation of GPMPs accounted for 26.1%, participation in TCAs accounted for 20.8% and MCPs performed in aged care facilities accounted for 2.6%.* *SAFKI Medicare Local's per capita coverage of chronic disease management items is lower than the state rate for Items 721 (GPMP) and 723 (TCAs) but higher than the state rate for Items 731 (MCPs for RACF residents) and 732 (GPMP/TCA reviews)*	*n.a.*	*Medicare Statistics Australia, 2013 and Regional Population Growth 2011-12, Australia, ABS Cat. 3218.0*
Medication management reviews		*During 2012, a total of 2,840 medication management reviews (MMR) were conducted by SAFKI Medicare Local GPs. This represents 25.5% of all MMRs conducted by South Australian GPs during 2012.* *Domiciliary (annual) MMRs made up 54.3% and Residential MMRs 45.7% of total MMRs undertaken by SAFKI Medicare Local GPs in 2012.* *On a weighted per capita basis, SAFKI Medicare Local GPs conducted a higher rate of residential MMRs than their state counterparts and a similar rate of domiciliary MMRs during 2012.*	*n.a.*	*Medicare Statistics Australia, 2013 and Regional Population Growth 2011-12, Australia, ABS Cat. 3218.0*
Case conferencing items		*SAFKI Medicare Local GPs organised and coordinated 97 case conferences and participated in a further 56 case conferences during the 2012 year. This represents 16.2% of all case conferences organised by SA GPs and 14.8% of all GP participations in case conferences across SA in 2012.* *SAFKI Medicare Local's per capita coverage of case conferences during 2012 was markedly lower than the state rate.*	*n.a.*	*Medicare Statistics Australia, 2013 and Regional Population Growth 2011-12, Australia, ABS Cat. 3218.0*

	Mental health treatment	*During 2012, SAFKI ML GPs provided 41,389 mental health service items, representing 27% of all GP mental health service items in SA.*	*GP mental health treatment items (MBS items 2702, 2710, 2712 and 2713) provide Medicare rebates where GPs undertake early intervention, assessment and management of patients with mental disorders. These items provide a structural framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, as well as providing referral pathways to clinical psychologists and allied mental health providers. From November 2011, there are four time-dependent mental health treatment plan MBS items. Access to each item depends on the GP mental health treatment plan and whether a GP has undertaken mental health skills training recognized through the General Practice Mental Health Standards Collaboration.* *The MBS item numbers included are:* *• Item 2700 Preparation of a GP Mental Health Treatment lasting 20 to <40 minutes (medical practitioner who has not undertaken mental health skills training)* *• Item 2701 Preparation of a GP Mental Health Treatment lasting at least 40 minutes (medical practitioner who has not undertaken mental health skills training)* *• Item 2712 GP Mental Health Treatment Plan Review* *• Item 2713 GP Mental Health Treatment Consultation* *• Item 2715 Preparation of a GP Mental Health Treatment lasting 20 to <40 minutes (medical practitioner who has undertaken mental health skills training)* *• Item 2717 Preparation of a GP Mental Health Treatment lasting at least 40 minutes (medical practitioner who has undertaken mental health skills training)* *During 2012, SAFKI ML GPs provided a total of 41,389 mental health services, representing around 27% of all GP mental health services across South Australia.*	*n.a.*	*Medicare Statistics Australia, 2013*
		During 2012, SAFKI ML GPs provided 115 focussed pshychological strategies, representing around 5% of all focussed pshychological strategies across South Australia.	*Focussed Psychological Strategies (FPS) are specific mental health care management strategies, derived from evidence based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These strategies are required to be provided to patients by a credentialed medical practitioner and are time limited; being deliverable, in up to ten planned sessions per calendar year. In exceptional circumstances, following review by the practitioner managing the patient either under the GP Mental Health Treatment Plan or under the Psychiatric Assessment and Management Plan, up to a further 6 services may be approved from 1 March 2012 to 31 December 2012 to an individual patient. Medical practitioners must be notified to Medicare Australia by the General Practice Mental Health Standards Collaboration that they have met the required standards for higher level mental health skills. A session should last for a minimum of 30 minutes.* *During 2012, SAFKI ML GPs provided 115 focussed pshychological strategies, representing around 5% of all focussed pshychological strategies across South Australia.*	*n.a.*	*Medicare Statistics Australia, 2013*
Primary Health Care System Capacity	**Health services**	*There is a wealth of health services and practitioners servicing the SAFKI ML region*	*Refer to numbers presented under the focus area: "Utilisation of Health Services" above*		*Health Workforce Australia and internal SAFKIML database*
	General practitioners	*The ratio of GPs per 10,000 residents is* ***lower*** *in SAFKI compared with that for SA as a whole, with the gap widening in recent years* *The GP per population ratio is* ***particularly low in Marion****.*	*In 2012, based on HWA data, there was around 480 GPs in the region, meaning there is around 12.0 GPs per 10,000 SAFKI ML residents. This compares with a ratio of 12.9 GPs per 10,000 residents across the state.* *In 2010, there were around 450 GPs in the region => a ratio of 11.4 GPs per 1,0000 SAFKI ML residents, compared with a ratio of 12.1 GPs per 1,00000 residents for SA as a whole, meaning the ratio of GPs to resident population is lower in SAFKI compared to SA.* *Further while the ratio increased slightly between 2010 and 2012, it did not increase as much as that for SA)*	*The GP per population ratio is particularly low in Marion.*	*Health Workforce Australia*
	Dentists	*The ratio of Dentists per 10,000 residents is* ***lower*** *in SAFKI compared with that for SA as a whole* *The dentists per population ratio is* ***particularly low in Alexandrina.***	*In 2012, based on HWA data, there was around 170 Dentists in the region, meaning there is around 4.3 per 10,000 SAFKI ML residents. This compares with a ratio of 5.8 per 10,000 residents across the state.*	*The ratio of dentists per 10,000 population is low in Alexandrina (2.3) and Victor Harbor (4.0)*	*Health Workforce Australia*
	Pharmacists	*The ratio of pharmacists per 10,000 residents is slightly higher in SAFKI ML compared with that for SA as a whole* *The pharmacists per population ratio is* ***particularly low in Marion and Onkaparinga, and also in Victor Harbor***	*In 2012, based on HWA data, there was around 300 pharmacists in the region, meaning there is around 7.4 per 10,000 SAFKI ML residents. This compares with a ratio of around 7.3 per 10,000 residents across the state.*	*The ratio of pharmacists per 10,000 population is low in Marion (4.6), Onkaparinga (4.7) and Victor Harbor (6.1)*	*Health Workforce Australia*
	Physiotherapists	*The ratio of physiotherapists per 10,000 residents is* ***slightly lower*** *in SAFKI ML compared with that for SA as a whole* *The physiotherapists per population ratio is* ***particularly low in Onkaparinga, Alexandrina and Marion***	*In 2012, based on HWA data, there was around 375 physiotherapists in the region, meaning there is around 9.3 per 10,000 SAFKI ML residents. This compares with a ratio of around 9.6 per 10,000 residents across the state.*	*The ratio of physiotherapists per 10,000 population is low in Onkaparinga (4.5), Alexandrina (4.9) and Marion (5.1)*	*Health Workforce Australia*
	Optometrists	*The ratio of optometrists per 10,000 residents is* ***similar i****n SAFKI compared with that for SA as a whole* *The optometrists per population ratio is* ***low in Onkaparinga.***	*In 2012, based on HWA data, there was 56 optometrists in the region, meaning there is around 1.4 per 10,000 SAFKI ML residents. This compares with a ratio of 1.4 per 10,000 residents across the state.*	*The ratio of optometrists per 10,000 population is low in Onkaparinga (1.0)*	*Health Workforce Australia*
	Psychologists	*The ratio of psychologists per 10,000 residents is* ***lower*** *in SAFKI compared with that for SA as a whole* *The psychologists per population ratio is* ***particularly low in Alexandrina and Marion.***	*In 2012, based on HWA data, there was 177 psychologists in the region, meaning there is around 4.9 per 10,000 SAFKI ML residents. This compares with a ratio of 5.8 per 10,000 residents across the state.*	*The ratio of psychologists per 10,000 population is low in Alexandrina (1.3), Marion (2.6) and Onkaparinga (4.3)*	*Health Workforce Australia*
	Podiatrists	*The ratio of podiatrists per 10,000 residents is* ***the same*** *in SAFKI compared with that for SA as a whole* *The podiatrists per population ratio is* ***particularly low in Onkaparinga and Alexandrina.***	*In 2012, based on HWA data, there was 80 podiatrists in the region, meaning there is around 2.0 per 10,000 SAFKI ML residents. This compares with a ratio of 2.0 per 10,000 residents across the state.*	*The ratio of podiatriststs per 10,000 population is low in Onkaparinga (1.2), Alexandrina (1.2) and Marion (1.7)*	*Health Workforce Australia*
	Health service coordinaton and communication	*Several issues/gaps connected with health service provision were raised during community consultation*	*Feedback provided from Community consultations:* *Kangaroo Island community would like a 'one-stop shop/no wrong door' style service* *Need for specialised partnerships and relationships* *Better networking among health providers* *Overcome boundary and funding restrictions => sharing resources/systems* *Building information/knowledge resouces/systems*		*Community consultation*
	After hours services/clinics	*Only around 12% of practices in the metropolitan region provide comprehansive after hours services/clinics.*	*In the metropolitan region, only approximately 12% of practices provide comprehensive after hours services/clinics, approximately 20% provided very limited after hours services (e.g. open until 7pm on or doctor on call for own patients only) and approximately 7% provide services after hours on weekends.* *Over 80% of metropolitan practices utilise the Medical Deputising Service (MDS), gpSolutions which provides gpConnect After Hours Home Visits within the Adelaide Metro area for after hours care coverage.* *In the rural and remote region, 9 out of the 10 General Practices are involved in providing after hours care in some form in both the sociable and unsociable hours . The model varies and in the majority of cases is linked with the provision of emergency care for their community. No MDS exists in the rural or remote region. Apart from Victor Harbor and Kangaroo Island, no locum service exists and after hours is provided via rosters of local GPs. This system is supported by the first point of contact through the nursing assessment and triage service at the local hospital.*		*various*
	Community health services	*Several issues/gaps connected with community health services were raised by services providers aduring community consultation*	*Feedback from Service providers:* *Issues/gaps in community health services included a lack of GPs, provision of nursing support, particularly in the after-hours period, lack of low cost transport, after hours and on-call services, turnaround for medical imaging, community nursing, ongoing development of chronic condition self-management capacity, ongoing development and implementation of Out of Hospital type programs, palliative care, Very high demand for Intra Uterine Device insertion, poor taxi services, insufficient community care packages, access to community disability support services, cancer-specific services, health networks outside of GP and pharmacists are poor.*		*Health provider consultation*

	Aged care	*Several issues/gaps connected with aged care were raised by services providers and consumers during community consultation*	*Feedback from Service providers:* *Issues/gaps in aged care included dementia support and respite, social isolation of older persons and those with mental illness, access to disability care support/services, accessing after-hours GP services at RACFs, accessing specialists in pain management, lackof skilled professional staff to change indwelling catheters, supra pubic catheters, Percutaneous Endoscopic Gastrostomy (PEG) tubes or give intramuscular injections, lack of psycho-geriatricians and psychologists available to visit or provide advice on care and management of difficult behaviours and address issues of depression, accessing dental care, transport options for the frail aged, etc* *Feedback from Focus groups:* *While several good aged care services in the SAKFI area were noted. Issues discussed were the availability and cost of residential aged care, the need for increasing levels of community care to assist an ageing population, the provision of enough aged care staff to meet future needs, and the gaps in the provision of mental health services for older people.*		*Health provider consultation*
	Health information	*The need to be able to access accurate, timely health information is seen as a major gap within the SAFKI community*	*A wide range of information is available including the National Health Services Directory (NHSD) which is an online public tool for 'searching for health service locations by type'. The NHSD also has a smart-phone app but not all health services types are available for searching on the app. Following the release of the NHSD, SA Health Service Finder (HSF) was decommissioned by SA Health. There exists some data quality issues between the NHSD and what was in the HSF, which are still being worked through.* *Feedback received from Focus groups:* *Participants across all life stages had difficulty finding accurate health information. Some of this difficulty was due to not knowing where to go to find the information and some of it was because the information they needed was not available or they were not given comprehensive information when they enquired.* *There were both similarities and differences in how people in various life stages wanted to access health information. Some elderly people require written information in large type and do not have the technology or the skills to access information on the internet. Information on cards that could be attached to the fridge with a magnet was identified as useful in both the retirees and older people and the babies and children's focus groups.* *For some people in all the focus groups accessing information on their smart phones was useful. Although some people in other groups thought that a Facebook site was a good idea, the young people's group was the only cohort to identify YouTube and flash mobs as a useful way of promoting primary health care services*		*Community consultation*
	Mental health services	*A **number** of mental health issues/gaps were raised by services providers and consumers during community consultation*	*Feedback from Service providers:* *Issues/gaps in mental health included suicide prevention, more community-based specialists, sexuality support, support between hospitals and home, not enough support, phsychiatry support to compliment private services, timely access for mental health care including assessment and treatment options, issues with mental health and increasing dementia levels, etc* *Feedback from Focus groups:* *Lack of after-hours support for people with mental health conditions was identified as a major gap in mental health services. Access to mental health services being linked to the person's primary diagnosis resulted in people who would benefit from mental health programs being excluded. Young carers caring for a parent with a mental health condition were often hidden carers who received no support. The problem of a taboo surrounding mental health conditions was discussed in the focus groups for adults, palliative care and carers, and young people. Concern for the gaps in mental health services was expressed in all the focus groups but people in different life stages focused on mental health for different reasons. People in the retirees and older people's focus group were most concerned about young people's mental and suicide rate because they had grandchildren. Participants in the babies and children's focus group were mothers who were concerned about the lack of support for their own mental health when parenting became too demanding. The young people's focused groups discussed mental health more than any other group and were concerned not only about the gaps in mental health provision but how the services were provided. They felt strongly that the services had to be attractive to young people, available after-hours, and not linked to school. A youth drop-in centre that provided social activities as well as counselling was identified as important by both the retirees and older people and the young people's focus group. The young people strongly identified social media as the best means of providing mental health information to their peers.* *Other issues raised included support for young people, (particularly in rural regions and Kangaroo Island), community wellness drop-in centres, more support for new parents, more supported community housing, greater clarity in the patient pathway, better community education, more services to handle difficult patients, distribution of information, better coordination of case management, more Aboriginal staff, etc*	*Further analysis revealed there is a need for a substantial increase in mental health services in rural and remote regions*	*Health provider and community consultation*
	Child and youth health services	*Several issues/gaps were raised by services providers and consumers during community consultation*	*Feedback from Service providers:* *Issues/gaps in connection with children and youth services included the need to expand the capacity of these services, Health and safety for Aboriginal & Torres Strait Islander youth and insufficient bulk billing access in regional areas for STI testing for young people.* *Feedback from Focus groups:* *The main problems identified were waiting times for appointments when a mother needed help with her baby and the major gap in service provision after-hours. An after-hours; child specific telephone helpline that parents could ring in the middle of the night was needed. Being able to have professional home visits would be ideal*		*Health provider and community consulation*
	Culturally and Linguistically Diverse (CALD) health services (including Indigenous health	*Several issues were raised by service providers during community consultation*	*Feedback from Service providers:* *Issues raise included the need for interpreters, cultural competancy training, develop a register of CALD and Aboriginal health professionals, establishing links with hospitals, SALHN and SAFKI ML, Co-ordination of care between primary and tertiary services, better coordinated service for chronic disease, etc*		*Health provider consulation*
	Accessing GPs	*Several issues connected with accessing GPs were raised during community consultation*	*Feedback from Focus groups:* *Access to general practitioners was an issue that was discussed in all focus groups. The main issues identified in accessing general practitioners were being able to get an appointment when needed, the cost, having to see a different doctor each time at the bulk billing clinics and having very little time seeing the doctor, and the lack of after-hours medical centres*		*Community consultation*
	Cost of health care	*Several issues connected with the cost of health care were raised during community consultation*	*Feedback from Focus groups:* *The main issue discussed in all focus groups in relation to cost was the necessity of being able to access bulk billing clinics. Dental care in particular was seen as too expensive for many people without private health insurance to access. Other issues discussed were the affordability of private health insurance and the lack of public access to specialist radiography services*		*Community consultation*
	Technology	*Several issues connected with the cost of health care were raised during community consultation*	*Feedback from Focus groups:* *Focus group participants in all life stages found technology useful for accessing health information and services. Smart phones were seen as particularly useful as information can be accessed anywhere. As well as searching for information on the internet, Facebook pages and blogs were also seen as useful. However, the cost of internet access could prevent low income people from using information technology.*		*Community consultation*
	Geographic location	*Some regional-specific issues were raised during community consultation*	*Feedback from Focus groups:* *Although, overall, there was not a lot of discussion in the focus groups on regional health services, the issues identified were lack of mobility or transport impeding access to health services, gaps in the funding for patient transport assistance, the lack of health care services on Kangaroo Island, the need for people in regional areas to travel into the metropolitan area to be able to access some services, and a lack of services for young people, especially those questioning their gender identity who were at risk of suicide.*		*Community consultation*
	Spport for parents	*A few issues connected with parental support were raised during community consultation*	*Feedback from Focus groups:* *There were a few issues specific to mothers caring for babies and young children that were centred around the need for parental support. The first was being able to go to a mothers and babies group, which were sometimes booked out or not available in some areas. The second was not being taken seriously by health professionals when they were concerned about their child and having difficulty in finding which service to access. The third was a need for support other than from family and friends when needed.*		*Community consultation*
	Sexual health and young people	*A few issues connected with sexual health were raised during community consultation*	*Feedback from Focus groups:* *here were a few issues identified by young people in relation to sexual health: STI testing, support for same sex attracted people, and having information readily available on how to access the morning after pill. There was a consensus that a youth centre offering multiple services would be best so it would not be obvious what service the person was accessing. Privacy was seen as important as was information conveyed tactfully.*		*Community consultation*
	Support for carers	*A few issues connected with carer support were raised during community consultation*	*Feedback from Focus groups:* *There were a few issues raised in relation to support for carers. The first was a lack of support groups for carers. The second was the lack of respite care for younger people with a disability. The third was that the Carer Support Centre was under-resources and, finally, there was no support for young carers*		*Community consultation*
	Community development	*Supporting, assisting and resourcing community marketing*	*Feedback provided from Community consultations at Hackham, Strathalbyn and Kangaroo Island)* *Supporting, assisting and resourcing community marketing to have improved health services and health and wellbeing knowledge and awareness*		*Community consultation*

SAFKI Medicare Local Comprehensive Needs Assessment: 2014 Report

Appendix 2 - Table 4 Shortlist of issues/needs based on evidence

ML No.	**Issue/Need** Maximum of 2-3 words *(e.g. mental health)*	**Brief description of issue/need** In dot point form *(e.g. lack of child and adolescent psychiatry services)*	**Population group(s) affected and inequities identified** *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	**Summary of key evidence** Drawn from Table 3 In a dot point form	**Links to Table 6 Priorities for 2014-15** Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	**If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation?** Answer 'Yes/No/In Partnership/ Unsure	**If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type** *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Accessing dentists	The dentist to population ratio is lower in SAFKI ML compared to the state as a whole The dentist to population ratio is noticeably low in Alexandrina and Victor Harbor	General population	In 2012, based on HWA data, there was around 170 Dentists in the region, meaning there is around 4.3 per 10,000 SAFKI ML residents. This compares with a ratio of 5.8 per 10,000 residents across the state. The ratio of dentists per 10,000 population is low in Alexandrina (2.3) and Victor Harbor (4.0)	No	No	
	Accessing General Practitioners (GPs)	Waiting times to see a GP could be better	General population	Waiting times for urgent appointments with a GP are longer within SAFKI ML when compared to Australia and SAFKI's ML 'peer' group. The proportion of adults feeling they wait longer than acceptable to get a GP appointment is higher for SAFKI than for Australia and SAFKI's Medicare Local (ML) 'peer' group.	Yes (all identified priority areas)		
	Accessing GPs	The GP to population ratio is lower in SAFKI ML compared to the state as a whole with the 'difference' between SAFKI and SA ratios widening. The GP to population ratio is noticeably low in Marion	General population, but particularly those in Marion	In 2012, based on HWA data, there was around 480 GPs in the region, meaning there is around 12.0 GPs per 10,000 SAFKI ML residents. This compares with a ratio of 12.9 GPs per 10,000 residents across the state. In 2010, there were around 450 GPs in the region => a ratio of 11.4 GPs per 1,0000 SAFKI ML residents, compared with a ratio of 12.1 GPs per 1,00000 residents for SA as a whole, meaning the ratio of GPs to resident population is lower in SAFKI compared to SA. While this ratio increased slightly between 2010 and 2012, it did not increase as much as that for SA) Further, based on the age profile of GPs, it is anticipated as much as half of the GP workforce in the SAFKI ML region will retire in the next 5 to 10 years. The GP per population ratio is particularly low in Marion - at 6.6 GPs per 10,000 population. A general lack of GPs was also raised during community consultations.	Yes (all identified priority areas)		
	Accessing optometrists	The optometrist to population ratio is noticeably low in Onkaparinga	General population, but particularly those in Onkaparinga	In 2012, based on HWA data, there was 56 optometrists in the region, meaning there is around 1.4 per 10,000 SAFKI ML residents. This compares with a ratio of 1.4 per 10,000 residents across the state. The ratio of optometrists per 10,000 population is low in Onkaparinga (1.0)	No	No	
	Accessing pharmacists	The pharmacist to population ratio is noticeably low in Marion, Onkaparinga and Victor Harbor	General population in Marion, Onkaparinga and Victor Harbor	In 2012, based on HWA data, there was around 300 pharmacists in the region, meaning there is around 7.4 per 10,000 SAFKI ML residents. This compares with a ratio of around 7.3 per 10,000 residents across the state. The ratio of pharmacists per 10,000 population is low in Marion (4.6), Onkaparinga (4.7) and Victor Harbor (6.1)	No	No	
	Accessing physiotherapists	The physiotherapist to population ratio is noticeably low in Onkaparinga, Alexandrina and Marion	General population, but particularly those in Onkaparinga, Alexandrina and Marion	In 2012, based on HWA data, there was around 375 physiotherapists in the region, meaning there is around 9.3 per 10,000 SAFKI ML residents. This compares with a ratio of around 9.6 per 10,000 residents across the state. The ratio of physiotherapists per 10,000 population is low in Onkaparinga (4.5), Alexandrina (4.9) and Marion (5.1)	No	No	

ML No.	Issue/Need Maximum of 2-3 words *(e.g. mental health)*	Brief description of issue/need In dot point form *(e.g. lack of child and adolescent psychiatry services)*	Population group(s) affected and inequities identified *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	Summary of key evidence Drawn from Table 3 In a dot point form	Links to Table 6 Priorities for 2014-15 Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation? Answer 'Yes/No/In Partnership/ Unsure	If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Accessing podiatrists	The podiatrist to population ratio is noticeably low in Onkaparinga and Alexandrina	General population, but particularly those in Onkaparinga and Alexandrina	In 2012, based on HWA data, there was 80 podiatrists in the region, meaning there is around 2.0 per 10,000 SAFKI ML residents. This compares with a ratio of 2.0 per 10,000 residents across the state. The ratio of podiatriststs per 10,000 population is low in Onkaparinga (1.2), Alexandrina (1.2) and Marion (1.7)	No	No	
	Accessing psychologists	The psychologist to population ratio is lower in SAFKI ML compared to the state as a whole The psychologist to population ratio is noticeably low in Alexandrina and Marion, and to a lesser extent, in Onkaparinga	General population, but particularly those in Alexandrina, Marion and Onkaparinga	In 2012, based on HWA data, there was 177 psychologists in the region, meaning there is around 4.9 per 10,000 SAFKI ML residents. This compares with a ratio of 5.8 per 10,000 residents across the state. The ratio of psychologists per 10,000 population is low in Alexandrina (1.3), Marion (2.6) and Onkaparinga (4.3)	Yes (all identified priority areas with Mental Health specifically)		
	Affordable health care	Access to free or lower cost health services in general	General population, particularly those on lower incomes, living in lower SES areas, the aged and students	Issues raised by focus group participants included: Accessing bulk billing clinics Affordability of private health insurance Lack of public access to specialist radiography services Cheaper healthy food Free exercise sessions/gyms	No	No	
	Affordable health care	Access to lower dental care	General population	19% of SAFKI ML adults who saw or needed to see a dentist, dental hygienist or dental specialist for their own health in the preceding 12 months delayed seeing or did not see a dentist or hygienist due to cost.	No	No	
	After-hours medical care	Lack of comprehensive after hours services/clinics	General population, including parents with children, aged persons and person living in rural/remote areas	In the metropolitan region, only approximately 12% of practices provide comprehensive after hours services/clinics, approximately 20% provided very limited after hours services (e.g. open until 7pm on or doctor on call for own patients only) and approximately 7% provide services after hours on weekends. Over 80% of metropolitan practices utilise the Medical Deputising Service (MDS), gpSolutions which provides gpConnect After Hours Home Visits within the Adelaide Metro area for after hours care coverage. In the rural and remote region, 9 out of the 10 General Practices are involved in providing after hours care in some form in both the sociable and unsociable hours . The model varies and in the majority of cases is linked with the provision of emergency care for their community. No MDS exists in the rural or remote region. Apart from Victor Harbor and Kangaroo Island, no locum service exists and after hours is provided via rosters of local GPs. This system is supported by the first point of contact through the nursing assessment and triage service at the local hospital. This issue was also raised during stakeholder and community consultations	Yes (all identified priority areas)		
	Aged care	Increasing demand for health services among SAFKI ML's ageing population	General population	Australia's population is 'ageing' and the proportion of older persons is expected to rise from 18% in 2011 to around 23% in 2025. As people age, their health needs become more complex. In general, health outcomes and burden of disease highly correlated with age as does the risk of hospitalisation due to falls. Largest growth in terms of number of older persons is expected in the LGAs of Onkaparinga, Marion and Mitcham. Largest 'proportional' growth is expected in rural LGAs of Alexnadrina, Yankalilla and Victor Harbor.	Yes (Ageing Population)		

ML No.	Issue/Need Maximum of 2-3 words *(e.g. mental health)*	Brief description of issue/need In dot point form *(e.g. lack of child and adolescent psychiatry services)*	Population group(s) affected and inequities identified *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	Summary of key evidence Drawn from Table 3 In a dot point form	Links to Table 6 Priorities for 2014-15 Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation? Answer 'Yes/No/In Partnership/ Unsure	If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Aged care	Increasing demand for dementia support & respite	Older persons (generally)	In 2011, Among Australians aged 65 and over, almost 1 in 10 (9%) had dementia. And among those aged 85 and over, 3 in 10 (30%) had dementia. With Australia's aging population, it is estimated the number of people living with dementia is projected to triple by 2050. Dementia is a major reason why older people enter residential aged care or seek assistance from community care programs. Dementia was the third leading cause of death in 2010. For people aged 65 and over, dementia was the second leading cause of burden of disease and the leading cause of disability burden.	Yes (Ageing Population)		
	Aged care	Improved access to primary health care servcies	Olders persons living in in residential aged care facilities (RACFs) or in the cmmunity	There were 50 RACFs in SAFKI with an estimated 63.7 beds per 1,000 population aged 65+ (ie around 4,030 beds) in June 2013. Older persons generally suffer more ill health, disability and home or aged care confirment. Frailty of aged care residents, declinging GP availabilty and changing worforce patterns in RACFS mean residents of RACFs are sometimes transferred to hospital when they could have been cared for in their facility. The ageing population will increase demand for access to PHC services, particularly amongst SAFKI ML's ageing rural regions.	Yes (Ageing Population)		
	Aged Care	General issues/gaps raised during community consultation	Older persons	Other issues/gaps in mental health raised by service providers: dementia support and respite, social isolation of older persons and those with mental illness, access to disability care support/services, accessing after-hours GP services at RACFs, accessing specialists in pain management, lackof skilled professional staff to change indwelling catheters, supra pubic catheters, Percutaneous Endoscopic Gastrostomy (PEG) tubes or give intramuscular injections, lack of psycho-geriatricians and psychologists available to visit or provide advice on care and management of difficult behaviours and address issues of depression, accessing dental care, transport options for the frail aged Issues/gaps raised by focus group participants incude: availability and cost of residential aged care, the need for increasing levels of community care to assist an ageing population, the provision of enough aged care staff to meet future needs, gaps in the provision of mental health services for older people.	Yes (Ageing Population)		
	Being overweight/obese	Overweight and obesity weights are increasing across Australia	General population, but more so for Indigenous Australians and those living in more remote and lower SES	The proportion of adults who are obese is higher in SAFKI compared with SA. The proportion of adults who are overweight or obese is slightly higher in SAFKI comapred with its peer ML group. Overweight and obesity weights are increasing across Australia. Health problems related to excess body weight have a majrt impact on the health care system. The percentage of adults who are overweight or obese increases with geographical remoteness and lower socio-economic status. Obesity rates are higher in Aboriginal and TSI population	No	Yes	LHNs Local Government
	CALD health services	Cultural competence training for health service professionals	CALD persons, including Aboriginal and TSI persons	22% of SAFKI ML residents were born overseas and 8% were born in a non-English speaking country, Furthermore, 9% speak a language other than English at home. This issue was raised by service providers during community consultations (and also by the Aboriginal community)	Yes (Aboriginal and Torres Strait Islander Health & Wellbeing)		
	CALD health services	Develop a list of CALD health professionals	CALD persons	22% of SAFKI ML residents were born overseas and 8% were born in a non-English speaking country, Furthermore, 9% speak a language other than English at home. This issue was raised by service providers during community consultations	No	Yes	General practice Migrant health service

ML No.	Issue/Need Maximum of 2-3 words *(e.g. mental health)*	Brief description of issue/need In dot point form *(e.g. lack of child and adolescent psychiatry services)*	Population group(s) affected and inequities identified *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	Summary of key evidence Drawn from Table 3 In a dot point form	Links to Table 6 Priorities for 2014-15 Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation? Answer 'Yes/No/In Partnership/ Unsure	If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	CALD health services	Access to interpreters	CALD persons, including refugees	22% of SAFKI ML residents were born overseas and 8% were born in a non-English speaking country, Furthermore, 9% speak a language other than English at home. This issue was raised by service providers during community consultations	No	Yes	General practice Migrant health service
	Carers	General issues/gaps raised during community consultation	Carers	Issues/gaps raised by focus group participants incude: Lack of support groups for carers The Carer Support Centre is under-resources Little support for young carers	No	Yes	Carers SA Consumers Health Alliance SA
	Children & Youth Services	General issues/gaps raised during community consultation	General population caring for children/youth	Issues/gaps raised by service providers incude: The need to expand the capacity of children and youth services in general Health and safety for Aboriginal & Torres Strait Islander youth Insufficient bulk billing access in regional areas Free STI testing for young people. Issues/gaps raised by focus group participants incude: Waiting times for appointments when a mother needed help with her baby Major gap in service provision after-hours. An after-hours, child specific telephone helpline that parents could ring in the middle of the night Professional home visits	Yes (Aboriginal and Torres Strait Islander Health & Wellbeing)		
	Community health	General issues & gaps identified through service provider and community consultation		Issues/gaps in community health services include: provision of nursing support, particularly in the after-hours period, turnaround for medical imaging, community nursing, ongoing development of chronic condition self-management capacity, ongoing development and implementation of Out of Hospital type programs, Very high demand for Intra Uterine Device insertion, insufficient community care packages, access to community disability support services, cancer-specific services, health networks outside of GP and pharmacists are poor.	Yes (all identified priority areas)		
	Disability	Unmet or under-met demand for health care	People with profound or severe disability	An estimated 5.4% of SAFKI's residential population has a severe or profound disabaility. People with disability experience significantly worse health outcomes than the general population People with disability often have high and complex needs for health care. In 2003, half of all Australians with disability (about 2 million people) had multiple types of disability. In addition, the average person with disability had 3.1 long-term health conditions, which are not always directly associated with their disability. People with severe or profound limitations are extensive users of health services, and are more likely than those without disability to consult general practitioners, specialist doctors and other health-care professionals, as well as social workers and welfare workers. In 2009, 59% of people aged 5–64 with severe or profound core activity limitations needed personal help with their health care, but almost 1 in 10 reported that they did not receive any assistance . Research suggests that people with disabilities may be especially susceptible to inadequate or inappropriate health care if their interactions with services are additionally complicated by communication or behavioural difficulties. Persons with a profound or severe disability can be extensive users of health services, a result of the high prevalence of multiple long-term conditions, and comorbidity of mental disorders and physical conditions.	No	Unsure - In partnership	Minda LAG
	Disability	Lack of respite care for younger people with a disability	Younger people with a disabilty	Need raised by consumers during community consultations	No	No	

ML No.	**Issue/Need** Maximum of 2-3 words *(e.g. mental health)*	**Brief description of issue/need** In dot point form *(e.g. lack of child and adolescent psychiatry services)*	**Population group(s) affected and inequities identified** *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	**Summary of key evidence** Drawn from Table 3 In a dot point form	**Links to Table 6 Priorities for 2014-15** Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	**If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation?** Answer 'Yes/No/In Partnership/ Unsure	**If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type** *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Emergency Department (ED) usage	High reliance on EDs for semi-urgent and non-urgent care	General population	Emergency Department presentations across the SAFKI ML region increased by around 5.1% in 2012. More than half of all ED presentations within the SAFKI region in 2012 were classified as 'semi- or non-urgent'. Among all adults who visited a hospital emergency department (ED) for care in the preceding 12 months, 21% of adults (Australia) thought their care could have been provided by a GP instead of an ED.	Yes (all identified priority areas)		
	Geographic location	Difficulty accessing health services due to location	Persons living in rural and remote regions	Withint he SAFKI ML region, 11.7% of residents live in remoteness category 'RA2' (inner regional) and 1.2% live in remoteness category 'RA4' (remote) Persons livuing in rural and remote areas have larger distances to major cities and available health services. People living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities. Generally, higher level of disadvantage in rural/remote areas, higher levels of tobacco smoking and less access to health services	No	Yes	SAHA Local Government
	Geographic location	Worse health outcomes are observed for those liuving in lower SES areas	Persons living in areas of higher disadvantage/lower SES	Health status within a population typically follows a gradient, with overall health tending to improve with each step up the socioeconomic ladder. This is commonly known as the socioeconomic gradient of health, or the social gradient of health, and is a global phenomenon seen in low, middle and high income countries. For example: a strong social gradient is tobacco smoking: in 2010 its prevalence among people living in the lowest socioeconomic areas was 25%, twice the rate among people living in the highest socioeconomic areas. This gradient has persisted since 2007, even though overall prevalence declined over that period. Other social gradients are presented throughout Australia's health 2012, for example: • risk factors such as physical inactivity and obesity, as well as the prevalence of multiple risk factors in an individual • adverse outcomes such as lower cancer survival, poor oral health and incidence of end-stage kidney disease • summary measures such as life expectancy and self-assessed health status • the ability to find, understand and apply information about health—that is, health literacy. Social gradients also exist in the access to, and use of, health-care services and resources in Australia, with the strength and direction of the relationship varying between service groups. For example, people living in the most disadvantaged areas have relatively high rates of general practitioner (GP) consultation. On the other hand, they are less likely to receive preventive dental care and more likely to be hospitalised for potentially preventable conditions.	No	No	SAHA Local Government
	Health information & Technology	The need to access accurate, timely health information and resources	General population	Focus group participants in all life stages had difficulty finding accurate health information. Some of this difficulty was due to not knowing where to go to find the information and some of it was because the information they needed was not available or they were not given comprehensive information when they enquired.	Yes (all identified priority areas)		

ML No.	Issue/Need Maximum of 2-3 words *(e.g. mental health)*	Brief description of issue/need In dot point form *(e.g. lack of child and adolescent psychiatry services)*	Population group(s) affected and inequities identified *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	Summary of key evidence Drawn from Table 3 In a dot point form	Links to Table 6 Priorities for 2014-15 Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation? Answer 'Yes/No/In Partnership/ Unsure	If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Health literacy	Around half of all Australians do not have at least an adequate level of health literacy.	General population, but more so among older persons, those living outside major cities and/or in areas of lower SES.	In 2006, 41% of Australians aged 15–74 had at least an adequate level of health literacy. 83% of older Australians (aged 65–74) did not have an adequate level of health literacy. Lower health literacy is associated with living outside Major cities and with lower SES. Lower levels of health literacy are associated with poorer self-assessed health status. South Australians with lower health literacy were more likely to have chronic conditions such as diabetes, heart disease and stroke, and less likely to have recently visited a doctor. Further, those aged over 64 with inadequate health literacy were more likely to have been admitted to hospital than those with adequate health literacy.	Yes (all identified priority areas)		
	Health service coordinaton and communication	Generall issues/gaps in health service coordination and communication	General population	Feedback provided from Community consultations: Kangaroo Island community would like a 'one-stop shop/no wrong door' style service Need for specialised partnerships and relationships Better networking among health providers Overcome boundary and funding restrictions => sharing resources/systems Building information/knowledge resouces/systems	Yes (all identified priority areas)		
	Homelessness	Unmet need for specialised health care for the homeless	Persons designated as homeless	Being 'homeless' is associated with risk of chronic disease of increased severity and complexity than the general population, as well as infectious diseases associated with poor living conditions. While specialist homelessness services provide, or refer people to, a range of specialist health-care services, including psychological and psychiatric services, alcohol and other drug treatment, pregnancy/family planning support as well as general health/medical services, homeless people report unmet need for general and specialised health care, including medicines and dental treatment.	No	Yes	PIR
	Indigenous health	Aboriginal and Torrest Strait islander people are generally less healthy than other Australians, die at much younger ages, have more disability and a lower quality of life	Aboriginal and Torres Strait Islander people	Life expectancy is much lower for Aboriginal and Torrest Strait islander people than for non-Indigenous Australians (around 11 years for males and 10 years for females) One of the reasons for poorer health is that Indigenous Australians are socioeconomically disadvantaged compared with other Australians. Contributing factors are nutrition, Physical activity, Immunisation, Alocohol use, Tobacco smoking, Body Weight, Drug use, Unemployment, Poor housing, Poverty, Poor health in youth, Mental health.	Yes (Aboriginal and Torres Strait Islander Health & Wellbeing)		
	Indigenous health	Indentified barriers to health services	Aboriginal and Torres Strait Islander people	Issues identified through community consultation include: Lack of tranport, particularly for rural and remote areas; Venue of health service isn't always appropriate for Aboriginal perons which leads to feeling uncomfortable and not attending; Lack of cultural competency and relationship building of health professionals	Yes (Aboriginal and Torres Strait Islander Health & Wellbeing)		
	Indigenous health	Identified areas of need	Aboriginal and Torres Strait Islander people	Issues identified through community consultation include: Youth services and mental health; Young people not attending school due to social and emotional issues/health; Lack of services & programs for Aboriginal youth; Lack of housing options in rural regions; Lack of accommodation for patients and families when relocating to access hospitals and other medical care.	Yes (Aboriginal and Torres Strait Islander Health & Wellbeing)		

ML No.	Issue/Need Maximum of 2-3 words *(e.g. mental health)*	Brief description of issue/need In dot point form *(e.g. lack of child and adolescent psychiatry services)*	Population group(s) affected and inequities identified *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	Summary of key evidence Drawn from Table 3 In a dot point form	Links to Table 6 Priorities for 2014-15 Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation? Answer 'Yes/No/In Partnership/ Unsure	If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Indigenous health	Immunisation rates are lower for Aboriginal and Torres Strait Islander children than non-Aboriginal and Torres Strait Islander children	Aboriginal and Torres Strait Islander children	According to The Australian Childhood Immunisation Register (ACIR) for 2011-12: Immunisation rates for Aboriginal & Torres Strait Islander (Indigenous) children: 89.0% of SAFKI Indigenous children aged 1 year (12-15 months) were immunised (2011/12) - SA 79.6% 91.4% of SAFKI Indigenous children aged 2 years (24-27 months) were immunised (2011/12) - SA 87.4% 75.8% of SAFKI Indigenous children aged 5 years (60-63 months) were immunised (2011/12) - SA 79.2% This compares with: 92.8% of all SAFKI children aged 1 year (12-15 months) were immunised (2011/12) - SA 92.3% 92.2% of all SAFKI children aged 2 years (24-27 months) were immunised (2011/12) - SA 92.6% 86.5% of all SAFKI children aged 5 years (60-63 months) were immunised (2011/12) - SA 87.7%	Yes (Aboriginal and Torres Strait Islander Health & Wellbeing)		
	Indigenous health	There is no Aboriginal Community Controlled Health Service(ACCHS) within the SAFKI region	Aboriginal and Torres Strait Islander people	The closest ACCHS is in the Adelaide CBD	Yes (Aboriginal and Torres Strait Islander Health & Wellbeing)		
	Mental health	Lack of after-hours support and support for young people	General population, but more so in young people	Lack of after-hours support for people with mental health conditions was identified as a major gap in mental health services during community consultation and focus groups The young people's focused groups discussed mental health more than any other group and were concerned not only about the gaps in mental health provision but how the services were provided. They felt strongly that the services had to be attractive to young people, available after-hours, and not linked to school. A youth drop-in centre that provided social activities as well as counselling was identified as important by both the retirees and older people and the young people's focus group. The young people strongly identified social media as the best means of providing mental health information to their peers.	Yes (Mental Health)		
	Mental health	Suicide prevention.	General population, but more so in young people aged 15-24 years and (to a lesser extent) adults aged 25 to 64 years.	Raised as an issue by health providers during community consultation Also, aeading causes of death across SAFKI: Young people (15-24 yrs): 1. Unintentional injuries (41%), 2. intentional injuries (27%); Adults (25-64 ys): 1. Cancers (47%), 2. cadiovasular disease (21%), 3. intentional injuries (8%)	Yes (Mental Health)		
	Mental health	Anxiety and depression is high among adults and young people.	General population, but more so in young people aged 15-24 years and (to a lesser extent) adults aged 25 to 64 years.	Leading causes of burden of disease and injury across SAFKI: Young people (15-24 yrs): 1. Anxiety and depression (21%); Adults (25-64 yrs): 1. Anxiety and depression (9%)	Yes (Mental Health)		
	Mental health	Support for new parents	New parents	Participants in the babies and children's focus group were mothers who were concerned about the lack of support for their own mental health when parenting became too demanding.	Yes (Mental Health)		
	Mental health	Sexuality support	Gay and Lesbian community	Need rasised by service providers during community consultations	Yes (Mental Health)		
	Mental health	Access to community-based specialists	General population	Need raised by service providers during community consultations	Yes (Mental Health)		
	Mental health	Young carers caring for a parent with a mental health condition	General population, including youth	Need raised by consumers during community consultations	Yes (Mental Health)		

ML No.	Issue/Need Maximum of 2-3 words *(e.g. mental health)*	Brief description of issue/need In dot point form *(e.g. lack of child and adolescent psychiatry services)*	Population group(s) affected and inequities identified *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	Summary of key evidence Drawn from Table 3 In a dot point form	Links to Table 6 Priorities for 2014-15 Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation? Answer 'Yes/No/In Partnership/ Unsure	If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Mental health	General issues/gaps raised during community consultation	General population	Other issues/gaps in mental health raised by service providers: suicide prevention, support between hospitals and home, phsychiatry support to compliment private services, timely access for mental health care including assessment and treatment options, increasing dementia levels, etc Other issues/gaps in mental health raised by focus group participnats: Lack of after-hours support for people with mental health conditions Access to mental health services being linked to the person's primary diagnosis resulted in people who would benefit from mental health programs being excluded The problem of a taboo surrounding mental health conditions was discussed in the focus groups for adults, palliative care and carers, and young people. People in the retirees and older people's focus group were most concerned about young people's mental and suicide rate because they had grandchildren. Participants in the babies and children's focus group were mothers who were concerned about the lack of support for their own mental health when parenting became too demanding. The young people's focused groups discussed mental health more than any other group and were concerned not only about the gaps in mental health provision but how the services were provided. They felt strongly that the services had to be attractive to young people, available after-hours, and not linked to school. A youth drop-in centre that provided social activities as well as counselling was identified as important by both the retirees and older people and the young people's focus group. The young people strongly identified social media as the best means of providing mental health information to their peers. Other issues raised included support for young people, (particularly in rural regions and	Yes (Mental Health)		
	Multiple health risks	Persons living with multiple risk factors is higher in Country SA than metropolitan Adelaide	General population, but more so for those living in rural and remote regions.	Over one half (58%) of South Australians are living with at least one risk factor while more than a quarter (27%) are living with two or more risk factors. Furher, prevalence of persons living with multiple risk factors was statistically significantly higher in Country SA than metropolitan Adelaide in 2011. Trend data also indicates that the gap between Country SA and metropolitan Adelaide is widening. The prevalence of the population living with multiple risk factors increases with age Prevalence rates are similar between males and female	No	Yes	LHNs Local Government

ML No.	Issue/Need Maximum of 2-3 words *(e.g. mental health)*	Brief description of issue/need In dot point form *(e.g. lack of child and adolescent psychiatry services)*	Population group(s) affected and inequities identified *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	Summary of key evidence Drawn from Table 3 In a dot point form	Links to Table 6 Priorities for 2014-15 Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation? Answer 'Yes/No/In Partnership/ Unsure	If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Oral health	"suboptimal" dental care	General population, but predominantly among disadvantaged people	According to research, Australia's oral health is 'suboptimal' and there is room for improvement in Australian oral health particularly among disadvantaged groups. There are major problems in accessibility of dental services, including a maldistribution of dentists, and the lack of universal government-funded coverage. Although most dentists are primary health care practitioners, they generally work in private practice, in isolation from the rest of primary health care. Their services are less affordable than most primary health care services because they are often not subsidised. Dental care has been largely excluded from Medicare, the universal healthcare insurance system that funds much primary health care, particularly medical services provided by general practitioners. Most dental care is provided by private dentists on a user-pays basis, albeit often subsidised by private health cover. Aboriginal & Torres Strait Islander people have substantially worse oral health than other Australians, particularly in terms of tooth loss, untreated decay, and tooth wear. They report higher rates of toothache and difficulty eating because of dental problems. Their poor oral health status is compounded by lack of access to dental care. Poor oral health is common in elderly Australians.	No	Yes	General practice (75+ Health assessments)
	Palliative Care	Generall issues/gaps in palliative care	General population connceted with palliative care	he Palliative Care Council South Australia (PCCS) has identified the following issues/gaps: 1. Lack of understanding about palliative care, difficulty obtaining information about services and the timing of referrals for palliative care 2. Provision of palliative care and services to care for the dying - Access to community services and to specialist palliative care; Access to specialist palliative care for GPs; Co-ordination of services; After hours and weekend availability (24/7 services); Financial and cost implications of end of life care 3. Support for dying at home - End of life packages; Respite care; Place of death and experience of end of life care 4. Quality, accountability and funding - Qualifications, training and experience; Attitude, dignity and respect; Cultural competence, culturally appropriate care service providers; GP involvement in providing end-of-life care; 5. Attitudes to death and dying - need to normalise death and increase public awareness of palliative care ; advanced care planning; voluntary euthanasia	No	Yes	SAHA
	PHC development	Generall issues/gaps	General population	Feedback provided from Community consultations at Hackham, Strathalbyn and Kangaroo Island) Supporting, assisting and resourcing community marketing to have improved health services and health and wellbeing knowledge and awareness	Yes (all identified priority areas)		
	Sexual health	Increasing trend in Chlamydia	General 'adult' population, but predominantly young females 15 to 29 years	Chlamydia remains the most frequently reported STI in South Australia. An increasing trend is observed over the past five years predominantly involving young people aged 15 to 29 years. The number of notifications amongst females exceeds that of males by 43%.	No	Yes	headspace General Practice LHNs
	Sexual health	Higher rates of STIs among Aboriginal and TSI persons	Aboriginal and Torres Strait Islander persons, particularly those aged 15 to 29 years	Aboriginal peoples are 3.7 times more likely to be diagnosed with chlamydia compared to the non-Aboriginal population. Aboriginal peoples are disproportionately affected by gonorrhoea and are 33.7 times more likely to be diagnosed with gonorrhoea compared with their non-Aboriginal counterparts. Aboriginal peoples experience a higher burden of infectious syphilis compared to non-Aboriginal people. In 2012, the rate of diagnosis of infectious syphilis in Aboriginal peoples was 13 times that of non-Aboriginal people.	Yes (Aboriginal and Torres Strait Islander Health & Wellbeing)		

ML No.	**Issue/Need** Maximum of 2-3 words *(e.g. mental health)*	**Brief description of issue/need** In dot point form *(e.g. lack of child and adolescent psychiatry services)*	**Population group(s) affected and inequities identified** *(e.g. children and adolescents and lack of access to health services. Can use N/A where appropriate)*	**Summary of key evidence** Drawn from Table 3 In a dot point form	**Links to Table 6 Priorities for 2014-15** Answer 'Yes'/'No' (i.e., is the issue/need established as a priority for 2014-15?)	**If answered 'No' at Column F - will the issue/need be funded and/or implemented by another organisation?** Answer 'Yes/No/In Partnership/ Unsure	**If answered 'Yes' or 'In Partnership' at Column G - describe the organisation's type** *(e.g. local or state government; LHN; NGO; consortium of MLs)*
	Transport	Access to adeqtate low cost transport to and from health care visits	General population	Transport to/from health services is an integral part of health care. Access to health services for persons living in rural/remote areas is a known issue Issues connected with lack of low cost transport and poor taxi services were raised during community consultation.	No	Yes	LHNs Local Government

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Appendix 3 - Table 6: Summary of issues/needs and strategies to address (include all priorities identified in the Excel spreadsheet established as priorities for 2014-15)

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcomes
Aboriginal and Torres Strait Islander Health & Wellbeing **(Indigenous Health)** **(Children & Youth)**	Early Intervention and Disease Prevention	Support Services for keeping people well and out of hospital Encompassing: 1. Community Education (Alcohol in Moderation, Immunisation, Obesity, Smoking Cessation, Oral Health, Sexually Transmitted Infections) 2. Piloting 'holistic' Comphrehensive Health Assessments - TBC 3. Complimenting CTG, CCSS programs	Aboriginal and Torres Strait Islander people (Indigenous Australians) generally have significantly more ill health than other Australians. They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health. SAFKI Medicare Local is the traditional lands of the Kaurna and Ngarrindjeri peoples. According to 2011 census data we have a relatively small population (1.0% compared with 2.5% nationally) who predominately reside in our rural and most disadvantaged metropolitan areas (Noarlunga, Christies, Hackham, Morphett). This target area is in-line with national and state priorities and initiatives. It will also provide input into SAFKI Medicare Local's Key Reporting Areas.	Successful community education program developed and delivered in-line with clinical CPD program Enhanced primary health care service delivery for Indigenous patients
Aboriginal and Torres Strait Islander Health & Wellbeing **(Indigenous Health)** **(CALD including ATSI persons)** **(Sexual Health)**	Quality and Safety in PHC	Driving better quality and safety within primary health care services Encompassing: 1. Continued investment in timely and quality continuing professional development (CPD) events and activities including (but not limited to): Cultural Awareness training, Multidisciplinary Chronic Disease management, Sexually Transmitted Infections 2. Implementation and ongoing development of an effective and efficient Clinical and Community Governance/Connection that by consolidating our patient satisfaction and experience work and investment in a Cultural Consultant and continued investment in a diverse structure that facilities good governance.	as above	Extensive CPD program developed and delivered to GPs and other PHC professionals in the region & Learning objectives met by 90% of attendees Evidence of consumer satisfaction/experience and CPD data supports quality improvement changes in primary health care practice Continued investment/commitment from clinicians and consumers regarding organisation activity governance

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcomes
Aboriginal and Torres Strait Islander Health & Wellbeing **(Indigenous Health)** **(Health Information)** **(Health Literacy)**	Health Information and Health Literacy	Delivering better health information and improved health literacy Encompassing: 1. Development and delivery of a “PHC Network Navigator” Policy/Model using health care system ‘‘No Wrong Door’ concepts and principles to assist GPs and PHC providers to better connect with one another and the community and support/inform future development of responsive Primary Health Networks in SA 2. Comprehensive service mapping incorporating NHSD/CRM update/s 3. Audit/Review of existing PHC resources (with a ‘Health Literacy’ lens) and resource development and promotion where appropriate	as above	Awareness and implementation of the service navigation model amongst GPs and PHC providers and community. NHSD information accurate and updated in a timely manner GPs and other PHC professionals will have an Increased awareness and understanding of health literate language for use with patients/consumers and when developing or reviewing resources.
Aboriginal and Torres Strait Islander Health & Wellbeing **(Indigenous Health)** **(Children & Youth)** **(Community Health)** **(Health Coordination & Communication)**	PHC Service Information, Coordination & Delivery	Leading better primary health care through service information, coordination, integration and delivery Encompassing: 1. Development and implementation of our approach to better PHC by supporting referrals and linkages with CTG and CCSS services abd reating other innovative means of complimenting these services 2. Creation and enhancement of SAHA projects and cross sectoral integration that focus on ‘out of hospital’ and/or ‘improved patient experience’ eg. clinical pathways and hospital avoidance strategies	as above	Accessible and adequate After hours services are available to the community Reduced ED presentations Continuation of SAHA and ongoing project successes regarding hospital avoidance
Ageing Population **(Aged Care)**	Early Intervention and Disease Prevention	Support Services for keeping people well and out of hospital Encompassing: 1. Community Education (Service Access, Dying with Dignity options, Mental Health) 2. Piloting 'holistic' Comphrehensive Health Assessments for 75+ on the South Coast 3. Complimenting After Hours programs - incentives for GP services in RACFs	In general, health outcomes and burden of disease highly correlated with age as does the risk of hospitalisation due to falls. In 2009, around half of persons aged 65–74 had five or more long-term conditions with this rate increasing to 70% of those aged 85 or over. Further, around 1 in 10 prsons aged 65 years and over have dementia, and among those aged 85 and over, 3 in 10 have dementia. As Australia's population ages, more people will be affected by dementia. According to 2011 Census data nearly 17% of the SAFKI Medicare Local Population are aged 65 years and older. This proportion is expected to rise to around 23% by 2025. In line with national and state trends our region will experience ageing population issues particularly increased demand for community based care such as support services in the home and community nursing. This target area will also provide input into SAFKI Medicare Local's Key Reporting Areas.	Successful community education program developed and delivered in-line with clinical CPD program Comprehensive Health Assessment piloted in General Practice and recommendations acknowledged and prepared for broader implementation Enhanced service delivery for older peole and RACF residents.

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcomes
Ageing Population **(Aged Care)**	Quality and Safety in PHC	Driving better quality and safety within primary health care services Encompassing: 1. Continued investment in timely and quality continuing professional development (CPD) events and activities including (but not limited to): GP in RACFs - Learning from REACH, RACF site upskilling, multidisciplinary chronic disease management, dying with dignity, advance care directives 2. Implementation and ongoing development of an effective and efficient Clinical and Community Governance/Connection that by consolidating our patient satisfaction and experience work and investment in Aged Care Clinical Consultant and continued investment in a diverse structure that facilities good governance.	as above	Extensive CPD program developed and delivered to GPs and other PHC professionals in the region & Learning objectives met by 90% of attendees Evidence of consumer satisfaction/experience and CPD data supports quality improvement changes in primary health care practice Continued investment/commitment from clinicians and consumers regarding organisation activity governance
Ageing Population **(Aged Care)** **(Health Information)** **(Health Literacy)**	Health Information and Health Literacy	Delivering better health information and improved health literacy Encompassing: 1. Development and delivery of a “PHC Network Navigator” Policy/Model using health care system ‘‘No Wrong Door’ concepts and principles to assist GPs and PHC providers to better connect with one another and the community and support/inform future development of responsive Primary Health Networks in SA 2. Comprehensive service mapping incorporating NHSD/CRM update/s 3. Audit/Review of existing PHC resources (with a ‘Health Literacy’ lens) and resource development and promotion where appropriate (Aged Care Gateway, NHSD, SSS directory)	as above	Awareness and implementation of the service navigation model amongst GPs and PHC providers and community. NHSD information accurate and updated in a timely manner GPs and other PHC professionals will have an Increased awareness and understanding of health literate language for use with patients/consumers and when developing or reviewing resources.
Ageing Population **(Aged Care)** **(Health Coordination & Communication)**	PHC Service Information, Coordination & Delivery	Leading better primary health care through service information, coordination, integration and delivery Encompassing: 1. Development and implementation of our approach to better PHC by supporting and incentiving hours care services, referrals and linkages with direct health care services,SAHA, LG and NGOs, and creating other innovative means of complimenting these services 2. Creation and enhancement of SAHA projects and cross sectoral integration that focus on ‘out of hospital’ and/or ‘improved patient experience’ eg. clinical pathways and hospital avoidance strategies	as above	Accessible and adequate After hours services are available to the community Reduced ED presentations Continuation of SAHA and ongoing project successes regarding hospital avoidance

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcomes
Mental Health	Early Intervention and Disease Prevention	Support Services for keeping people well and out of hospital Encompassing: 1. Community Education (Access to After Hours GP Services awareness, Mental Health stigma and service options, Mental Health first-aid training) 2. Piloting 'holistic' Comphrehensive Health Assessments - TBC 3. Complimenting ATAPS, PIR and Headspace programs	There is a high prevalence of mental health issues with approximately 44000 patients identified in SAFKI Medicare Local with mental and behavioural problems (practice data suggests this may be higher). It is another area in-line with national and state priorities and initiatives. There is strong community support for better metal health services particularly ones that support young people and new parents. This target area will also provide input into SAFKI Medicare Local's Key Reporting Areas.	Successful community education program developed and delivered in-line with clinical CPD program Comprehensive Health Assessment piloted in General Practice and recommendations acknowledged and prepared for broader implementation Enhanced service delivery for mental health patients.
Mental Health	PHC Support Services	Advancing frontline primary health care support services Encompassing 1. Development and implementation (covering the Mental Health sector in the first instance) of an innovative 'PHC Network Navigator' model/policy for leading integrated and coordinated patient journeys for primary health care consumers and support to service providers 2. Implementation and ongoing development of an effective and efficient Clinical and Community Governance/Connection that encompasses patient satisfaction and experience work and achieving National Mental Health Accreditation for relevant services 3. Continued investment in a diverse structure that facilitates good governance including professional leadership and connection at all levels of the organisation (Mental Health Clinical Consultant) 4. Continued investment in timely and quality education and continuing professional development (CPD) events and activities including (but not limited to) Mental Health Literacy 5. Leading and facilitating integrated Mental Health professional networking/socialising and mentoring/leadership 6. Continued investment in PHC practice support (including but not limited to) Referral and clinical template development , Clinical pathways development	as above	Awareness and implementation of the service navigation model amongst GPs and PHC providers and community with a focus on mental health services. Evidence of consumer satisfaction/experience supporting quality improvement changes in mental health care practice Success with National Mental Health Accreditation process Continued investment from clinicians and consumers regarding organisation activity governance. Extensive CPD program developed and delivered to GPs and Mental Health professionals in the region with learning objectives met by 90% of attendees Successful practice support program developed and implemented.

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcomes
Mental Health	Quality and Safety in PHC	Driving better quality and safety within primary health care services Encompassing: 1. Continued investment in timely and quality continuing professional development (CPD) events and activities including (but not limited to): Cultural awareness training, RACF site up skilling, Mental Health clinician competencies/requirements, multidisciplinary chronic disease management and advance care directives. 2. 2. Implementation and ongoing development of an effective and efficient Clinical and Community Governance/Connection by consolidating our patient satisfaction and experience work, achieving National Mental Health Accreditation, enhancing and improving internal systems (reporting, quality improvment, risk management) and continued investment in a diverse structure that facilities good governance.	as above	Extensive CPD program developed and delivered to GPs and other PHC professionals in the region & Learning objectives met by 90% of attendees Evidence of consumer satisfaction/experience and CPD data supports quality improvement changes in primary health care practice Enhanced primary health care service delivery for Mental Health patients Success with National Mental Health Accreditation process Continued investment/commitment from clinicians and consumers regarding organisation activity governance
Mental Health **(Health Information)** **(Health Literacy)**	Health Information and Health Literacy	Delivering better health information and improved health literacy Encompassing: 1. Development and delivery of a “PHC Network Navigator” Policy/Model using health care system ‘‘No Wrong Door’ concepts and principles to assist GPs and PHC providers to better connect with one another and the community and support/inform future development of responsive Primary Health Networks in SA 2. Comprehensive service mapping incorporating NHSD/CRM update/s 3. Audit/Review of existing PHC resources (with a ‘Health Literacy’ lens) and resource development and promotion where appropriate (including promotion/sharing of mental health and wellbeing information)	as above	Awareness and implementation of the service navigation model amongst GPs and PHC providers and community. NHSD information accurate and updated in a timely manner GPs and other PHC professionals will have an Increased awareness and understanding of health literate language for use with patients/consumers and when developing or reviewing resources.
Mental Health **(Accessing psychologists)** **(Health Coordination & Communication)**	PHC Service Information, Coordination & Delivery	Leading better primary health care through service information, coordination, integration and delivery Encompassing: 1. Development and implementation of our approach to better PHC by supporting and incentiving after hours primary care services, supporting referrals and linkages with direct health care services, complimenting direct health care funded and provided through ATAPS, Shared Care, PIR and Headspace programs, and creating other innovative means of complimenting these services 2. Creation and enhancement of SAHA projects and cross sectoral integration that focus on ‘out of hospital’ and/or ‘improved patient experience’ eg. clinical pathways and hospital avoidance strategies	as above	Accessible and adequate After hours services are available to the community Reduced ED presentations Continuation of SAHA and ongoing project successes regarding hospital avoidance

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcomes
Primary Health Care Workfoce Support and Wellbeing	Early Intervention and Disease Prevention	Support Services for keeping people well and out of hospital Encompassing: 1. Community Education (Health Literacy, Disability Services, Cultural awareness, Dying with dignity, Social Media, Open Disclosure, De-escalation, CPR, Accessing After Hours GP Services, Alcohol in Moderation, Immunisation, Obesity, Smoking Cessation, Oral Health, Sexually Transmitted Infections, Mental Health stigma awareness and service options) 2. Piloting 'holistic' Comphrehensive Health Assessments - TBC	The SAFKI Medicare Local region has in excess of 100 general practices, approximately 500 General Practitioners and 200 Practice Nurses. We estimate 50% of the GP workforce will retire in the next 5-10 years. Our understanding of other primary care providers (e.g. allied, CALD health professionals) is limited and requires attention in 2014-15. This target area will also provide input into SAFKI Medicare Local's Key Reporting Areas.	Successful community education program developed and delivered in-line with clinical CPD program Comprehensive Health Assessment piloted in General Practice and recommendations acknowledged and prepared for broader implementation Enhanced service delivery for patients.
Primary Health Care Workfoce Support and Wellbeing (Accessing GPs) (PHC Development)	PHC Support Services	Advancing frontline primary health care support services Encompassing 1. Development and implementation (covering the Mental Health sector in the first instance) of an innovative 'PHC Network Navigator' model/policy for leading integrated and coordinated patient journeys for primary health care consumers and support to service providers 2. FutureGP Phase 2 – recommendation consideration and action 3. International Medical Graduate (IMG) and Undergraduate Connection 4. Supporting after hours primary care services 5. Implementation and ongoing development of an effective and efficient Clinical and Community Governance/Connection Continued investment in a diverse structure that facilitates good governance including professional leadership and connection at all levels of the organisation 6. Continued investment in timely and quality education and continuing professional development (CPD) events and activities including (but not limited to) Health Literacy, Social Media, CPR, Open Disclosure, De-escalation Training 7. Leading and facilitating integrated PHC sector networking/socialising and mentoring/leadership	as above	Awareness and implementation of the service navigation model amongst GPs and PHC providers and community with a focus on mental health services. Implementation of FutureGP recommendations. Evidence of support and advice provided to IMGs in region – with the provision of CPD and networking. Evidence of consumer satisfaction/experience supporting quality improvement changes in primary health care practice Success with National Mental Health Accreditation process Continued investment from clinicians and consumers regarding organisation activity governance. Extensive CPD program developed and delivered to GPs and other PHC professionals in the region with Learning objectives met by 90% of attendees Successful practice support program developed and implemented.

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcomes
Primary Health Care Workfoce Support and Wellbeing	Quality and Safety in PHC	Driving better quality and safety within primary health care services Encompassing: 1. Continued investment in timely and quality continuing professional development (CPD) events and activities including (but not limited to): Cultural awareness training, RACF site up skilling, mental health clinician competencies/requirements, multidisciplinary chronic disease management and advanced care directives. 2.Implementation and ongoing development of an effective and efficient Clinical and Community Governance/Connection by consolidating our patient satisfaction and experience work, achieving National Mental Health Accreditation, enhancing and improving internal systems (reporting, quality improvment, risk management) and continued investment in a diverse structure that facilities good governance.	as above	Extensive CPD program developed and delivered to GPs and other PHC professionals in the region & Learning objectives met by 90% of attendees Evidence of consumer satisfaction/experience and CPD data supports quality improvement changes in primary health care practice Enhanced primary health care service delivery for patients Continued investment/commitment from clinicians and consumers regarding organisation activity governance
Primary Health Care Workfoce Support and Wellbeing **(Health Information)** **(Health Literacy)** **(PHC Development)**	Health Information and Health Literacy	Delivering better health information and improved health literacy Encompassing: 1. Development and delivery of a “PHC Network Navigator” Policy/Model using health care system ‘‘No Wrong Door’ concepts and principles to assist GPs and PHC providers to better connect with one another and the community and support/inform future development of responsive Primary Health Networks in SA 2. Comprehensive service mapping incorporating NHSD/CRM update/s 3. Audit/Review of existing PHC resources (with a ‘Health Literacy’ lens) and resource development and promotion where appropriate	as above	Awareness and implementation of the service navigation model amongst GPs and PHC providers and community. NHSD information accurate and updated in a timely manner GPs and other PHC professionals will have an Increased awareness and understanding of health literate language for use with patients/consumers and when developing or reviewing resources.
Primary Health Care Workfoce Support and Wellbeing **(After hours medical care)** **(ED usage)** **(Health Coordination & Communication)**	PHC Service Information, Coordination & Delivery	Leading better primary health care through service information, coordination, integration and delivery Encompassing: 1. Development and implementation of our approach to better PHC by supporting and incentivising after hours primary care services, supporting referrals and linkages with direct health services, and creating other innovative means of complimenting these services 2. Creation and enhancement of SAHA projects and cross sectoral integration that focus on ‘out of hospital’ and/or ‘improved patient experience’ eg. clinical pathways and hospital avoidance strategies	as above	Accessible and adequate After hours services are available to the community Reduced ED presentations Continuation of SAHA and ongoing project successes regarding hospital avoidance