2026 Adelaide PHN Aboriginal and Torres Strait Islander Health Needs Assessment

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June 2026

Acknowledgement of Country

The Discipline of Trauma and Injury at Flinders University acknowledges the Traditional Owners and Custodians of the lands on which this report was developed—the Kaurna people of Kaurna Yerta. We pay our deepest respects to Elders past and present and extend that respect to emerging leaders. We recognise that sovereignty was never ceded.

We also gratefully acknowledge the Aboriginal knowledges generously shared in good faith through the yarning sessions conducted with communities across Kaurna Yerta.

Cultural Safety Warning

This report contains material, including both data and narratives, relating to traumatic events and deaths. While individuals and specific Aboriginal communities are not named, readers are advised that the content may be distressing. We encourage readers to engage with this material with care.

Data Currency Statement

Adelaide PHN commissioned this Health Needs Assessment for completion between December 2025 and 30 June 2026. Data updates could not be incorporated beyond a defined cut-off, irrespective of topic relevance. All data presented were current as of 19 June 2026.

Suggested Citation

Henderson, P., Bradley, C., Mc-Neill-Kovacic, R., Ryder, C (2026) 2026 Adelaide PHN Aboriginal and Torres Strait Islander Health Needs Assessment. Adelaide Primary Health Network, Adelaide.

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Executive Summary

The Adelaide Primary Health Network's 2026 Aboriginal and Torres Strait Islander Health Needs Assessment presents a comprehensive, strengths-based analysis of the health and wellbeing of Aboriginal and Torres Strait Islander people living on Kaurna Yerta and in the Adelaide PHN region. It updates and extends the 2022 Aboriginal Health Needs Assessment by integrating quantitative data and culturally grounded community consultation, aligned with Indigenous Data Sovereignty and Governance principles.

Aboriginal and Torres Strait Islander peoples belong to the oldest continuing cultures in the world. Health is understood by Aboriginal and Torres Strait Islander peoples holistically, encompassing cultural, physical, psychological, social and spiritual dimensions. Community perspectives emphasise the central role of family, culture, connection to Country and social and emotional wellbeing.

Key findings

Strong cultural identity and kinship networks underpin health across Kaurna Yerta. Community consultations consistently highlight these as active protective factors that support resilience, wellbeing and engagement with services when care is culturally safe and locally relevant.

The Aboriginal and Torres Strait Islander population in the Adelaide PHN region is young. It is simultaneously geographically dispersed and concentrated in several high-growth areas including Playford, Salisbury, Onkaparinga and Port Adelaide Enfield.

Health and wellbeing are shaped by interacting social and cultural determinants:

- Many households demonstrate day-to-day financial stability and capacity to manage routine costs.
- Housing stress, rental dependence and homelessness are significant pressures, and these challenges highlight the need for coordinated, cross-sector responses.
- Employment rates are high, but workplace cultural safety remains a concern.
- Community members are undertaking significant amounts of unpaid and volunteer work, including care and community organisation roles.
- Educational attainment is improving, with the majority completing Year 12 or higher in most local areas.

Physical health status in the region is supported by relatively good engagement with health-promoting activities and declining rates of risky behaviours. High chronic disease and

disability burden necessitates ongoing engagement with the health system and multidisciplinary care.

- Rates of risky health behaviours like excessive alcohol consumption and tobacco smoking are declining.
- Childhood vaccination rates are high, although rates of participation in adolescent and adult vaccination programs, and cancer screening initiatives, present opportunities for improvement.
- Affordable, accessible, high quality dental care is a key concern of community members, with oral health directly impacting physical health and wellbeing.
- Much of the Aboriginal and Torres Strait Islander population on Kaurna Yerta live without any major chronic health conditions, however a significant proportion in all areas of the Adelaide PHN region already live with multi-morbidity.

Access to health services reflects both strong engagement and opportunities for whole-system improvement:

- Health service access barriers include workforce constraints, resource limitations, fragmented care pathways, cultural safety, and competing life priorities.
- Existing Adelaide PHN initiatives enabling care access are well received and provide a basis for scaling effective models.
- High levels of engagement with health services are evident in many parts of the system, even where this is not captured through formal measures such as annual health check completions.
- Aboriginal Community Controlled (Health) Organisations and Aboriginal-led services deliver trusted, culturally grounded care.
- Integrated models such as the Aboriginal Social and Emotional Wellbeing Centre demonstrate effective coordination across sectors.
- Community feedback demonstrates clear willingness to engage when services are flexible, culturally safe and coordinated

Mental health indicators show both need and opportunity:

- High levels of psychological distress occur alongside strong protective factors, including family support, cultural connection and community-led services.
- Engagement with services leveraging existing crisis and response systems provide a base for strengthening early intervention and continuity of care.

Across health conditions and risk factors, the data highlights opportunities for impact:

- High levels of contact with the health system create repeated opportunities for prevention, screening and early management.
- Participation in sport, cultural activities and community life provides a foundation for strengthening healthy behaviours.
- Strong maternal and early childhood indicators, including high antenatal engagement and healthy birthweight, demonstrate effective program approaches.

The limitations of publicly available quantitative data are substantial and impede a comprehensive, up-to-date understanding of the Aboriginal and Torres Strait Islander communities living in the Adelaide PHN region. Gaps in Indigenous-specific data, a lack of local-level granularity, and inconsistent data collection and release over time constrain planning and evaluation. However, the findings of this Health Needs Assessment overall describe a system with strong community assets, meaningful service engagement and clear opportunities to improve health equity through culturally safe design and better sector integration, supported by targeted commissioning.

Priority needs

The Adelaide PHN is well-positioned to influence Aboriginal health outcomes through both direct commissioning and system leadership, guided by the key themes emergent from this Health Needs Assessment (Figure ES-1).

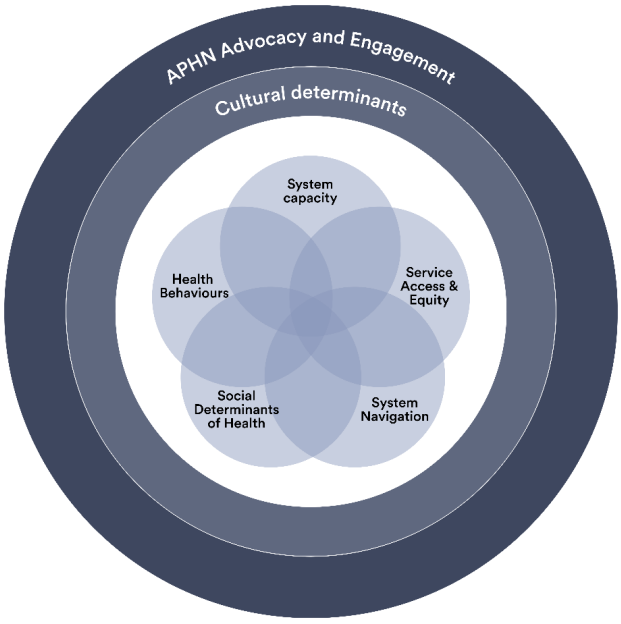

Figure ES-1: 2026 Aboriginal Health Needs Assessment thematic framework

1. System capacity

To introduce system-level changes that support appropriate, integrated care, the Adelaide PHN can target future commissioning to address:

- Workforce capacity and distribution, including sufficient staffing and equitable geographic spread
- Service coordination and integration, such as the co-location of services, multidisciplinary teams and multi-sectorial coordination, and a "single front door approach
- Resource allocation approaches that improve funding certainty for successful programs
- Strengthened Aboriginal sovereignty, governance and leadership

System capacity priority needs:

- **Commissioning that supports continuity of care and long-term impact, not episodic activity, including block funding and outcomes-based payments where appropriate.**
- **Recognition and protection of sovereignty and self-determination in health system design, delivery, and evaluation with Aboriginal-led models where relevant.**
- **Sufficient primary care, allied health, and specialist workforce to meet current and projected demand across Adelaide PHN catchment areas, with targeted supply in outer metropolitan areas, growth corridors, and areas of socioeconomic disadvantage.**
- **A single, clear entry pathway ("single front door") to reduce duplication, inappropriate referrals, and delays.**

2. Health service access and equity

The Adelaide PHN has a direct role supporting actions that improve access to culturally safe health services and service equity, including:

- Supporting the growth of the Aboriginal clinical workforce and ongoing career development
- Actions that increase the cultural safety of mainstream health service settings and workforce
- Mechanisms that improve health service waiting times, service quality and the community's confidence in health services.

Health services access and equity priority needs:

- **Culturally safe and appropriate care embedded across all primary health services, informed by Aboriginal and Torres Strait Islander leadership and community priorities.**
- **Timely access—including reduced waiting times—to primary care, mental health, social and emotional wellbeing and allied health services across the Adelaide PHN region.**
- **Targeted Aboriginal and Torres Strait Islander health workforce recruitment pipelines, including school-based pathways, vocational training, and tertiary education aligned to local workforce demand.**

3. System navigation

The Adelaide PHN can act as a system facilitator by supporting actions that make it easier for community to navigate the health system by:

- Increasing awareness of available services and programs in local communities
- Improving understanding of health risks, prevention and early intervention, and address gaps in knowledge
- Strengthening community confidence and agency in navigating the health system
- Supporting factors that influence help-seeking and continued engagement in care

Health system navigation priority needs:

- **Simple navigation supports – including care coordinators, navigators, and multi-modal communication – to create clearer care pathways.**

4. Social determinants of health

While many of the social determinants of health are not the direct remit of the Adelaide PHN, the PHN can provide leadership and co-commission cross-sector initiatives to address:

- Improved housing quality, stability and affordability
- Strengthening food security and nutrition security for all community members, including households with young children and people living with chronic conditions
- Increased social support and community connection
- Trauma-informed care and increased community and family safety

Social determinants of health priority needs:

- **Integrated pathways between primary health care, housing services, and social supports to address housing instability and housing-related health needs.**

5. Healthy behaviours

The Adelaide PHN has a critical role in supporting actions that encourage the healthy and health-seeking behaviours of Aboriginal and Torres Strait Islanders on Kaurna Yerta, including:

- Supporting expansion of Aboriginal-led and community-controlled service models.
- Facilitating holistic social and emotional wellbeing approaches across primary care, mental health and alcohol and drug services.
- Building on demonstrated success of Aboriginal-led and birthing on Country perinatal programs to meet the needs of Aboriginal mothers and mothers of Aboriginal babies

Supporting healthy behaviours priority needs:

- **Models of coordinated care across primary, maternity and community support services that reflect holistic concepts of wellbeing, including cultural, social, and emotional dimensions**

There is also a role for the Adelaide PHN to advocate for improved, place-based, Aboriginal and Torres Strait Islander data supply, to better inform future Health Needs Assessments as well as support essential monitoring of performance and impact. These priority needs statements align with the strengths identified in community and the existing health service system. They position the Adelaide PHN to deliver measurable improvements in access, experience and outcomes.

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
ADII	Australian Digital Inclusion Index
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute for Health and Welfare
AIR	Australian Immunisation Register
AOD	Alcohol and Other Drugs
APHN	Adelaide Primary Health Network (also, Adelaide PHN)
ASEWBC	SA Aboriginal Social and Emotional Wellbeing Centre
BMI	Body Mass Index
CaFHS	Child and Family Health Service
CDoH	Cultural Determinants of Health
COPD	Chronic obstructive pulmonary disease
DASSA	Drug and Alcohol Services SA
DHW	Department of Health and Wellbeing
FASD	Foetal alcohol spectrum disorder
GCCSA	Greater Capital City Statistical Area
IARE	Indigenous Areas
IDGov	Indigenous Data Governance
IDSov	Indigenous Data Sovereignty
LGA	Local Government Area (also called councils)
LHN	Local Health Network
NATSIHMS	National Aboriginal and Torres Strait Islander Health Measures Survey
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NBCSP	National Bowel Cancer Screening Program
NCSP	National Cervical Screening Program
NIAA	National Indigenous Australians Agency
NIP	National Immunisation Program
NLCSP	National Lung Cancer Screening Program
OOPHE	Out-of-pocket healthcare expenditure
PATS	Patient Assisted Travel Scheme

PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
SA	South Australia
SDoH	Social Determinants of Health
SEWB	Social and Emotional Wellbeing
SHS	Specialist Homelessness Services
SA3	Statistical Area Level 3
SA4	Statistical Area Level 4

Glossary

Census	The Australian Bureau of Statistics' Census of Population and Housing. The census counts every person and household in Australia every five years. Current census data was collected mid-2021 and the next Census will be on Tuesday 11 August 2026.
Closing the Gap	An Australian Government initiative that aims to reduce disparities in health, social, and economic outcomes between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, through targeted, culturally appropriate policies, programs, and partnerships.
Families	
Health Needs Assessment	An evidence-based process used to describe the health status and determinants of a defined population, identify unmet health and service needs, and prioritise actions to inform planning, commissioning, and resource allocation
Health Performance Framework	Drawing data from a range of sources, the Aboriginal and Torres Strait Islander Health Performance Framework is the national system for measuring, monitoring, and reporting on the health of Aboriginal and Torres Strait Islander peoples and the performance of the health system that serves them
Households	Households are defined, by ABS, as being where one or more person (one of whom, at least, is 15 years of age) who are usually resident in the same private dwelling.(1)
Indigenous Data Governance	The processes, structures, and principles that enable Aboriginal and Torres Strait Islander peoples to exercise decision-making authority over the collection, management, access, and use of data relating to their communities, ensuring accountability, cultural integrity, and alignment with community priorities.
Indigenous Data Sovereignty	The right of Aboriginal and Torres Strait Islander peoples to own, control, access, and govern data that derive from or relate to their people, communities, and Country, ensuring data are used in ways that respect cultural values, support self-determination, and deliver benefit to communities.
Kaurna Yerta	The traditional Country of the Kaurna people, encompassing the Adelaide Plains and surrounding areas of South Australia. The term recognises the enduring cultural, spiritual, and custodial connection of Kaurna people to this land.
Primary Health Networks	Regionally based organisations funded by the Australian Government to assess local health needs, plan and commission primary health care services, and improve coordination and integration of care to achieve better health outcomes, particularly for priority populations.
Type 1 diabetes	Type 1 diabetes is a lifelong autoimmune disease that can be diagnosed at any age but most commonly develops in people

	aged under 30. The exact cause is unknown, but it is believed to be the result of an interaction of genetic and environmental factors. A person with type 1 diabetes needs insulin replacement to survive and, except in cases where a pancreatic or islet cell transplant occurs, insulin will be required every day for the rest of their life.(2)
Type 2 diabetes	Type 2 diabetes is a condition in which the body becomes resistant to the normal effects of insulin and gradually loses the capacity to produce enough insulin in the pancreas. The condition has strong genetic and family-related (non-modifiable) risk factors and is also often associated with modifiable risk factors.(2)

1 Introduction / Background

The Adelaide Primary Health Network (PHN) is the local Primary Health Network for Kaurna Yerta (land), also known as Adelaide.(3) As an independent organisation the Adelaide PHN works with health professionals and communities to improve primary health care across the Kaurna Yerta region. Central to Adelaide PHN's work is their comprehensive Needs Assessments, including Aboriginal and Torres Strait Islander Health Needs Assessments, which play a critical role in identifying local health priorities, service gaps, and inequities experienced by communities across Kaurna Yerta.

The 2026 Aboriginal and Torres Strait Islander Health Needs Assessment (hereafter, respectfully, the Aboriginal Health Needs Assessment) was commissioned through the Discipline of Trauma and Injury (Flinders Health and Medical Research Institute and College of Medicine and Public Health, Flinders University). It involves the synthesis of available Indigenous data,[1] and collaboration with Aboriginal and Torres Strait Islander community members who live in Kaurna Yerta, along with sector stakeholders, to identify relevant health needs.

The Adelaide PHN has recently articulated a more place-based approach to primary health system design and delivery. This focus centres on understanding the unique needs of local communities and sub-regions, and working in partnership with consumers, providers and stakeholders to co-design targeted responses rather than applying one-size-fits-all solutions. The Adelaide PHN's *2023–2026 Strategic Plan*(5) centrally positions place-based care and equitable access, recognising that health and wellbeing are shaped by local context, service access, and broader determinants.

The 2026 Aboriginal Health Needs Assessment builds on the substantial body of work already undertaken by the Adelaide PHN, including the 2022 Needs Assessment, and informs future commissioning for the Adelaide PHN. Working in collaboration with Advisory Councils, peak bodies, health professionals, and Aboriginal Community Controlled Health Organisations (ACCHOs), the Adelaide PHN is better positioned to support culturally appropriate, accessible, and equitable health services, to meet the needs of Aboriginal and Torres Strait Islander people who reside across Kaurna Yerta in an evidence-based way.

[1] Indigenous data, is data in any format or medium that is about, from, or relates to Indigenous peoples, communities, lands, cultures, knowledges (knowing, being and doing).(4)

The Adelaide PHN's geographical reach and operation extends across the unceded Yerta of the Kaurna people Figure 1 (below). Geographic boundaries relevant to this Health Needs Assessment are outlined below.

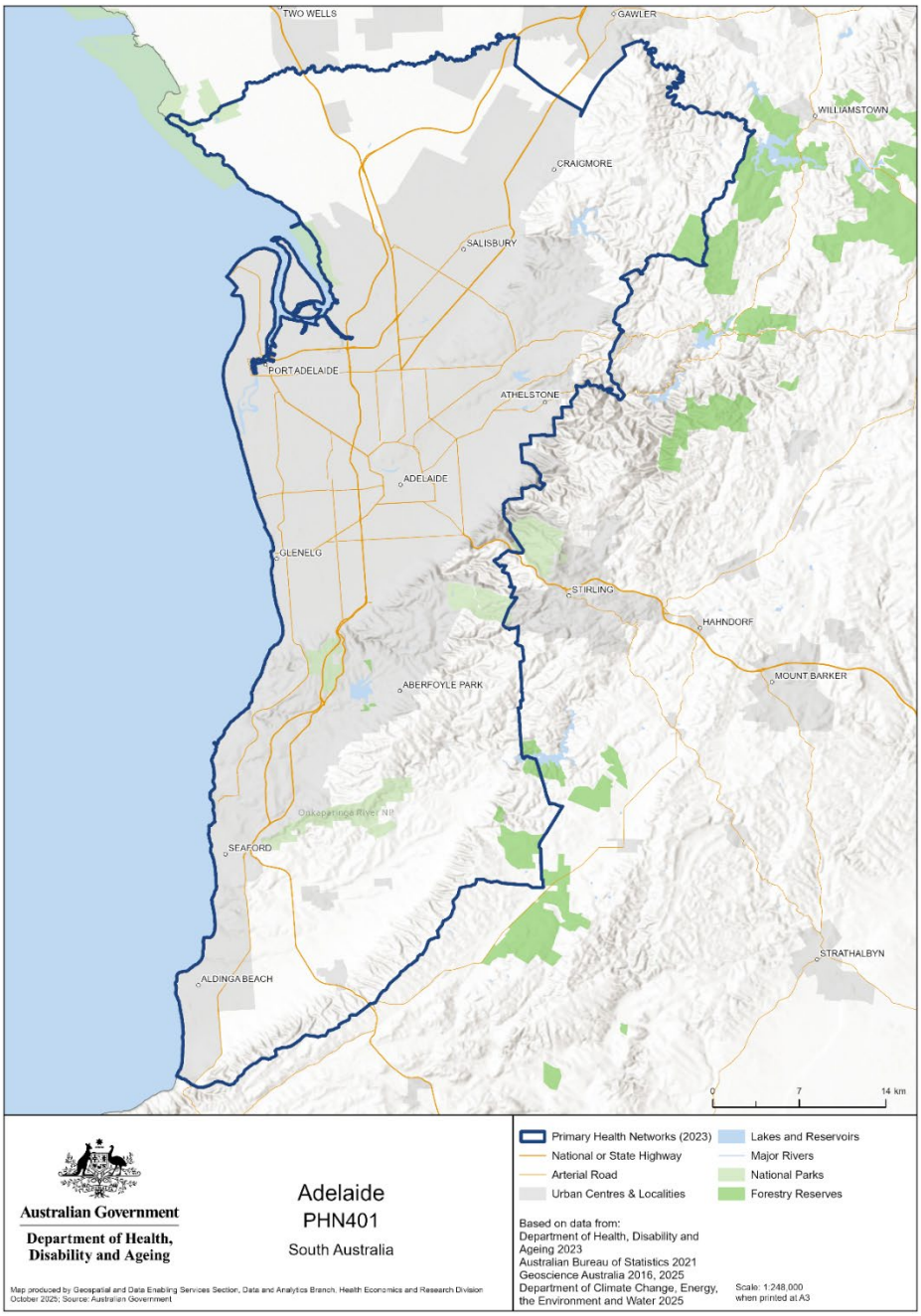

Figure 1: The geographic region of the Adelaide Primary Health Network

Source:(6)

2 Methods

2.1 Sources

This report draws on multiple sources of Indigenous data to offer a comprehensive Health Needs Assessment. Indigenous data has been derived from quantitative administration sources including (but not necessarily limited to) the Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), the Aboriginal and Torres Strait Islander Health Performance Framework, Closing the Gap, and Public Health Information Development Unit (PHIDU). Where appropriate, peer-reviewed, grey and other published literature were utilised, to provide important contextual information and analytical insights.

2.1.1 Community and stakeholder consultations

While quantitative data can provide insights into health trends and patterns, qualitative data provides opportunities to explore context and meaning to help understand the experiences and the 'why' behind quantitative data. As such, in addition to synthesising publicly available quantitative data, this Health Needs Assessment also employed qualitative data collection strategies, to enrich and contextualise the analysis.

Yarning is an important, culturally grounded approach to sharing knowledge, insights, and stories. It provides a relational and respectful opportunity to learn from and with Aboriginal and Torres Strait Islander peoples.(7) As such, yarning was incorporated as a key qualitative method, ensuring that community perspectives and insights were respectfully and effectively reflected throughout this report.

The group yarning circles undertaken involved a broad cross-section of community members and stakeholders:

- Grannies Group (Northern suburbs): 10 older Aboriginal women, plus 2 companions
- Kura Yerlo Youth Group and Connected Beginnings (Western suburbs): >6 women aged 20–55
- Neporendi Women's Group (Southern suburbs): ~14 women aged 20–65+
- Adelaide PHN Aboriginal Staff and Council: 4 Aboriginal staff (2 men, 2 women)
- Sector stakeholders: 13 professionals from government and non-government organisations across Kaurna Yerta, (8 women, 5 men)

Individual yarns with three key health sector leaders were also undertaken:

- Tanya McGregor (Chief Executive Officer, Aboriginal Health Council of South Australia)
- Cheyne Sullivan (Director, Aboriginal Health Partnerships and Engagements, SA Health)
- Ian James (Principal Aboriginal Mental Health Advisor, Mental Health Strategy and Planning, Office of the Chief Psychiatrist)

The mix of participants ensured representation across age groups, lived experience, service delivery, leadership, and policy perspectives.

A decolonising methodological approach guided the analysis.(8) Flinders University held overall responsibility and applied both Indigenous and Western methodologies. The process was iterative, relational, and respectful, and centred Aboriginal and Torres Strait Islander knowledges, experiences, and cultural expertise. The Flinders University team members who led the yarning sessions identified key themes from the dataset. This initial analysis was presented to the Health Needs Assessment's Steering Committee for collaborative discussion and refinement. Outcomes from this process informed the final outputs.

2.2 Indigenous Data Sovereignty and Governance

Indigenous Data Sovereignty (IDSov) and Indigenous Data Governance (IDGov) are critical concepts relating to data and the health and wellbeing of Aboriginal and Torres Strait Islander peoples. In the context of this Health Needs Assessment, IDSov refers to the rights of Aboriginal and Torres Strait Islander peoples to govern the collection, ownership and application of data about Aboriginal and Torres Strait Islander communities, peoples, lands, and resources.(9) IDGov refers to the rights of Indigenous peoples to autonomously determine what data is collected, why they are collected, and how they are analysed, and used.(10)

Although Aboriginal and Torres Strait Islander peoples have collected, analysed, and used data since time immemorial, the formal recognition of IDSov and IDGov in Australian institutions is relatively recent. As such, this Health Needs Assessment draws on extant data sources relating to Aboriginal and Torres Strait Islander peoples that do not necessarily conform to IDSov and IDGov principles or practices. Where possible, including through community consultations, efforts have been made to respect and operationalise IDSov and IDGov principles through privileging community voice, context and interpretations.

2.3 Data framing (approaches / standpoints)

2.3.1 Strengths-based

This Health Needs Assessment adopts a strengths-based approach throughout, which in the context of health data reporting requires re-setting to counter deficit interpretations and narratives relating to health inequities which are a direct outcome of colonisation.(11) Deficit narratives impose a "damaging characterisation" of Aboriginal and Torres Strait Islander peoples and position Aboriginal and Torres Strait Islander people "as the problem" which impedes progress towards health equity.(12) Strengths-based approaches represent a deliberate shift from deficit discourses that do not deny health disparities exist but rather, they seek to "change the narrative".(13)

To achieve the strength-based standpoint in this report, the Flinders University team has drawn on the work shared by the Lowitja Institute.(13) Specifically, we:

- Adopt a salutogenic approach by exploring factors that support and promote health (rather than disease)
- Utilise decolonising approaches that centre Aboriginal and Torres Strait Islander peoples' knowledges and perspectives
- understand health as holistic concept (rather than a more narrow, biomedical definition)

2.4 Comparison framework

This Health Needs Assessment has prioritised the implementation of CARE[2] principles for IDGov, while deliberately resisting dominant BADD[3] approaches(16) which are inconsistent with IDGov and IDSov. Accordingly, comparisons between data relating to Aboriginal and Torres Strait Islander people and non-Indigenous people has been intentionally avoided throughout this report. These comparisons lend themselves to deficit discourses, centring non-Indigenous health status as the implicit benchmark, they are also devoid of contextualisation and neglect to consider the structural and systemic factors contributing to health statuses and data.(16) By resisting deficit-based comparisons, this analysis creates space to centre Aboriginal and Torres Strait Islander peoples, knowledges and experiences, as recommended by Gamilaroi academic Thunig.(17) Comparative data can

[2] Collective benefit, Authority to control, Responsibility, Ethics.(14)

[3] Blaming, Aggregate, Decontextualised, Deficit, Restricted.(15)

also lend itself to deficit discourses, especially when differences or disparities are devoid of contextualisation and neglect to consider the structural and systemic factors contributing to health statuses and data. In this Health Needs Assessment, if comparisons have been necessary or valuable, these have been limited to comparing data relating to Aboriginal and Torres Strait Islander people (for example, living in the Adelaide PHN region or the Greater Adelaide Greater Capital City Statistical Area [GCCSA]) with data for Aboriginal and Torres Strait Islander people elsewhere (for example, in South Australia [SA] or Australia) depending on data availability.

2.5 Age-standardised rates

Age-standardisation is a strategy used to adjust and account for the effect of differences in population age structures when comparing crude rates between population groups.(18) However, as this Health Needs Assessment does not seek to draw comparisons between Aboriginal and Torres Strait Islander peoples and non-Indigenous peoples (see above), age-standardised rates have not been prioritised. Instead, crude rates have been used where possible, as they reflect the actual prevalence, burden and distribution of outcomes in a population.(19) This approach supports the CARE principles by centring Aboriginal and Torres Strait Islander peoples' health experience, on their own terms, without imposing external comparative benchmarks.

2.6 Absolute v Relative Frequencies

For the Health Needs Assessment, both absolute and relative measures have been used throughout. For example, absolute data has been used to describe the number of times, or frequency, a particular condition or concern occurs, while relative frequency has been included to describe the proportion or percentage of a condition or concern compared to total sample size.

2.7 Geography / regions

This Health Needs Assessment relates to the Adelaide Primary Health Network (Adelaide PHN), an administrative jurisdiction comprising 17 Local Government Areas, or LGAs (Table 1, Figure 2). To provide insights that are as relevant as possible to the Adelaide PHN, quantitative data were sought, where available, from datasets specifically relating to the Adelaide PHN region and local councils.

Table 1: Local Government Areas (LGAs) in the Adelaide PHN

City of Adelaide	City of Mitcham	City of Prospect
City of Burnside	City of Norwood, Payneham & St Peters	City of Salisbury
City of Campbelltown		City of Tea Tree Gully
City of Charles Sturt	City of Onkaparinga	City of Unley
City of Holdfast Bay	City of Playford	Town of Walkerville
City of Marion	City of Port Adelaide Enfield	City of West Torrens

Not all quantitative data required for this Health Needs Assessment are released at the LGA level. As such, where necessary, data were sought from: Indigenous Areas (IARE), Statistical Area Level 3 (SA3), Statistical Area Level 4 (SA4) (comprising Adelaide North, Adelaide South, Adelaide Central and Hills, Adelaide West), South Australian data via remoteness, State and Territory data (specifically, South Australian), and Australian-wide data. An explanation of statistical geography is located here.

Irrespective of the granularity of jurisdiction is important to acknowledge that these boundaries represent divisions of land informed by Western systems and do not necessarily reflect the knowledges of Aboriginal and Torres Strait Islander peoples or areas of community significance across Kaurna Yerta.

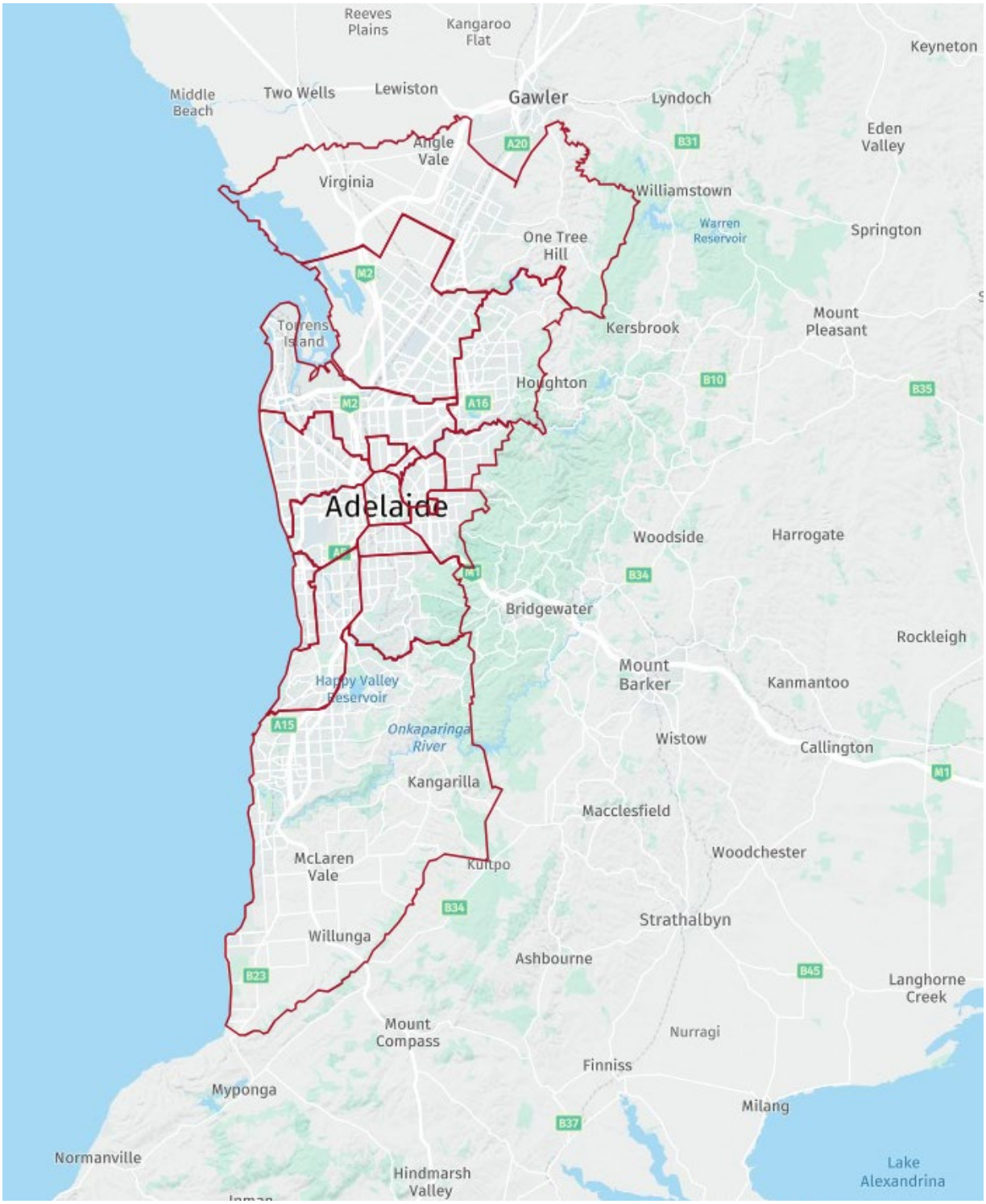

Figure 2: Geographic representation of LGAs (n=17) within the Adelaide PHN

Source: (20)

Figure 3: SA4 Geographic representation of Local Health Networks (LHNs, n=4) within the Adelaide PHN

Source:(21)

2.8 Reporting timeframe

The most recent data at time of reporting has been used in this Health Needs Assessment. Dates of data publication are detailed throughout the report. It is acknowledged that some publicly available data sources have not been updated since the development of the 2022 Health Needs Assessment report. Further, some very recent data updates could not be incorporated given analysis and report-production constraints. All data presented were current as of 19 June 2026.

2.9 Respect for privacy

At times, due to privacy concerns arising from small numbers of Aboriginal and Torres Strait Islander peoples in some jurisdictions, data from some council areas have either been aggregated or omitted. Throughout the report, we have sought to clearly identify where this has occurred.

3 Adelaide PHN population characteristics

3.1 Population

In 2021, there were nearly 24,000 Aboriginal and Torres Strait Islander people residing across Kaurna Yerta.(22) The following section provides insights into age and sex demographics, as well as information about residence and housing, work and employment, and education.

3.2 Age and life expectancy

The most recent data available pertaining to age was reported in 2021. With the next Australian Census scheduled for August 2026, the next release of such data is estimated to be in or after 2027.

In 2021, the median age of Aboriginal and Torres Strait Islander people across Greater Adelaide was 23 years. Table 2 details the median age of Aboriginal and Torres Strait Islander people for each of the local council areas in the Adelaide PHN (where available). This table shows that the areas with the areas with the youngest median age are City of Onkaparinga (20 years) and City of Playford (20 years), while City of Norwood, Payneham & St Peters (and City of Unley (32 and 31 years, respectively) have the highest median age, followed by City of Prospect.

Table 2: Median age of Aboriginal and Torres Strait Islander people living within Adelaide PHN in 2021, according to LGA

LGA	Median Age (years)
City of Adelaide	27
City of Burnside	26
City of Campbelltown	25
City of Charles Sturt	25
City of Holdfast Bay	27
City of Marion	24
City of Mitcham	25
City of Norwood, Payneham & St Peters	32
City of Onkaparinga	20

City of Playford	20
City of Port Adelaide Enfield	27
City of Prospect	30
City of Salisbury	22
City of Tea Tree Gully	23
City of Unley	31
Town of Walkerville*	–
City of West Torrens	26
Greater Adelaide (GCCSA)	**23**

* No data available for Town of Walkerville

Sources: (22–39)

The Productivity Commission provided an update in March 2024 detailing life expectancy data for Aboriginal and Torres Strait Islander people by selected states and territories. However, jurisdictional data specific to SA is not available in this dataset.(40)

3.3 Sex

Table 3 (below) details the proportion of females and males in each of the Council areas encompassing the Adelaide PHN. The use of female and male reflects biological classifications[4] recorded in available data assets and does not capture the larger social construct of gender or gender identity, as these constructs are not appropriately collected in current data assets.

ABS data indicate that, in 2024, in Greater Adelaide, broadly, there were fewer males than females (with a ratio of 96 males for every 100 females). This represents a sex distribution of approximately 49% male and 51% female.(42) 2021 data indicates that these proportions are reflected in some, but not all, of the Council areas of the Adelaide PHN. For example, as demonstrated in Table 3, in the City of Adelaide there was a greater proportion of males, while the reverse was true for the City of Campbelltown. Notably, there was a more

[4] Approximately 99.7% of the Australian population is reported to fall within the sex categories of female and male, with estimated 0.3% of the Australian population aged 16 and over reportedly born with variations on sex characteristics.(41)

substantial difference between the proportion of males and females in the Town of Walkerville (Table 3).

Table 3: Sex distribution of Aboriginal and Torres Strait Islander peoples in Greater Adelaide and LGAs within the Adelaide PHN, 2021

LGA	Female (%)	Male (%)
City of Adelaide	43.7	56.3
City of Burnside	47.9	52.1
City of Campbelltown	55.9	44.1
City of Charles Sturt	51.3	48.7
City of Holdfast Bay	48.6	51.4
City of Marion	50.0	50.0
City of Mitcham	48.6	51.4
City of Norwood, Payneham & St Peters	51.6	48.4
City of Onkaparinga	51.9	48.1
City of Playford	51.4	48.6
City of Port Adelaide Enfield	50.3	49.7
City of Salisbury	50.2	49.8
City of Tea Tree Gully	49.8	50.2
City of Unley	52.8	47.2
Town of Walkerville*	40.0	60.0
City of West Torrens	49.6	50.4
Greater Adelaide (GCCSA)	**50.6**	**49.4**

* No data available for Town of Walkerville

Sources: (22–39)

3.4 Residence and housing

Aboriginal and Torres Strait Islander people reside across all local council areas located in the Adelaide PHN. Based on most recent available data (2021), the council areas with the greatest number of Aboriginal and Torres Strait Islander people were the City of Playford (n=4,228), followed by City of Salisbury (n=3,475), City of Onkaparinga (n=3,369), and City of Port Adelaide Enfield (n=3,295) (Table 4).

Available data indicates Aboriginal and Torres Strait Islander people make up approximately 1.7% of the population of Greater Adelaide. Council areas reporting higher proportions than the Greater Adelaide region included the City of Playford (4.2%), City of Port Adelaide Enfield (2.5%) and City of Salisbury (2.4%). Council areas with the smallest proportion of Aboriginal and Torres Strait Islander peoples were the City of Burnside (0.4%) and City of Unley (0.5%).

Table 4: Number of Aboriginal and Torres Strait Islander people, and proportion of total population, within each LGA of the Adelaide PHN, 2021

	Aboriginal and/or Torres Strait Islander total	
LGA	**(n=)**	**(%)**
City of Adelaide	339	1.4
City of Burnside	186	0.4
City of Campbelltown	443	0.8
City of Charles Sturt	2,005	1.6
City of Holdfast Bay	320	0.9
City of Marion	1,274	1.3
City of Mitcham	420	0.6
City of Norwood, Payneham & St Peters	217	0.6
City of Onkaparinga	3,369	1.9
City of Playford	4,210	4.2
City of Port Adelaide Enfield	3,295	2.5
City of Prospect	212	1.0
City of Salisbury	3,480	2.4
City of Tea Tree Gully	1,278	1.3
City of Unley	194	0.5
Town of Walkerville*	–	–
City of West Torrens	763	1.2
Greater Adelaide (GCCSA)	**23,761**	**1.7**

*No data available for Town of Walkerville

Sources: (22–39)

Tenure type

Categorisation of housing tenure data across the Adelaide PHN is based on Western definitions and concepts of housing. These categories include residing in homes that they own outright, have a mortgage on, or rent. Other tenure types, from the ABS include other dwellings occupied rent-free, occupied under a life tenure scheme, or other (generic). It is important to know that these classifications do not capture culturally specific housing practices, such as transient or flexible living arrangements associated with kinship, mobility and cultural obligations which to not align with Western tenure categories. Table 5 details the distribution of the Western tenure types for Aboriginal and Torres Strait Islander people in the local council areas of the Adelaide PHN.

Home ownership

The 2022 Health Needs Assessment reported that the proportion of Aboriginal and Torres Strait Islander peoples in SA who owned their own homes (outright or with mortgage) increased from 31.4% to 39.6% between 2001 and 2021. More granular data, from 2021, shared in Table 5, indicates that 10.2% of Aboriginal and Torres Strait Islander people in Greater Adelaide owned their own homes outright, while 28.6% of the Aboriginal and Torres Strait Islander people in Greater Adelaide owned their home with a mortgage. The proportion of Aboriginal Torres Strait Islander people who owned their own home was greatest in the City of Holdfast Bay (17.8%) and the City of Prospect (16.4%), but the proportions were lower in City of Playford (7.1%) and City of Port Adelaide Enfield (7.8%). The proportions also varied substantially between different local council areas. For example, in the City of Mitcham and City of Onkaparinga were 40.5% and 36.6% (respectively), while the proportion was as low as 4.5% in the City of Adelaide.

Renting

In 2021, 58.0% of Aboriginal and Torres Strait Islander households[5] in Greater Adelaide rented their homes. As shown in Table 5, the proportion of Aboriginal and Torres Strait Islander people who were renting was greater than this in almost all local council areas, with City of Holdfast Bay (53.5%), City of Mitcham (44.2%), City of Onkaparinga (49.4%) City of Salisbury (56.4% and City of Tea Tree Gully (46.7%) being the exceptions. The City of

[5] Households are defined, by ABS, as being where one or more person (one of whom, at least, is 15 years of age) who are usually resident in the same private dwelling.(1)

Adelaide had the highest proportion of renters (88.0%) followed by City of Campbelltown (69.6%).

Table 5: Tenure type (proportion, %) for Aboriginal and Torres Strait Islander families in 2021, by LGA

LGA	Owned outright	Owned with mortgage	Rent	Other	Not Stated
City of Adelaide	8.3	4.5	88.0	0.0	3.0
City of Burnside	13.7	27.5	58.8	0.0	0.0
City of Campbelltown	10.0	20.0	69.6	0.0	1.2
City of Charles Sturt	10.2	19.2	67.3	1.4	2.5
City of Holdfast Bay	17.8	23.3	53.5	0.0	0.0
City of Marion	10.1	23.8	62.5	1.6	2.1
City of Mitcham	15.7	40.5	44.2	2.0	0.0
City of Norwood, Payneham & St Peters	13.6	13.6	67.1	2.0	0.0
City of Onkaparinga	11.6	36.6	49.4	1.0	1.7
City of Playford	7.1	28.4	61.1	1.0	2.3
City of Port Adelaide Enfield	7.8	21.9	66.3	2.0	2.6
City of Prospect	16.4	19.4	59.0	0.0	2.2
City of Salisbury	9.6	30.4	56.4	1.0	2.6
City of Tea Tree Gully	14.2	37.9	46.7	0.0	1.5
City of Unley	9.9	19.8	64.1	2.0	0.0
Town of Walkerville	–	–	–	–	–
City of West Torrens	10.3	24.8	63.4	1.0	2.2
Greater Adelaide (GCCSA)	**10.2**	**28.6**	**58.0**	**1.1**	**2.1**

*No data available for Town of Walkerville

Sources: (22–39)

3.4.1 Housing costs, affordability and stress

Housing costs

Mortgage and rental costs for Greater Adelaide and local council areas from 2021 are detailed in Table 6. In Greater Adelaide, in 2021, the median weekly rent was $296 but rents ranged from $154 in the Town of Walkerville to $353 in the City of Burnside. The median monthly mortgage repayment for Aboriginal and Torres Strait Islander families[6] in Greater Adelaide was $1,517 but repayments ranged from $1,300 in the City of Salisbury to $2,338 in the City of Burnside.

Housing affordability and stress

Housing affordability refers to the relationship between housing costs – such as dwelling prices, mortgage payments or rents – and household income.(44) Housing stress is commonly understood as households spending more than 30% of their gross income on housing and housing costs.(45) The 2022 Health Needs Assessment did not include data specifically addressing housing affordability and housing stress. (44,45)

More recent data (post-2021) related to rental expenses for Aboriginal and Torres Strait Islander people in the Adelaide PHN is not available, and it is important to recognise that there have been substantial increases in recent years. For example, in Greater Adelaide as a whole, median house rentals increased from $375 per week in June 2021 to $550 per week in June 2025(46) (representing nearly 46.7% increase), while median unit rentals increased from $310 per week in June 2021 to $470 per week in June 2025 (representing a 51.6% increase).(46)

Drawing on data relating to median weekly household income in 2021, the proportion of weekly income that was spent on rent was calculated and reported in Table 6. These calculations suggest that rental costs accounted for 21% of Aboriginal and Torres Strait Islander people's income across Greater Adelaide. The proportion of income spent on rent was substantially greater than this for people living in the City of Adelaide (35%) but less in the City of Mitcham (15%). Although the proportion of income spent on rent was greater than for Greater Adelaide in eight of the 17 local council areas, the official threshold for housing

[6] Families are defined, by ABS, as being two or more people (one of whom is at least 15 years) who are related by blood, adopting, step, fostering, or are married or in a de factor relationship, and usually reside in the same household.(43)

stress was only exceeded in the City of Adelaide (and the proportion of income spent in rent in the City of Campbelltown was not far off at 28%).

Monthly household income data were not available in the 2021 Census output. As such the calculations offered in Table 6 have assumed monthly income amounts to 4.3 times a week's income. Using this method, we calculated that in Greater Adelaide, Aboriginal and Torres Strait Islander families in 2021 were spending 26% of their monthly income on their mortgage repayments. The proportions were substantially larger, and well above the 30% threshold for housing stress,[7] in the City of Adelaide (57%) and Town of Walkerville (56%). The proportions also exceeded the 30% threshold in the City of Campbelltown (31%), City of Charles Sturt (33%), City of Marion (33%), City of Norwood, Payneham & St Peters (35%) and City of Port Adelaide Enfield (31%).

Table 6: Weekly and monthly income and proportions spent on rent or mortgage in 2021, by LGA

LGA	Median weekly household income	Median weekly rent	Proportion of weekly income (%)	Calculated monthly income (*4.3 weekly)	Median monthly mortgage repayments	Proportion of monthly income
City of Adelaide	$855	$296	35	$3,677	$2,100	57
City of Burnside	$1,916	$353	18	$8,239	$2,383	29
City of Campbelltown	$1,173	$323	28	$5,044	$1,550	31
City of Charles Sturt	$1,358	$300	22	$5,839	$1,950	33
City of Holdfast Bay	$1,733	$320	18	$7,452	$1,975	27
City of Marion	$1,310	$290	22	$5,633	$1,841	33
City of Mitcham	$2,094	$310	15	$9,004	$2,000	22
City of Norwood, Payneham & St Peters	$1,542	$320	21	$6,631	$2,308	35
City of Onkaparinga	$1,398	$310	22	$6,011	$1,517	25
City of Playford	$1,207	$265	22	$5,190	$1,300	25

[7] Housing stress is understood as the situation whereby more than 30% of households' gross income is spent on housing and housing costs.(47)

City of Port Adelaide Enfield	$1,227	$280	23	$5,276	$1,625	31
City of Prospect	$1,552	$330	21	$6,674	$1,950	29
City of Salisbury	$1,389	$300	22	$5,973	$1,300	22
City of Tea Tree Gully	$1,738	$330	19	$7,473	$1,600	21
City of Unley	$1,916	$345	18	$8,239	$2,145	26
Town of Walkerville	$725	$154	21	$3,118	$1,757	56
City of West Torrens	$1,474	$290	20	$6,338	$1,748	28
Greater Adelaide (GCCSA)	**$1,382**	**$296**	**21**	**$5,943**	**$1,517**	**26**

Sources: (22–39)

Data in Table 6 also suggests that, in local council areas in the Adelaide PHN, the housing stress threshold is met relatively frequently in households with mortgages but not in those households paying rent. This conflicts with other reports, specific to Aboriginal and Torres Strait Islander households in SA, that indicate that housing stress is more prevalent amongst people who are renting than those with mortgage.(48) A range of factors have been identified as contributing to this additional burden for renters in SA. These include limited housing supply, few social housing options, under-resourced support systems and sharp increases in rental prices.(49)

3.4.2 Housing suitability

Data provided in the Aboriginal and Torres Strait Islander Health Performance Framework updates (released March 2026) indicate that in 2022–23, most (88.5%) Aboriginal and Torres Strait Islander people in non-remote areas of SA were living in appropriately sized houses (that is, there were no additional rooms needed). However, 11.8% were considered to be living in overcrowded houses.(50) Older data, but more specific to the context of the Adelaide PHN, is available from the 2021 Census, indicates 7.3% of households indicated they needed at least one more bedroom.(22)

A challenge for population-level housing data is the capture of the state of repair of people's housing. While the number of rooms in a house maybe sufficient, the house itself may be in poor condition (e.g. broken plumbing, mould, broken doors and windows) and this could have significant health impacts on the household. Data reported in the Aboriginal and Torres Strait Islander Health Performance Framework suggests that about a quarter (26.6%) of households in SA in 2022–23 had major structural issues, but nothing is known specific for

non-remote SA or metropolitan Adelaide.(51) Community members involved in the consultations undertaken for this Health Needs Assessment described the effect that poorly maintained (public) housing was having on their health and wellbeing, and also how these issues intersect and are exacerbated by involvement with the Department of Child Protection.

3.4.3 Homelessness

Aboriginal and Torres Strait Islander people are over-represented in homelessness statistics, accounting for nearly 19% of the homeless population in SA.(48) There were 4,475 Aboriginal and Torres Strait Islander Specialist Homelessness Services (SHS) clients recorded for SA in 2024–25. In the previous year, 2023–24, more females (n = 2,875) than males (n = 1,878) were recorded as SHS clients in SA. Family and domestic violence, mental health, alcohol and other drugs and various combinations of these were issues reported as facing the people accessing SHS in SA.(52)

Another challenge for housing data for Aboriginal and Torres Strait Islander communities is the capture of circumstances such as transient living, whereby families or individuals may move between different locations (i.e. metropolitan to rural), between houses or families. Transient living is not routinely measured in administrative datasets, however evidence across Kaurna Yerta indicates Aboriginal people experience high levels of housing mobility, moving between overcrowded or unrepaired dwellings, temporary accommodation, and periods of homelessness.(50) These patterns reflect both systemic housing inequities and culturally embedded practices of mobility and kinship.(53)

3.5 Work and employment

Work and employment are key social determinants of health (SDoH), with substantial impacts across multiple domains of an individual's life. For example, being employed, or not, influences an individual's capacity to engage in health promoting behaviours and activities.(54) Employment conditions (for example, being securely employed versus in precarious employment) has substantive impacts on mental health and wellbeing.(54,55) The strength of this relationship is unsurprising given the way in which employment is linked with other SDoH factors, such as income and housing. In addition to the SDoHs, the cultural determinants of health (CDoH), such as cultural connection, identity, collective wellbeing, are additional factors which influence the health and wellbeing of Aboriginal and Torres Strait Islander peoples. The CDoH, CDoH interactions with SDoH and other conditions can have both positive and negative impacts on health and wellbeing in work settings.

Lack of cultural safety is a key factor detrimental to health and wellbeing in work settings. Recent reporting indicates, nationally, over one-quarter of Aboriginal and Torres Strait Islander people feel as though their workplaces are culturally unsafe, where nearly three-quarters of respondents reported having been exposed to a racial slur in the past year.(56) The recent Jumbunna Institute for Education and Research report also identified that Aboriginal and Torres Strait Islander people experience greater work demands than their non-Indigenous colleagues, often feeling they are required to work harder to prove their capabilities in workplace environments shaped by systemic inequities. Similar concerns have been identified elsewhere, along with unconscious bias in job promotions for Aboriginal and Torres Strait Islander employees,(57) and discriminatory attitudes towards Aboriginal and Torres Strait Islander job applicants.(58) These factors need to be given consideration regarding outcomes presented in this section.

The data available for Aboriginal and Torres Strait Islander people in Greater Adelaide indicates that, in 2021, of those in the labour force, nearly 86% were employed.(23) The proportions of Aboriginal and Torres Strait Islander people who were employed in 2021 varied between council areas. For example, the proportions of employed people in City of Burnside, City of Holdfast Bay, City of Prospect, and City of Unley exceeded 90%. A smaller proportion of people in City of Adelaide (72%) and City of Playford (79%) were employed.

Table 7: Proportion of Aboriginal and Torres Strait Islander people in the labour force who were employed or unemployed in 2021, by LGA

LGA	Employed (%)	Unemployed (%)
City of Adelaide	72	27
City of Burnside	97	9
City of Campbelltown	83	15
City of Charles Sturt	87	13
City of Holdfast Bay	92	9
City of Marion	86	13
City of Mitcham	92	8
City of Norwood, Payneham & St Peters	86	15
City of Onkaparinga	87	12
City of Playford	79	21
City of Port Adelaide Enfield	84	16

City of Prospect	96	8
City of Salisbury	86	14
City of Tea Tree Gully	88	11
City of Unley	98	6
Town of Walkerville	–	–
City of West Torrens	89	12
Greater Adelaide (GCCSA)	**86**	**14**

Sources: (22–39)

Across Kaurna Yerta, Aboriginal and Torres Strait Islander people are employed in a range of fields and industries. Table 8 outlines the five most frequently reported industries of employment for Aboriginal and Torres Strait Islander peoples across council areas and in Greater Adelaide.

Table 8: Most common employment fields or industries in 2021, by LGA

City of Adelaide		**City of Burnside**		**City of Campbelltown**	
State Government Administration	7.2	Hospitals (exc. Psychiatric Hospitals)	9.3	Supermarket / Grocery stores	8.2
Plumbing Services	6.2	Pubs, Taverns, Bars	5.8	Other Heavy and Civil Engineering Construction	3.4
Advertising Services	5.2	State Government Administration	4.7	Site Preparation Services	3.4
Labour Supply Services	5.2	Higher Education	4.7	Primary Education	3.4
Business and Professional Association Services	5.2	Poultry Farming	3.5	Carpentry Services	2.7
City of Charles Sturt		**City of Holdfast Bay**		**City of Marion**	
Other Social Assistance Services	4.2	Other Social Assistance Services	6.4	Hospitals (exc. Psychiatric Hospitals)	5.5
Primary Education	3.7	Cafes & Restaurants	5.7	Higher Education	3.6
State Government Administration	3.4	Non-Residential Building Construction	4.3	Other Social Assistance Services	3.6

Supermarket and Grocery Stores	3.3	Management Advice and Related Consulting Services	3.6	Supermarket and Grocery Stores	3.1
Takeaway Food Services	2.8	Sales Workers	3.6	State Government Administration	2.9
City of Norwood, Payneham & St Peters		**City of Onkaparinga**		**City of Playford**	
State Government Administration	12.0	Hospitals (exc. Psychiatric Hospitals)	5.2	Supermarket and Grocery Stores	5.1
Central Government Administration	6.0	Supermarket and Grocery Stores	4.9	Other Social Assistance Services	4.3
Hospitals (exc. Psychiatric Hospitals)	6.0	Aged Care Residential Services	4.3	State Government Administration	3.4
Call Centre Operation	5.0	Takeaway Food Services	3.8	Hospitals (exc. Psychiatric Hospitals)	2.8
Defence	4.0	State Government Administration	3.3	Road Freight Transport	2.6
City of Port Adelaide Enfield		**City of Prospect**		**City of Salisbury**	
Other Social Assistance Services	5.1	Electrical Services	5.1	Other Social Assistance Services	4.8
State Government Administration	4.6	Hospitals (exc. Psychiatric Hospitals)	5.1	Supermarket and Grocery Stores	4.2
Central Government Administration	4.4	Cafes and Restaurants	4.1	State Government Administration	3.8
Supermarket and Grocery Stores	3.9	State Government Administration	4.1	Defence	3.4
Hospitals (exc. Psychiatric Hospitals)	3.4	Defence	4.1	Takeaway Food Services	2.8
City of Tea Tree Gully		**City of Unley**		**Town of Walkerville***	
Other Social Assistance Services	4.7	Hospitals (exc. Psychiatric Hospitals)	11.8	n/a	–
Central Government Administration	4.2	Cafes and Restaurants	5.4	n/a	–
State Government Administration	4.2	Engineering Design and Engineering Consulting Services	5.4	n/a	–
Hospitals (exc. Psychiatric Hospitals)	4.2	Central Government Administration	5.4	n/a	–
Primary Education	2.9	Higher Education	5.4	n/a	–
City of West Torrens		**Greater Adelaide (GCCSA)**			

State Government Administration	7.4	Other Social Assistance Services	4.0
Central Government Administration	4.8	Hospitals (exc. Psychiatric Hospitals)	3.9
Hospitals (exc. Psychiatric Hospitals)	4.2	State Government Administration	3.8
Other Social Assistance Services	4.2	Supermarket and Grocery Stores	3.8
Takeaway Food Services	3.5	Central Government Administration	3.1

*No data available for Town of Walkerville

Sources: (22–39)

3.5.1 Unpaid and volunteer work

The proportions of Aboriginal and Torres Strait Islander people reporting having undertaken unpaid and voluntary work in 2021 are detailed in Table 9. These figures are likely to underestimate the extent of unpaid or voluntary work, particularly for Aboriginal and Torres Strait Islander people who organise or participate in community activities and events, such as NAIDOC and Kaurna Day.(59) Additionally, Aboriginal and Torres Strait Islander worldviews centre on kinship and family (for example, shared care and collective responsibility) and can explain why there are higher rates reported for unpaid care for some Aboriginal and Torres Strait Islander individuals, and their wider families, than the dominant Australian population.(60)

Table 9: Unpaid work undertaken by Aboriginal and Torres Strait Islander peoples in 2021, by LGA

LGA	Did unpaid domestic work (week before Census Night)	Provided unpaid care for child/children (during two weeks before Census Night)	Provided unpaid assistance to a person with a disability, health condition or due to old age (during two weeks before Census Night)	Did voluntary work through an organisation or group (last 12 months)
City of Adelaide	42.8	9.1	9.4	14.7
City of Burnside	63.2	17.0	9.9	20.6
City of Campbelltown	62.1	24.1	13.3	15.1
City of Charles Sturt	59.8	23.2	15.1	12.5
City of Holdfast Bay	74.2	25.6	14.2	12.6
City of Marion	63.4	25.7	13.5	12.2
City of Mitcham	69.6	27.0	16.4	18.1
City of Norwood, Payneham & St Peters	71.8	21.5	12.9	13.4
City of Onkaparinga	64.5	32.7	15.2	11.7
City of Playford	56.4	30.0	15.7	7.9
City of Port Adelaide Enfield	48.3	21.9	13.1	8.6
City of Prospect	64.0	18.5	17.3	10.5
City of Salisbury	58.0	30.2	15.1	7.7
City of Tea Tree Gully	64.9	28.6	14.9	11.6
City of Unley	72.8	21.9	16.1	13.5
Town of Walkerville*	–	–	–	–
City of West Torrens	62.3	21.8	14.3	14.0
Greater Adelaide (GCCSA)	**59.5**	**27.1**	**14.7**	**10.9**

*No data available for Town of Walkerville

Sources: (22–39)

3.6 Income

Income is widely recognised as a fundamental social determinant of health(61) influencing health through multiple, interconnected pathways, including: individual or household food security,(62) housing stability,(63) healthcare services and medications including affordability and compliance,(64) and capacity to engage in health-enhancing behaviours such as maintaining social networks, sports or physical activity.(65) Financial stress[8] due to low or insufficient income also impacts mental health and wellbeing.(66)

Census data from 2021demonstrates uneven distribution of weekly incomes for individuals, families, and households across the Adelaide PHN region. As shown in Table 10, the median personal income for Aboriginal and Torres Strait Islander people living in Greater Adelaide was $552 per week but ranged from $409 in City of Adelaide to $782 in City of Prospect. The weekly median income for families for Greater Adelaide was $1,457. The median weekly household income was greatest for those in City of Mitcham ($2,402) and lowest for households in City of Playford ($1,180). Household income for Greater Adelaide was $1,382 and ranged from $855 in City of Adelaide to nearly $2,100 in City of Mitcham.

Table 10: Median weekly household income for Aboriginal and Torres Strait Islander for individuals, families, and households, in 2021, by LGA

LGA	Personal income ($)	Family income ($)	Household income ($)
City of Adelaide	409	1,875	855
City of Burnside	629	2,208	1,916
City of Campbelltown	536	1,460	1,173
City of Charles Sturt	575	1,449	1,358
City of Holdfast Bay	566	2,205	1,733
City of Marion	495	1,455	1,310
City of Mitcham	739	2,402	2,094
City of Norwood, Payneham & St Peters	620	2,250	1,542
City of Onkaparinga	552	1,405	1,398
City of Playford	512	1,180	1,207

[8] The situation whereby households experience difficulty in meeting their daily financial commitments

City of Port Adelaide Enfield	506	1,355	1,227
City of Prospect	782	1,916	1,552
City of Salisbury	555	1,379	1,389
City of Tea Tree Gully	636	1,812	1,738
City of Unley	749	2,183	1,916
Town of Walkerville*	–	–	–
City of West Torrens	614	1,924	1,474
Greater Adelaide (GCCSA)	**552**	**1,457**	**1,382**

*No data available for Town of Walkerville

Sources: (22–39)

Although more recent data than 2021 is not available for the Adelaide PHN region, there is strong evidence supporting increases to financial stress for Australian households. For example, the proportion of Life in Australia™ [9] participants who reported they were 'just getting along' increased from 24% in 2021 to 30% in 2024, while the 2024 Mapping Social Cohesion Report showed that more adults skipped meals due to a lack of money in 2024 than in 2021 (14% compared to 9%).(67) This same report recognises that 18% of respondents went without healthcare or medicine due to a lack of money in 2024 (no 2021 data available). Although these statistics are not specific to Aboriginal and Torres Strait Islander peoples, the Centre for Social Impact(68) suggests Aboriginal and Torres Strait Islander people are more likely to face financial stress than the non-Indigenous population. Outcomes exploring the impacts of out-of-pocket healthcare expenditure (OOPHE) for Aboriginal households in rural SA suggest significant financial burden on Aboriginal households when accessing healthcare.(69) Reported coping strategies included selling assets, delaying medical attention or borrowing money to manage healthcare costs. Furthermore, government initiatives designed to ease this financial burden, such as the Patient Assisted Travel Scheme (PATS), were inadvertently creating additional barriers due to challenges associated with eligibility, administrative complexities and accessibility.(69) Aboriginal households on Kaurna Yerta can experience comparable financial burden, driven in part by kinship obligations to support family members who travel to Kaurna Yerta to access specialist healthcare.

[9] Life in Australia™ is an Australian-wide study by the Social Research Centre, Australian National University

Another measure of household financial strength looks at whether households have "days without money for basic living expenses". The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2022–23 estimated that about 52.5% of Aboriginal households in the Adelaide PHN region were in a position of relative financial strength, not having had days without money for basic living expenses in the last 12 months.(70) Similarly, about 56.6% of Aboriginal households in the Adelaide PHN region could raise $2,000 in a week, in an emergency situation. (70,71) The community consultations supported this fragile situation—many people are managing day to day, but only just, and a large proportion of households are close to financial stress, with limited reserves to meet basic household needs.

3.7 Education

Education is a social determinant that strongly contributes to health and wellbeing throughout an individual's life. Education is associated with enhanced employment opportunities and income, with generative effects through opportunities to engage in health promoting behaviours and health enhancing activities. (72,73)

ABS data from the 2021 Census, relating to people's highest levels of formal (as recognised by the state and federal governments) educational attainment, is detailed in Table 11, below. It is important to recognise that references to education here refer to institutional attainment at Western institutions that are chiefly informed by Western knowledge systems and values and do not necessarily reflect the breadth of cultural education and knowledges that Aboriginal and Torres Strait Islander people possess. Lower levels of formal educational attainment have, historically, been positioned as lack of effort and investment from Aboriginal and Torres Strait Islander peoples, more recently, research has looked to the roles that institutions play in perpetuating disparities.(74,75) For example, there is evidence to suggest that those whose cultural backgrounds match that of the knowledge system informing the curriculum, pedagogies, and assessments, are privileged over those where there may be cultural mismatch.(75,76)

Table 11 details the highest level of formal educational attainment for Aboriginal and Torres Strait Islander peoples in the local council areas, as captured by the 2021 Census. According to this data, in all but two of the local council areas, over 50% of the Aboriginal and Torres Strait Islander population had completed Year 12 or above. The two exceptions were the City of Playford and City of Port Adelaide Enfield (with City of Campbelltown and City of Salisbury either at, or close to, 50%). This data also shows an uneven spread of formal educational attainment amongst Aboriginal and Torres Strait Islander peoples throughout the local council areas. For example, the City of Unley had substantial proportions of

residents reporting a Bachelor degree or above as above as their highest level of education (31% and 23%, respectively), only 4% of Aboriginal and Torres Strait Islander people living in the City of Playford and fewer than 5% of those living in the City of Salisbury did.

Table 11: Highest level of formal educational attainment in 2021, by LGA

LGA	Bachelor degree level or above	Advanced diploma and diploma level	Cert IV	Cert III	Yr 12	Yr 11	Yr 10	Cert II	Cert I	Year 9 or below	Inadequately described	No education	not stated
City of Adelaide	9.8	6.2	2.9	13.0	23.1	7.2	19.5	0.0	0.0	9.4	1.6	10.0	3.3
City of Burnside	22.7	6.4	5.7	11.3	18.4	10.6	9.2	0.0	0.0	13.5	2.8	0.0	2.1
City of Campbelltown	9.3	6.8	4.6	12.3	17.0	10.2	13.9	0.0	0.0	11.7	1.9	0.0	9.9
City of Charles Sturt	10.0	6.5	5.3	16.5	16.6	11.2	13.9	0.2	0.0	12	2.4	0.6	4.7
City of Holdfast Bay	18.1	7.1	3.1	14.6	14.6	13.8	14.6	0.0	0.0	6.7	2.4	3.1	3.9
City of Marion	10.0	6.1	4.9	17.6	16.7	12.5	13.7	0.6	0.0	10.3	2.4	1.1	5.2
City of Mitcham	20.1	8.6	4.3	14.1	17.8	6.9	8.2	0.0	0.0	7.6	2.6	1.6	3.9
City of Norwood, Payneham & St Peters	22.0	5.4	5.4	23.1	13.4	5.9	10.8	0.0	0.0	6.5	1.6	2.2	1.6
City of Onkaparinga	8.2	6.3	6.1	18.0	15.7	13.7	13.7	0.0	0.0	9.6	3	0.4	5.0
City of Playford	3.5	5.0	4.5	17.5	16.1	13.8	17.4	0.4	0.0	13.5	1.7	1.0	5.8
City of Port Adelaide Enfield	8.3	4.8	4.1	14.2	14.6	11.8	20.1	0.2	0.0	11.8	2.0	0.8	6.7

City of Prospect	15.4	10.5	6.8	19.1	19.1	6.8	9.3	0.0	0.0	6.2	1.9	0.0	5.6
City of Salisbury	4.9	6.0	4.8	19.4	16.0	13.7	15.5	0.1	0.0	12.1	2.0	0.4	5.4
City of Tea Tree Gully	9.1	9.1	5.1	17.1	15.5	13.3	11.8	0.0	0.0	10.2	2.2	0.6	4.8
City of Unley	31.0	7.1	4.5	12.3	17.4	8.4	9.0	0.0	0.0	9.7	2.6	0.0	2.6
Town of Walkerville*	–	–	–	–	–	–	–	–	–	–	–	–	–
City of West Torrens	17.0	9.0	3.0	15.0	18.0	11.0	12.0	0.0	0.0	8.0	1.9	1.7	3.0
Greater Adelaide (GCCSA)	**8.9**	**6.2**	**4.8**	**17.0**	**16.2**	**12.3**	**15.0**	**0.2**	**0.0**	**11**	**2.2**	**0.8**	**5.3**

*No data available for Town of Walkerville

Sources: (22–39)

4 Community understandings of health

The community consultations undertaken for this Health Needs Assessment commenced with an open-ended question, inviting community members to describe what they considered to be good health. Where Western models of health have historically been biomedically focussed, Aboriginal and Torres Strait Islander understandings of health are more holistic, multifaceted and relational.(77) Responses from community members and stakeholders during the consultations echoed this perspective and emphasised the value of a social and emotional wellbeing lens to the discussions of health. Recent work(77) by Pat Dudgeon [Bardi] and their team on social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples provides the following conceptualisation (updated from the earlier work of Gee and others[74]):

Figure 4: Aboriginal and Torres Strait Islander Social and Emotional Wellbeing model

Source: (79)

The concepts described in Figure 4 speak to the multidimensional nature of health and wellbeing that also features in The Dance of Life Painting (below) by eminent Palyku woman, Professor Helen Milroy, who illustrates this multidimensional nature of health and wellbeing for Aboriginal and Torres Strait Islander peoples. Milroy's painting represents physical, psychological, social, spiritual, and cultural dimensions of health. A comprehensive overview of each of these dimensions is available here. These dimensions, shape the discussion about cultural determinants of health with respect to Adelaide PHN, below.

Figure 5: The Dance of Life, Milroy, 2006.(80)

4.1 Cultural health

Figure 6: Healing, Ceremony and Law— section from The Dance of Life, Milroy, 2006.(80)

Culture and connection to culture have been increasingly recognised, in Western spaces, as being important to Aboriginal and Torres Strait Islander peoples' health.(81) Cultural expressions can include language, storytelling, dance, ceremony, music, art, and kinship.(82) The 2022 Health Needs Assessment reported data from the National Aboriginal and Torres Strait Islander Social Survey (2014–15) which indicated that nearly two-thirds of Aboriginal and Torres Strait Islander peoples, nationally, attended a cultural event in the previous year. New survey data is not available. ABS data for 2021–22 relating to participation and attendance at cultural and creative activities for adults and children does not provide disaggregated data for Aboriginal and Torres Strait Islander people.(83)

The most recent NATSIHS (2022–23) data provides insights into cultural determinants of social and emotional wellbeing for Aboriginal and Torres Strait Islander people aged 18 years and over for the period of 2022–23. The survey explored topics related to cultural identification and connection to language. Although this survey does not provide data specific to the Adelaide PHN, these topics have been selected for the foci of this section.

In the 2022 Heath Needs Assessment, identity, as determined through self-reported ancestry, was reported for Adelaide's North, South, Western, Central and Hills regions, SA and Australia. This data was sourced from 2021 Census data. Although more recent data is not available, more granular data specific to the local council areas in the Adelaide PHN has

been released. Table 12 details the top responses of self-reported ancestry of Aboriginal and Torres Strait Islander peoples in the local council areas. For Greater Adelaide, broadly,

Table 12: Self-reported ancestry: top responses (%) from Aboriginal and Torres Strait Islander people in 2021, by LGA

LGA	Australian Aboriginal	Australian	English	Torres Strait	Irish	Italian	Scottish	German
City of Adelaide	71.4	20.6	15.6	5.9	5.6			
City of Burnside	80.1	37.6	20.4	6.5	8.6			
City of Campbelltown	86.2	32.7	18.5	5.0		5.2		
City of Charles Sturt	87.9	35.2	17.3	4.6	3.7			
City of Holdfast Bay	89.1	42.5	20.3	4.4	6.6			
City of Marion	87.3	36.4	17.2		4.1		4.9	
City of Mitcham	83.3	38.3	22.1		4.8		5.2	
City of Norwood, Payneham & St Peters	83.4	26.7	25.8	6.5	6.9			
City of Onkaparinga	89.0	39.7	21.6		4.0		4.2	
City of Playford	88.2	36.8	22.1	4.0	3.4			
City of Port Adelaide Enfield	83.4	28.8	15.8	3.0			3.4	
City of Prospect	79.2	27.4	26.4	5.7	5.7			
City of Salisbury	90.6	35.4	16.5		3.4		3.7	
City of Tea Tree Gully	90.3	37.1	17.5		4.9			4.6
City of Unley	83.5	35.6	16	8.8			10.3	
Town of Walkerville*								
City of West Torrens	86.8	30.1	17.0	5.5	5.2			4.6
Greater Adelaide (GCCSA)	**87.3**	**35.5**	**19.3**	**3.9**	**3.9**			

*No data available for Town of Walkerville

NB: Total percentages exceed 100% as respondents were able to select multiple options)

Sources: (22–39)

Census data from 2021 indicates that, across Greater Adelaide, most (89.1%) Aboriginal and Torres Strait Islander families only use English at home and that only a small proportion of families use an Aboriginal language (4%). However, as detailed in Table 13, a greater proportion than this use an Aboriginal language in households in the City of Adelaide (7.7%) and the City of Prospect (7.1%). Further, the City of Burnside (5.9%), City of Charles Sturt (5.1%), City of Mitcham (5.5%), City of Port Adelaide Enfield (6.0%), and City of Mitcham (5.7%) also all have higher proportions of households using Aboriginal languages than for Greater Adelaide. No Aboriginal and Torres Strait Islander households in the City of Unley reported using an Aboriginal language, and proportion was also small in City of Holdfast Bay (2.2%) and City of Playford (2.6%).

Greater Adelaide data indicates that Ngarrindjeri (0.9%) is the most frequently spoken Aboriginal language in Greater Adelaide, followed Pitjantjatjara (0.4%), Kaurna (0.4%) and Narungga (0.2%). A further 0.7% of families in Greater Adelaide used an Aboriginal language that was not defined or described in the available data. Data from the 2021 Census indicates that across the Adelaide PHN at least 15 other Aboriginal languages are spoken.

Although the proportion of households using Aboriginal languages may be relatively low, language is a fundamental component of Aboriginal health and wellbeing. It also serves as a powerful indicator of cultural revitalisation, connection, and reconnection among communities affected by ongoing colonisation.

Table 13: Households (%) using Indigenous languages at home in 2021, by LGA

LGA	Australian Indigenous languages used at home	English only used at home
City of Adelaide	7.7	68.7
City of Burnside	5.9	88.2
City of Campbelltown	3.4	89.8
City of Charles Sturt	5.1	88.2
City of Holdfast Bay	2.2	90.6
City of Marion	3.9	88.1
City of Mitcham	5.5	89.0
City of Norwood, Payneham & St Peters	5.1	87.1

City of Onkaparinga	3.0	93.6
City of Playford	2.6	92.7
City of Port Adelaide Enfield	6.0	84.0
City of Prospect	7.1	84.9
City of Salisbury	4.1	90.4
City of Tea Tree Gully	4.6	89.0
City of Unley	0.0	95.4
Town of Walkerville*	–	–
City of West Torrens	3.8	87.4
Greater Adelaide (GCCSA)	**4.0**	**89.1**

*No data available for Town of Walkerville

Sources: (22–39)

4.2 Physical health

Figure 7: Born from Country— section from The Dance of Life, Milroy, 2006.(80)

Milroy's painting explains that the physical dimension of health is grounded in Country[10] and connections to Country. Physical health and Country are inextricably connected and are unable to be separated from one another.(80) In this way, an Aboriginal and Torres Strait Islander person's physical health and wellbeing is related to cultural connections with Country as well as the health of their Country.(84) An understanding of the importance of Country to health, it is also important to recognise the deliberate interference of Aboriginal and Torres Strait Islander peoples' connection to Country through a multitude of colonial practices and policies, with substantive ramifications on people's health both historically and contemporarily.

ABS data also supports the connection between health and Country. Nationally, a greater proportion of Aboriginal and Torres Strait Islander people report excellent or very good self-assessed health status when they live on their homelands or traditional Country (77.9%) or are allowed to visit (72.5%) than those who are not allowed to visit (47.4%). Further, a greater proportion of Aboriginal and Torres Strait Islander people, nationally, who are not allowed to visit their homelands or traditional Country report having three or more long-term health conditions (68.4%) than those who either live on (45.1%) or visit (54.9%) their homelands or traditional Country.(85) SA-specific data indicates that two-thirds (64.7%) of Aboriginal and Torres Strait Islander people residing in SA identify with a clan, tribal or language group. Data from the Aboriginal and Torres Strait Islander Health Performance Framework released in June 2026 indicates that in 2022–23 only 13.1% lived on their homelands or traditional Country, but 58.8% were allowed to visit. A small proportion (1.3%) were not allowed to visit, and nearly one-fifth (23.5%) did not recognise a homeland or traditional Country.(86)

[10] Here, and throughout this report, 'Country' refers to a living spiritual consciousness with land, sea, waterways, sky, people, animals, and plants and exists across past, present, and future.(81)

4.3 Psychological health

Figure 8: Living Life—section from The Dance of Life, Milroy, 2006.(80)

Social and emotional wellbeing and mental health are foundational to health across the life course. For Aboriginal peoples in the Adelaide PHN, indicators show both elevated risk and substantial resilience, with sustained engagement with health services providing important opportunities for prevention, early intervention and culturally safe continuity of care.

Data from the 2022–23 NATSIHS reported that close to one-third (30.2%) of Aboriginal and Torres Strait Islander people in SA had a high or very high psychological distress level.(68) This proportion is comparable to the national data reporting high and very high psychological distress being higher in non-remote areas than remote areas (31.4% and 24.4% respectively),(87) likely reflecting both ongoing exposure to structural stressors and access to metropolitan support services.68) This proportion is comparable to the national data reporting high and very high psychological distress being higher in non-remote areas than remote areas (31.4% and 24.4% respectively),(87) likely reflecting both ongoing exposure to structural stressors and access to metropolitan support services.

Data available for the Adelaide PHN, indicates that between 2019 and 2023, the average annual age-standardised rate (per 100,000) of deaths by suicide and self-inflicted injuries was 35.5, which was slightly higher than for Greater Adelaide (33.9). More granular data pertaining to the Adelaide PHN region is available for some, but not all, areas and is presented in Table 14. There are some substantive differences between locations: there

were no reports of deaths by suicide or self-inflicted injuries reported in Unley, Burnside or Mitcham but relatively high rates reported for Adelaide – Prospect – Walkerville (99.5).(88)

Table 14: Average annual of death by suicide and self-inflicted injuries by IARE in the Adelaide PHN (2019–23)

IARE	Average annual age-standardised rate (per 100,000)
Adelaide – Prospect – Walkerville	99.5
Campbelltown – Norwood	..
Charles Sturt	49.9
Holdfast Bay – West Torrens	..
Marion	..
Onkaparinga	37.2
Playford	36.3
Port Adelaide – Enfield	..
Salisbury	39.9
Tea Tree Gully	..
Unley – Burnside – Mitcham	0.0
Adelaide PHN	**35.5**
Greater Adelaide (GCCSA)	**33.9**

Source: (88)

In terms of identifying potential subgroups of people who are potentially more at risk, it is necessary to look at SA-wide data (as more detailed population level data is not available for Adelaide PHN). According to ABS data, for the period of 2020–24, the crude rate (per 100,000) of suicides for Aboriginal and Torres Strait Islander people in SA was 30.6. Sex-specific data demonstrates that the crude rate (per 100,000) was greater for males (42.9) than for females (18.2). Age-specific data (detailed in Table 15) also indicates that in SA, the suicide rate is greater for Aboriginal and Torres Strait Islander people ages between 25–34 years and 34–44 years than for those younger than 24 and older than 45.(89) These statistics highlight the importance of accessible crisis services, primary care engagement and Aboriginal-led social and emotional wellbeing programs. Sustaining and strengthening these supports remains critical for all Aboriginal and Torres Strait Islander people, but particularly for people aged 25–44 and men.

Table 15: Age-specific rates (per 100,000) of suicide amongst Aboriginal and Torres Strait Islander people in SA

Age group (years)	Age-specific rate (per 100,000)
0–24	16.8
25–34	52.2
35–44	59.9
45+	33.9

Source: (89)

4.3.1 Self-harm

Hospitalisations for intentional self-harm represent both serious health events and opportunities for intervention. The Suicide and Self-harm Monitoring System incorporates data from the National Hospital Morbidity Database and provides opportunities to identify trends over time.(90) As evident in Table 16, the number and rate of hospitalisations, nationally, from intentional self-harm have reduced every year from 2016–17 to 2023–24 (with the exception of 2020–21).

Table 16: Intentional self-harm hospitalisations for Aboriginal and Torres Strait Islander peoples, nationally from 2016–17 to 2023–24

Measure	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24
Number	33,133	29,486	29,434	28,643	29,886	26,866	24,765	24,074
Rate (per 100,000)	135.8	119.0	117.0	112.4	116.4	103.9	94.1	90.3

Source: (90)

While this database reports hospitalisations for intentional self-harm by PHN and for Aboriginal and Torres Strait Islander people, small case counts limit disaggregation by Indigenous status for small geographies. Instead, we look to the PHIDU publication *Aboriginal and Torres Strait Islander Social Health Atlas* which draws on SA3 level intentional self-harm data from 2019-20 to 2022–23. Like the intentional self-harm deaths described above, the rates of intentional self-harm hospitalisations vary considerably throughout the Adelaide PHN regions (Table 17).

Data specific to the Adelaide PHN region regarding emergency department presentations for injury (not specifically self-inflicted), poisoning and certain other external causes is detailed in Section 8.7 Injury.

Table 17: Average annual rate of admissions for intentional self-harm, Aboriginal people by IARE in the Adelaide PHN (2019–23)

IARE	No.	Average annual age-standardised rate (per 100,000)
Adelaide – Prospect – Walkerville	20	517.1
Campbelltown – Norwood (part a)	9	277.6
Charles Sturt	63	642.9
Holdfast Bay – West Torrens	20	340.3
Marion	21	327.2
Onkaparinga	123	777.7
Playford	107	524.2
Port Adelaide – Enfield	52	298.6
Salisbury	70	410.5
Tea Tree Gully	13	226.4
Unley – Burnside – Mitcham	14	331.1
Adelaide PHN	**512**	**465.9**
Greater Adelaide (GCCSA)	**529**	**447.8**

Source: (88)

Protective factors and system strengths

Self-harm hospitalisation rates below the South Australian Aboriginal average (Adelaide PHN: 6.8 per 1,000 vs SA: 7.4 per 100,000)(88) suggest that existing crisis response and follow-up pathways are functioning relatively well in the Adelaide PHN. Each admission remains a critical opportunity for culturally safe assessment, continuity and referral into community-based care, however. Self-harm hospitalisation rates below the South Australian Aboriginal average (Adelaide PHN: 6.8 per 1,000 vs SA: 7.4 per 100,000)(88) suggest that existing crisis response and follow-up pathways are functioning relatively well in the Adelaide PHN. Each admission remains a critical opportunity for culturally safe assessment, continuity and referral into community-based care, however.

Key protective factors within the Adelaide PHN include strong Aboriginal Community Controlled Health Organisations, metropolitan crisis services, and opportunities for integrated care across primary, acute and community settings. These assets provide a strong foundation for Aboriginal-led, trauma-informed prevention strategies.

Case Study – SA Aboriginal Social and Emotional Wellbeing Centre

Throughout the HNA consultations, community members spoke of the importance of social and emotional wellbeing and the need for services offering culturally appropriate care. Located on Kaurna Yerta and serving residents in the Adelaide PHN and beyond, the SA Aboriginal Social and Emotional Wellbeing Centre (ASEWBC) delivers culturally safe, holistic care for Aboriginal and Torres Strait Islander people experiencing distress, trauma and mental health concerns. Its model of care is grounded in connection to family, community, culture, spirituality and Country, and has been co-designed with Aboriginal communities from across SA. At the time of writing, the ASEWBC was operating as an outreach-only model of care from an interim site, before its substantive site is operational.

Collaborative model

ASEWBC operates through a coordinated, partnership-based model rather than a standalone service. It has been intentionally established with Aboriginal Community Controlled Organisation control (through the National Indigenous Network Initiative) with formal partnership with nongovernment providers (Sonder, OARS Community Transitions) and SA Health.

ASEWBC links clients to existing services across primary care, specialist mental health, and Aboriginal Community Controlled Health Services; a deliberate approach that leverages existing services and strengthens the broader service system through patient centred care coordination. Accordingly, ASEWBC improves access and usability, rather than duplicates existing programs.

This approach benefits community members by offering:

- Coordinated care delivery. ASEWBC acts as a central resource for assessment, support and referral, connecting people to the services they need across sectors. ASEWBC delivers outreach pop up clinics, community-based appointments and supports partner sites to provide culturally safe care where people are, improving accessibility for guests who face transport, cultural or other barriers to accessing mainstream services.
- Cultural governance and safety. Aboriginal leadership and community input shape the model of care, ensuring services remain culturally responsive and trusted.
- Integration of knowledge systems. Clinical care is delivered alongside cultural healing practices, supporting engagement and recovery.
- System-level alignment. Ongoing collaboration with SA Health and community providers supports a more consistent and accessible care experience for mob throughout the healthcare

4.4 Social health

The social dimension of Aboriginal and Torres Strait Islander health encompasses family and community connections, including between generations, and involves consideration of both the past and the future.(80) Throughout this Health Needs Assessment's community consultations, community members spoke of the importance of family, opportunities to meet and connect with others, and to nourish relationships between generations to help keep one another healthy and to support health promoting activities (ranging from sharing culture, helping older family members with digital technology, and role-modelling parenting behaviours).

Figure 9: Community Strong Together—section from The Dance of Life, Milroy, 2006.(80)

4.5 Spiritual health

"Spirituality is a dynamic, evolving, contemporary expression of Indigeneity. Spirituality connects past, present and future. Spirituality emphasises people's relationships with each other, the living (other entities—animals) and non-living (mating season, tides, wind and mythology) life forces premised by an understanding or experience of their place of origination".(91)

Spirituality may have different interpretations and significance amongst Aboriginal and Torres Strait Islander people and communities(92), and can be expressed through a range of activities including art, song, story, ceremony and Dreaming.(93) Despite colonial efforts to disrupt Aboriginal and Torres Strait Islander peoples' connections to, and opportunities to, engage with their spirituality (93) many Aboriginal and Torres Strait Islander people have maintained strong spiritual connections and beliefs. As such, spirituality widely considered as being (along with the other dimensions of health as discussed above) fundamental to Aboriginal and Torres Strait Islander knowledges and health(92) . For example, Aboriginal participants in recent research described their spirituality as a "multi-sensory, whole of body experience", with spirituality being understood as "crucial for clearing one's mind and healing one's body". (94)(p.773)

Figure 10: The Tree of Life—section from The Dance of Life, Milroy (2006) (80)

The 2022 Aboriginal Health Needs Assessment reported that there was limited capacity to describe insights relating to spiritual wellbeing for Aboriginal and Torres Strait Islander people in the Adelaide PHN region. In 2026, the same finding is noted. However, as advocated by Australian Indigenous Health*InfoNet,* health practitioners' recognition of the significance of spirituality, as well as Country and culture, to Aboriginal and Torres Strait Islander peoples' health and wellbeing is essential.

According to 2021 national data, more Aboriginal and Torres Strait Islander people reported having ‘no religion’ than previously recorded (n = 252,422). There were, however, 93,538 Aboriginal and Torres Strait Islander people who identified as Catholic and 73,611 who identified as Anglican. There were a similar number of Aboriginal and Torres Strait Islander people who identified as Christian (n = 14,952) or as belonging to the Uniting Church (n = 14,662).(95)

5 Access to health services

5.1 Health checks

Aboriginal and Torres Strait Islander health checks (MBS Item 715) are structured, holistic risk assessments to guide prevention, early detection, and follow-up care, overseen by a GP.(96) A health check can be offered to Aboriginal and Torres Strait Islanders of all ages on an annual basis, and includes assessment of cardiovascular risk, diabetes risk, kidney disease, respiratory conditions, cancer risk, and other factors, including social determinants of health. A critical aspect of the annual health check is its pathway to follow up care and early prevention of disease. (97)

AIHW data describes that, as of December 2024, Aboriginal and Torres Strait Islander peoples residing in the Adelaide PHN region were less likely to have had a health check in the preceding 12-month period than Aboriginal and Torres Strait Islander people both nationally and in SA generally (Table 18).

Table 18: Number and proportion of Aboriginal and Torres Strait Islander people who had a health check in the previous 12 months in 2024

Adelaide PHN			**South Australia**			**Australia**		
Age (years)	**N =**	**Uptake (%)**	**Age (years)**	**N =**	**Uptake (%)**	**Age (years)**	**N =**	**Uptake (%)**
0–14	1,413	15.7%	0–4	1,140	20.0%	0–4	27,232	23.6
			5–14	2,033	17.4%	5–14	51,403	23.8
15–24	833	14.3%	15–24	1,714	16.1%	15–24	41,812	20.9
25–49	1,906	21.2%	25–49	3,803	22.4%	25–34	34,248	21.5
						35–44	29,401	25.3
						45–54	29,313	30.1
50+	1,284	27.3%	50+	2,914	29.0%	55–64	27,685	34.7
						65–74	17,617	38.6
						75+	7,136	37.4
All ages	**5,437**	**19.1%**	**All ages**	**11,607**	**21.1%**	**All ages**	**265, 847**	**28.4**

Source: (98)

With respect to sex differences, AIHW statistics for SA indicate that the proportions of females and males is the same or similar for those aged between 0 and 14. Differences occur after this age (Table 19). The higher proportions of women aged ≥15 years receiving health checks are highly likely to reflect differing levels of engagement with the health system more generally, whether for reproductive health support or other reasons.(99)

Table 19: Number and proportion of Aboriginal and Torres Strait Islander people in South Australia who had a health check in the previous 12 months in 2024, by age

Age (years)	Females		Males		Persons	
	Participants	Uptake	Participants	Uptake	Participants	Uptake
0–4	550	20.0%	590	20.0%	1,140	20.0%
5–14	958	16.9%	1,075	17.9%	2,033	17.4%
15–24	984	19.3%	730	13.2%	1,714	16.1%
25–49	2,300	27.0%	1,503	17.8%	3,803	22.4%
50+	1,681	31.7%	1,232	26.0%	2,914	29.0%
All ages	**6,474**	**23.7%**	**5,132**	**18.5%**	**11,607**	**21.1%**

Source: (98)

Differences have also observed in the uptake of health checks across various regions of the Adelaide PHN. In Table 20, one-quarter or more of Aboriginal and Torres Strait Islander people in Adelaide City (28.7%), Prospect – Walkerville (25.7%) and Playford (24.8%) reported having a health check in the previous 12-month period. However, the proportions were substantially lower in other areas, for example Holdfast Bay (9%), Burnside (9.5%), Campbelltown (10.7%) and Onkaparinga (12.8%).

Table 20: Number and proportion of Aboriginal and Torres Strait Islander peoples who had a health check in the previous 12 months, by SA3 level, 2024

SA3	Participants	Uptake (%)
Adelaide City	146	28.7%
Burnside	22	9.5%
Campbelltown (SA)	60	10.7%
Norwood – Payneham – St Peters	56	20.1%
Prospect – Walkerville	80	25.7%

Unley	41	17.6%
Playford	1,467	24.8%
Port Adelaide – East	391	18.6%
Salisbury	918	20.8%
Tea Tree Gully	194	13.4%
Holdfast Bay	33	9.0%
Marion	245	15.0%
Mitcham	68	13.5%
Onkaparinga	557	12.8%
Charles Sturt	506	20.1%
Port Adelaide – West	495	20.9%
West Torrens	150	15.0%

Source: (98)

Recent data suggests that the proportion of health check participants returning for follow-up services has decreased to below 2018 levels, after a peak in 2020 (Table 21).

Table 21: Aboriginal and Torres Strait Islander peoples who returned for follow-up care after a 715 health check in the previous 12 months by year, South Australia

Year	Health check participants	Follow-up patients	Follow-up percentage (%)
2018	3,977	1,219	30.7
2019	4,411	1,430	32.4
2020	4,694	1,614	34.4
2021	4,690	1,456	31.0
2022	4,477	1,492	33.3
2023	5,024	1,480	29.5

Source: (98)

During the Needs Assessment's community consultations, community members offered a wide range of reasons why Aboriginal and Torres Strait Islander people may not undertake health checks and follow-up appointments. Lack of cultural safety was frequently cited, along with the lack of capacity to invest the time and effort to undertake a health check, given competing priorities such as employment, housing issues, and caring roles and

responsibilities. This was compounded by a need to return to the health service multiple times, or access different service providers. Some community members described formal MBS 715 health checks as unnecessary as they were already highly engaged with healthcare services as they were managing chronic conditions, or because they enjoyed good health and were proactive with preventive measures. Health service provider feedback highlighted insufficient workforce to offer and/or promote the 715 health check. Lack of suitable staff to sign off on the health check (e.g., GPs) was given as a reason for not promoting these checks more widely, as is common in the Eastern States through the Deadly Choices campaign. These views counter assumptions that low uptake of health checks and follow-ups is due to low engagement by individuals and are critical considerations to support self-determination and the autonomy to make one's own decisions without judgement or prejudice.

5.2 Access to health services

Completing an annual health check, and undertaking any follow-up care flagged during the check, is a function of access to health services. Access to *culturally safe* healthcare services is discussed more below. In addition to the barriers to getting health checks (detailed above), community members also described issues with accessing services. Inability to book a same-day (or near to) appointment was frequently mentioned. Strategies employed by people included taking an appointment anywhere they could (rather than with who they wanted) or booking a next appointment, often up to three months in advance irrespective of whether they need it or not, as they finished one appointment with their GP. These actions were seen by community as a way to "beat the queue" and avoid lengthy wait-times for appointments with healthcare services.

While there does not seem to be recent data on Aboriginal and Torres Strait Islanders' health service access in SA, the community consultations undertaken for this report mirror the outcomes described in the NATSIHS (2022–23). This report indicated 17% of Aboriginal and Torres Strait Islander people living in non-remote areas needed to see a GP in the previous 12 months but did not, while 13.5% reported needing see another health professional (not including dentist) in the previous 12 months. A greater proportion (22%) reported needing to see a dentist in the previous 12 months but not. (68) Reasons outlined in this report included the costs associated with seeking services, as logistical and access barriers.(68) These concerns were echoed by community members during the consultations. Consultations with community health professionals highlighted that current Adelaide PHN initiatives to support MBS claiming for health checks delivered in tertiary settings, or to provide MBS-supported mental health care without a Care Plan being in place prior, have been very well received.

6 Culturally safe workforce and services

As discussed in previous sections, a culturally safe clinical workforce underpins effective primary health care for Aboriginal and Torres Strait Islander peoples. Evidence consistently shows that services are more accessible, effective, and trusted when care is delivered by clinicians who understand local community context, value Aboriginal ways of knowing, and practise cultural safety as defined by patients and communities.(100,101) Community yarns and 'kitchen tables' facilitated by the Adelaide PHN in recent years have regularly mentioned the importance of a culturally safe clinical workforce, as have the consultations undertaken for this Health Needs Assessment. Community members described two key ways that supported their likelihood of receiving culturally safe care: an expanded Aboriginal workforce and enhanced cultural safety of non-Indigenous practitioners and staff in health service settings.

Aboriginal clinicians play a central role in delivering high-quality, culturally safe care. Their contributions include strengthening communication, improving continuity of care, and supporting self-determination at both clinical and system levels. Services with a strong Aboriginal workforce are better positioned to respond to local priorities and reduce avoidable barriers to care.(102,103) While the Aboriginal clinical workforce has grown over the past decade, Aboriginal people remain under-represented across most registered health professions relative to population need.(104) Data from the 2024 National Health Workforce Dataset demonstrates that this is also the case for the Adelaide PHN regions (Table 22).

Table 22: Birthplace of AHPRA-registered clinicians for the Adelaide PHN region, National Health Workforce Dataset, 2024

Professional group	Indigenous (and Australian born)		Indigenous (not Australian born)		Not Indigenous or Not stated		Total
Aboriginal & Torres Strait Islander Health Practitioners	41	100%	0	0.0%	–	0.0%	41
Chiropractors	3	1.1%	0	0.0%	276	99.3%	278
Chinese Medicine Practitioners	–	0.0%	0	0.0%	184	98.9%	186
Dental Practitioners	14	0.7%	0	0.0%	1,870	99.2%	1,885
Medical Practitioners	41	0.5%	11	0.1%	8,380	99.4%	8,432
Medical Radiation Practitioners	6	0.4%	3	0.2%	1,377	99.4%	1,385

Nurses and Midwives	274	0.9%	42	0.1%	31,303	99.0%	31,619
Occupational Therapists	11	0.5%	0	0.0%	2,238	99.5%	2,250
Optometrists	–	0.0%	0	0.0%	402	99.8%	403
Osteopaths	–	0.0%	0	0.0%	42	100%	42
Pharmacists	6	0.3%	0	0.0%	2,208	99.7%	2,214
Physiotherapists	17	0.6%	0	0.0%	3,042	99.4%	3,060
Podiatrists	3	0.6%	0	0.0%	465	99.4%	468
Paramedicine Practitioners	10	0.8%	0	0.0%	1,235	99.2%	1,245
Psychologists	8	0.4%	3	0.1%	2,052	99.6%	2,061
Total	**434**	**0.8%**	**59**	**0.1%**	**55,074**	**99.1%**	**55,569**

Source:(105)

Additionally, the 2021 Census counts a further 73 Aboriginal and Torres Strait Islander Health Workers living (and presumably working) in the Adelaide PHN area. The 2021 Census data also suggests that there are 153 Aboriginal and Torres Strait Islander people working in Aged Care Residential Services, but it is impossible to know if these people are part of the AHPRA-registered workforce quantified above, unqualified personal care workers or kitchen and hotel services aged care workers.

Increasing the number and retention of the Aboriginal healthcare workforce is therefore both an equity and quality priority. National evidence highlights the importance of sustained investment in Aboriginal-led training pathways, culturally safe workplaces, mentoring, and leadership opportunities to support workforce growth.(106,107) The stakeholder consultations undertaken for this Needs Assessment suggest that early outcomes from an Adelaide PHN and Tauondi Aboriginal College partnership are promising, introducing school-aged children to pathways into healthcare careers, and that this program is something to continue and build upon.

For PHNs, partnering with Aboriginal organisations and building on existing workforce strengths is critical to developing a clinical workforce that is skilled, stable, and culturally safe for the communities they serve. However, as voiced by various health provider stakeholders during the consultations, it should not (just) be Aboriginal organisations who shoulder the responsibility and invest the time, effort and resources to develop conciliatory partnership efforts. That is, there is an important role for the PHNs and mainstream providers to play in terms of sharing this responsibility.

7 Modifiable risk factors

7.1 Low-risk alcohol and other drug use (including during pregnancy)

Alcohol consumption, in any form, impacts the health and wellbeing of individuals, families and communities, as recognised by the World Health Organization.(108) Excessive alcohol consumption is associated with a range of physical diseases (e.g. liver, kidney, heart, brain), mental health conditions (e.g. anxiety, depression, suicide), and behavioural and social concerns (e.g. intentional and unintentional injuries).(109) Australian guidelines on alcohol consumption focus on reducing the risk of harm from alcohol-related diseases and injuries, through lowering consumption, limiting consumption for those under 18 years of, and those who are pregnant and/or breastfeeding.(110) However, in Australia alcohol is the most widely consumed drug, likely due to normalisation in dominant Australian culture, where it is deeply embedded in identity (i.e. mateship) through social and sporting activities (e.g. sporting events), which masks the significant and ongoing impacts and harms.(110)

Prior to colonisation there was some evidence that Aboriginal communities practiced fermenting processes, however problematic and excessive use of alcohol was introduced with First Nations communities through colonisation, along with genocidal impacts, including dispossession of land, language, cultural and economic exclusion and intergenerational traumas.(111) Exposure to dehumanising treatment, and ongoing impacts of colonisations, evident through exclusion, denial, racism, and whiteness continue to negatively impacts on Aboriginal and Torres Strait Islander communities, and have been directly linked to levels of alcohol consumption.(111,112) Recognising this, the *South Australian Alcohol and Other Drugs Strategy (2025–2030)* is committed to collaborative, co-design of Aboriginal community-led prevention activities that reduce alcohol and other drug-related use and harm. Specifically, Preventive Health SA and SA Health (DASSA) are identified as key stakeholders in this commitment.(113)

Data specific to alcohol consumption by Aboriginal and Torres Strait Islander peoples residing in the Adelaide PHN is not available. The 2022–23 NATSIHS identified nearly 16% of Aboriginal and Torres Strait Islander peoples in non-remote areas of SA had abstained from alcohol consumption in the previous 12+ months, and that nearly half[11] had consumed

[11] The ABS warns that the statistic provided here have a high margin of error and thus should be used with caution.

alcohol but not in excess of guidelines[12]. Fewer than one-third of Aboriginal and Torres Strait Islander peoples in non-remote areas of SA exceeded alcohol consumption guidelines in the previous year. (70)

Recent data on "other"/recreational drug use by Aboriginal and Torres Strait Islanders living in the Adelaide region are limited, however the 2022–23 NATSIHS indicates that 29.0% of Aboriginal and Torres Strait Islander people reported non-medical substance use in the previous 12 months and 68.2% had **not** used substance(s) for non-medical purposes.(70)

7.1.1 Alcohol and other drugs during pregnancy

Foetal alcohol spectrum disorder (commonly referred to as FASD) is caused through prenatal exposure to alcohol, that is exposure in utero particularly during weeks three to eight of the first trimester, causing impairments and injury to the child's central nervous system and neurodevelopment, which has lifelong impacts on the child. As such, alcohol abstinence throughout pregnancy is advised, with recommendations carrying on postpartum while breastfeeding. Currently no publicly available data specific to the prevalence of FASD in SA is available. However, data provided through AIHW reports in 2020, indicates nearly 95% of Aboriginal and Torres Strait Islander mothers who birthed in SA had not consumed alcohol in the first 20 weeks' gestation, and over 96% had not consumed alcohol after 20 weeks.(114) Additionally, Preventive Health SA reported that, in 2023, approximately 2.3% of Aboriginal women in SA with a known alcohol consumption status reported consuming alcohol during pregnancy.(115) National perinatal datasets do not routinely collect detailed data on other drug use, as such, there is very limited data on other drug use in pregnant Aboriginal and Torres Strait Islander women.(116)

7.2 Smoke-free living

There are 22 species (and four subspecies) of *Nicotiana* native to Australia, including pituri and mingkulpa. Since time immemorial, these nicotine-rich plants have been used by Aboriginal communities through smokeless tobacco practices such as chewing (quid).(116) However, smoking of tobacco is an introduced practice to Aboriginal and Torres Strait Islander communities. Like alcohol consumption, smoking amongst Aboriginal and Torres Strait Islander communities is directly attributable to ongoing colonisation, along with the

[12] That is, they had not consumed more than 10 standard drinks in the previous week or had not consumed five and/or more standard drinks on a single day twelve times in the previous 12 months.

resultant interruptions to land, language and culture, systemic marginalisation and other inequities that have caused both historical and contemporary traumas and stress.(117)

Smoking is the primary modifiable risk factor for a range of respiratory diseases (such as asthma, Chronic Obstructive Pulmonary Disease (COPD), emphysema, lung fibrosis and lung cancer), in these cases explore is directly related to increased risk and severity. Smoking has other substantive negative and life-threatening impacts on heath, such as cardiovascular issues (including oxidative stress, atherosclerosis, and thrombogenesis).(118,119)

Recent research indicates that Aboriginal and Torres Strait Islander peoples are strongly motivated to quit smoking and participate in a range of quit strategies.(120) Findings from the NATSIHS (2022–23) indicate that nearly 41% of Aboriginal and Torres Strait Islander people, in non-remote areas of SA, have never smoked and nearly 62% have never used an e-cigarette or vaping device. This survey also reported that nearly one quarter (24.5%) of respondents identified as an 'ex-smoker'.

In 2022–23, one-third (33.9%) of Aboriginal and Torres Strait Islander people residing in non-remote SA identified as a current smoker. A greater proportion (40.7%) reported that they had never smoked, while nearly one-quarter (24.3%) indicated they were ex-smokers. (68)

7.2.1 Smoking during pregnancy

The associations between smoking and negative impacts, such as spontaneous abortions, ectopic pregnancies, placenta previa, low birthweight and small for gestational age, preterm (early) birth and even perinatal death is well established in the literature.(121,122) These significant health impacts are why smoke-free pregnancies are important. Across Australia, smoke-free pregnancies for Aboriginal and Torres Strait Islander mothers has increased, with the number of mothers reporting having smoked (at all) during pregnancy decreasing from 49% in 2011 to 38% in 2023.(123)

The proportion of Aboriginal and Torres Strait Islander women in Greater Adelaide who smoked during pregnancy in 2023 (36.1%) was slightly lower than the South Australian (38.5%) and Australian (38.7%) averages.(124) Further, fewer women smoked after 20 weeks (28.6%) compared to the first 20 weeks (35.2%) which could, at least in part, be attributed to smoking prior to knowledge of pregnancy. However, whilst the statistics indicate improvements, they still reflect a not-inconsequential number of babies who are being exposed to smoking in utero.

Research suggests that Aboriginal and Torres Strait Islander women are motivated to quit smoking(125) but quitting attempts are not always successful. Observations from

successful smoking cessation suggest that community-based initiatives are important.(126) Exemplary models include the First 1000 Days Australia initiative and the SISTAQUIT website and app.

7.3 Food security

Access to food that is safe, healthy, affordable, culturally acceptable, and sufficient for their needs constitutes food security. In contrast, food that is not safe, healthy, accessible, affordable, culturally acceptable or insufficient to meet needs is food insecurity.(127) Current evidence suggests individuals living in non-remote areas are more likely to be food secure than people in remote areas.(128) However Aboriginal and Torres Strait Islander peoples are at greater risk than non-Indigenous people to experience food insecurity.(129)

Limited data was available to provide comprehensive insights into food security across the Adelaide PHN region for the 2022 Adelaide PHN Aboriginal and Torres Strait Islander Health Needs Assessment. New reporting of community outcomes under NATSIHS 2022–23 allows reporting on Aboriginal and Torres Strait Islander households in SA, specifically regarding access to sufficient food, or money to buy food (over the last 12 months). Relevant to the Adelaide PHN region, the NATSIHS 2022–23 estimated that in non-remote areas of SA, 51.4% of Aboriginal households with children and 67.9% of Aboriginal households without children were considered food-secure, with 59.5% of Aboriginal households (irrespective of family make up) in non-remote SA were food-secure in 2022–23. This is very similar to the proportion of food-secure Aboriginal and Torres Strait Islander households in non-remote areas nationally (59.2%).(68)

The caution with this reporting is in that food security status assigned to a household, may not reflect the experience of everyone in the household and that the specific experiences of children in the household do not form part of the measure. Moreover, measures of food security for the Adelaide PHN region specifically, and the LGAs in the Adelaide PHN region, are currently not available and this limits further exploration of the quantitative data.

Community consultations undertaken to guide the development of this Needs Assessment suggested that food insecurity is not currently a priority for Aboriginal people in the Adelaide PHN area, despite current cost of living concerns generally, and the NATSIHS 2022–23 data as reported. Community voices also emphasised the importance of good quality food and nutrition, however, pointing out that “food is medicine”. The project team also heard of the strong community networks that share the load, ensuring food security for Aboriginal households, highlighting how food security intersects with the cultural determinants of health. While this is a strength of the Aboriginal communities of Kaurna Yerta, it also points

to a need for primary care services to be aware of the general proportion of households reporting a lack of food security and to seek opportunities to provide support to those who may not have strong community connections. It also points to a need for improved metrics regarding food security, improving both the granularity of available data and measurement of food quality and nutrition as opposed to sheer availability.

7.4 Adequate / sound nutrition

Yarning sessions with community across the Adelaide PHN region indicated that there were times where income constraints impacted food options available to them and that they were forced to purchase foods that were filling and cheap, but not necessarily nutritious. Further, when accessing foods via services such as Anglicare's Food Support Programs or SecondBite, recipients did not necessarily feel empowered to choose their own food and thus were essentially 'at the whim' of what foods were available which were not always their first choices or healthiest options. Stakeholder consultations echoed these concerns, noting that utilisation of non-government support services meant that specific dietary requirements (for example, relating to diabetes) are not necessarily able to be followed. These perspectives suggest that *nutrition security*[13] for some Aboriginal and Torres Strait Islander people on Kaurna Yerta (particularly those with low incomes and/or chronic conditions and using food support services) may be compromised.

The Australian dietary guidelines advise that people should consume a wide variety of foods (including vegetables, fruit, grains, meats, and dairy) daily, and limit foods heavy in saturated fats, added salt and sugar, and alcohol.(130) Specifically, the daily recommended fruit intake is 2 serves of 150g and 5-6 serves of 75g of vegetables for people aged 9+.(131) These recommendations are typically based on a western, monocultural ways of understanding healthy foods with Indigenous peoples' traditional foods often being "overlooked, understudied, and undervalued" in the development of dietary guidelines despite the fact that "many traditional food species could repositioned for a more colorful plate and wider selection". (132)(p. 3)

Data relating specifically to dietary nutrition of Aboriginal and Torres Strait Islander peoples' residing in the Adelaide PHN is not available. There is, however, data for SA from the NATSIHS (2022–23) that indicates that over two-thirds of Aboriginal and Torres Strait Islander people in non-remote SA do not meet the fruit intake guidelines, and over 90% do

[13] Nutrition security relates (more specifically than food security) to the nutritional value of accessible and available foods.

not meet the vegetable intake guidelines (Table 23). Further, this reporting indicated over three-quarters of Aboriginal and Torres Strait Islander survey respondent in SA consumed sugar sweetened drinks (includes soft drink, cordials, flavoured mineral waters, caffeinated energy drinks, sports electrolyte drinks) or diet drinks (including sugar free versions with artificial sweetener) at least once per week. While the fruit and vegetable consumption is not dissimilar in non-remote areas compared to non-remote areas, people residing in non-remote areas were more likely to not consume sugar sweetened or diet drinks.

Table 23: Proportion of Aboriginal and Torres Strait Islander people meeting fruit, vegetable and sweetened drink consumption recommendations (2022–23) by SA remoteness

	Remoteness	
	Non-remote areas	**Remote areas**
Daily fruit consumption		
Met recommended fruit guideline	30.4%	35.0%
Did not meet recommended fruit guideline	68.6%	65.0%
Daily vegetable consumption		
Met recommended vegetable guideline	6.8%	–
Did not meet recommended vegetable guideline	91.4%	100.0%
Sugar sweetened or diet drink consumption		
Usually consumes sugar sweetened or diet drinks	74.6%	82.5%
Does not usually consume sugar sweetened or diet drinks	24.6%	17.5%

Source: (70)[14]

[14] The ABS warns that the statistic provided here have a high margin of error and thus should be used with caution.

7.5 Physical activity

Physical activity is widely recognised as an important protective factor for health and wellbeing, while physical inactivity is associated with increased burden of disease contributing to greater levels of morbidity and mortality. (133) To enjoy the health benefits of physical activity, Australia's Physical Activity and Sedentary Behaviour Guidelines recommend, daily physical activity for adults, with moderate to vigorous intensity for cardiovascular health for at least 30 minutes per day, muscle strengthening activities on two or more days per week, functional activities on three or more days per week and several hours of light-intensive physical activity daily.(134) Data specific to physical activity levels of Aboriginal and Torres Strait Islander peoples' living in the Adelaide PHN are not available. As such, we look to South Australian data, with a particular focus non-remote locations (where possible) to understand current physical activity levels.

According to the NATSIHS (2022–23), most Aboriginal and Torres Strait Islander peoples in non-remote areas of SA reported not meeting the Australian guidelines in terms of being physically active.(70) The 2022–23 data indicate that only 13.6% of Aboriginal and Torres Strait Islander respondents from non-remote regions of SA reported meeting these guidelines. (68) It is not known whether these survey participants considered physically active cultural activities (such as ceremony, dancing, fishing, hunting, and caring for Country) in their calculations. If not, then there is potential that the data underrepresents the extent of physical activity truly being undertaken.

Sport predates colonisation.(135) For a range of reasons, sport is widely regarded as continuing to be important to many Aboriginal and Torres Strait Islander people.(136) Data from the 2025 AusPlay survey, relating to participation in sport by Aboriginal and Torres Strait Islander peoples in SA (without remoteness specified) across January to December 2025 is represented in Table 24. These data suggest that fewer than half (42.7%) of Aboriginal and Torres Strait Islander peoples in SA participated in sport or a physical activity, at least once per week, but that almost 38.6% reported participated twice per week, and only slightly fewer participated at least three times per week (29.5%).(137)

The proportion of South Australian Aboriginal and Torres Strait Islander adults who reported playing sport *at least once per year* in 2025 was relatively high (64.5%). A possible explanation for this is are annual carnivals such as Nunga Football, Nunga Netball and Nunga Tag Carnival, which have been described, for example by former professional rugby player and Gomeroi man, Owen Craigie, as being like a "*modern day corroboree where all your family and friends and tribes and nations come*" together, and identified as a "*good thing*".(138)

Table 24: Aboriginal and Torre Strait Islander adults' Sport and Physical Activity participation in South Australia (2025)

Gender	1+/year Participation Rate	1+/month Participation Rate	1+/fortnight Participation Rate	1+/week Participation Rate	2+/week Participation Rate
Female	59.4%	55.3%	47.1%	37.0%	33.3%
Male	67.8%	59.0%	53.7%	46.4%	42.1%
All	64.5%	57.5%	51.1%	42.7%	38.6%

Gender	3+/week Participation Rate	4+/week Participation Rate	5+/week Participation Rate	6+/week Participation Rate	7+/week Participation Rate
Female	22.0%	16.5%	n/a	13.8%	10.0%
Male	34.4%	29.7%	n/a	25.2%	20.7%
All	29.5%	24.5%	n/a	20.7%	16.5%

Source: (137)

A 2021 review by Allen et al.(139) explored barriers and facilitators influencing Aboriginal and Torres Strait Islander peoples' participation in sport. This study identified lack of transport, financial constraint, lack of time, competing work, family and cultural commitments as key barriers to participation, while facilitating or enabling factors included support from family, friends, and staff, as well as community and cultural connections.

The AusPlay data also identified that males reported greater participation, in all frequency categories, than females (Table 24).(137) Recently published research seeking to identify barriers to, and enablers of, physical activity and sport participation by Aboriginal and Torres Strait Islander women (albeit in Northern Territory[15]) identified similar and additional barriers for women. These included competing priorities, family responsibilities associated with being mothers and carers, logistics, health, shame, culturally unsafe spaces. This study

[15] There is lack of evidence relating to both physical activity and sport experiences, explicitly, of Aboriginal and Torres Strait Islander families within Adelaide and South Australia. This claim is premised on a systematic review published in 2020 that located no studies focusing on barriers and facilitators for Aboriginal and Torres Strait Islander children and adolescents living in South Australia (see for example, May et al.(140)).

also identified individuals' commitment to improving their personal health, access to and playing in team sports, having fun, culture and cultural activities that involved physical activity (such as traditional dancing, hunting, walking and being on Country) as enabling factors.(141)

7.5.1 Physical activity in children

The Australia's Physical Activity and Sedentary Behaviour Guidelines recommend that children (5–17 years) should be active every day, with at least 60 minutes of moderate–vigorous cardiovascular activities and muscle strengthening activities on at least three days per week (with limited sedentary behaviour).(142)

There is scarcity of recent data for South Australia Aboriginal and Torres Strait Islander children's participation in sport and physical activity, as evidenced in AusPlay data (Table 25, below). Beyond this, the most recent data available, relating to Aboriginal and Torres Strait Islander children's physical activity levels, does not offer insights specific to South Australia.

Table 25: Aboriginal and Torres Strait Islander children's Sport and Physical Activity participation in South Australia (2025)

Age	1+/year Participation Rate	1+/month Participation Rate	1+/fortnight Participation Rate	1+/week Participation Rate	2+/week Participation Rate
0–4 years	63.0%	48.1%	–	–	–
5–8 years	100.0%	38.0%	28.7%	13.5%	–
9–11 years	–	–	76.9%	–	–
12–14 years	100.0%	79.1%	50.8%	28.3%	–

Age	3+/week Participation Rate	4+/week Participation Rate	5+/week Participation Rate	6+/week Participation Rate	7+/week Participation Rate
0–4 years	–	–	–	–	–
5–8 years	–	–	–	–	–
9–11 years	–	–	43.0%	–	–
12–14 years	–	–	–	–	–

Source: (137)

7.6 Healthy weight

Maintaining a healthy weight offers many benefits associated with better quality of life, including reduced risk of diseases and management of chronic diseases(143) and can be influenced by nutrition, physical activity and a range of other social determinants of health. In the available data, overweight and obesity are measured via Body Mass Index (BMI) and waist circumference. These are explained by the AIHW here. It should be noted that BMI is a Western biomedical construct, developed using European populations, based on the average body proportions of European men. This measure also assumes one normal body standard ignoring different body compositions, along with not accounting for relationality across different cultural and social contexts.(144)

Data specific to Aboriginal and Torres Strait Islander people residing in the Adelaide PHN are not available. As such, data has been drawn from South Australian and Australian data from the NATSIHS (2022–23)[16]. Waist circumference data for Aboriginal and Torres Strait Islander adults living in non-remote areas of SA indicates that over one-fifth (22.6%) live in the 'lowered risk' range, but that over three-quarters are either at 'increased risk' (18.2%) or 'substantially increased risk' (60.9%) of poorer health associated with being overweight or obese. These statistics are less favourable than for Aboriginal and Torres Strait Islander peoples living in remote areas of SA, where nearly one-third (32.5%) are at lowered risk, and fewer are at 'increased risk' (15%) or 'substantially increased risk' (55.0%). Differences in data were observed between males and females (not specific to remoteness). Specifically, males were more likely to be at 'lowered risk' than females according to waist circumference measurements, and women were more likely to be at 'substantially increased risk' than males (70.5% compared to 45.5%). A similar proportion of males and females were identified as being at 'increased risk'.

BMI data from the NATSIHS (2022–23)[17] indicates that close to 16% of Aboriginal and Torres Strait adults in non-remote areas of SA are either underweight or of normal weight (compared to 30% of those in remote areas). Fewer Aboriginal and Torres Strait Islander adults in non-remote areas of SA are categorised as overweight (31%) compared to remote areas (37.5%), however this is reversed for the category of obesity (53.6% compared to 35%). BMI data also suggests fewer substantive differences between males and females. More males were considered to either underweight or normal weight than females (18.2% and

[16] Of which, some data is noted to have a high margin of error and is, thus, recommended to be used with caution.

[17] As above.

15.1% respectively). Males were also more likely to be overweight (37%) than women (26.5%) but less likely to be categorised as obese (44.8%) than females (54.8%). Please note caution must be taken with these results given the foundations of BMI as a measure.

For children, aged between 2–17 years of age, only BMI was used in the NATSIHS (2022–23). These data (which the ABS warns has a high margin of error and should be used with caution) indicates that two-thirds (67.6%) of Aboriginal and Torres Strait Islander children in SA are either underweight or of normal weight, meaning one-third are considered overweight or obese. These figures are not too dissimilar to the Australian population generally (70.4% and 29.9%, respectively).

7.7 Vaccinations and immunisation

Globally, immunisation is amongst the most effective medical interventions for preventing specific disease-related morbidity and mortality. In Australia, the National Immunisation Program (NIP) outlines a specific schedule for vaccines children and adults. This schedule contains additional vaccinations for individuals who identify as Aboriginal and/or Torres Strait Islander, to support stronger, early protection against infections and conditions that have historically impacted communities due to systemic inequities from ongoing colonisation.(145) For more information on this schedule, visit the Australian Government's Department of Health, Disability and Ageing website.(146)

During the creation of this report, high numbers of (vaccine-preventable) diphtheria cases (402+ since June 2026) were being closely monitored, with recorded outbreaks in remote areas of the Northern Territory, Western Australia and SA.(147) In response, SA Health have introduced a state-funded Diphtheria Outbreak Response Immunisation Program.(148) This program provides free vaccinations to identified groups, including Aboriginal people 10 years or older who have not had a diphtheria-containing vaccination in the previous five years, along with healthcare and frontline workers in priority areas as well as high and medium risk contacts who have not received this vaccination in the past 12 months or low risk contacts who have not had a diphtheria-containing vaccination in the past five years. (148)

7.7.1 Vaccination in children

The National Centre for Immunisation Research and Surveillance's 2025 Summary Report(149) utilising Australian Immunisation Register (AIR) data, suggests that, nationally, the proportion of Aboriginal and Torres Strait Islander children being classified as 'fully vaccinated' has decreased since 2020 to 2025. However, AIR data relating to the Adelaide PHN indicates that nearly 90% of Aboriginal and Torres Strait Islander children who are one

year of age are fully vaccinated, and while the proportion at two years of age is slightly less (84.9%), the proportion of five year olds is substantially greater, with nearly 96% of Aboriginal and Torres Strait Islander children being fully vaccinated.(150) This includes 96% of Aboriginal and Torres Strait Islander children by age 5 in the Adelaide PHN area as being vaccinated against diphtheria. Vaccination rates for other disease are also relatively high, with the Measles, Mumps, and Rubella vaccination and Varicella vaccination for two-year-olds being the lowest proportions of vaccination coverage (both at 87.93%).

Table 26: Proportions of Aboriginal and Torres Strait Islander children residing in Adelaide PHN who had the recommended vaccines for their age (2025)

Age	Diphtheria, Tetanus, Pertussis	Polio	Haemophilus influenzae type b	Hepatitis	Measles, Mumps, Rubella	Pneumococcal	Meningococcal C	Varicella	Fully Vaccinated
1 year	90.0%	90.0%	90.0%	92.1%		94.7%			90.0%
2 years	85.7%	95.8%	90.3%	96.1%	87.9%	94.2%	93.0%	88.0%	84.9%
5 years	95.9%	95.8%							95.6%

Source: (150)

SA3-level insights provided by the Department of Health, Disability and Ageing from AIR data (and shown in Table 27) indicate that Adelaide City has the lowest proportion of children aged one, two or five who were fully vaccinated by September 2025. (151)

Table 27: Proportion of Aboriginal and Torres Strait Islander children who are fully vaccinated (SA3, 2025)

SA3	Proportion of Aboriginal and Torres Strait Islander children who are fully vaccinated (%)		
	At 1 year of age	At 2 years of age	At 5 years of age
Adelaide City	87.8	85.8	83.3
Burnside	93.6	90.7	96.3
Campbelltown (SA)	92.7	89.5	92.9

Norwood – Payneham – St Peters	92.2	88.5	93.5
Prospect – Walkerville	95.1	88.4	92.2
Unley	94.6	89.2	96.3
Playford	93.0	90.7	96.0
Port Adelaide – East	93.0	90.4	94.4
Salisbury	92.8	90.3	94.0
Tea Tree Gully	93.1	90.5	94.3
Holdfast Bay	92.6	88.7	92.7
Marion	92.3	91.4	96.1
Mitcham	93.0	90.8	96.3
Onkaparinga	90.2	90.2	93.6
Charles Sturt	90.8	88.6	94.5
Port Adelaide – West	91.8	88.9	94.6
West Torrens	92.4	92.0	95.4

Source: (151)

7.7.2 Vaccinations in adolescents

The NIP schedule for adolescents in Australia includes vaccinations for diphtheria, tetanus and pertussis (offered in or about Year 7), human papillomavirus (HPV) (in or around Year 7) and Meningococcal ACWY (in or around Year 10). Additionally, Aboriginal and Torres Strait Islander adolescents are entitled to receive an influenza vaccine.(152) Data specific to the vaccination status of Aboriginal and Torres Strait Islander adolescents residing in the Adelaide PHN is limited. The National Centre for Immunisation Research and Surveillance utilises AIR data to provide national (and some state level) overviews for Aboriginal and Torres Strait Islander peoples' immunisation coverage.

Two-thirds (66.7%) of Aboriginal and Torres Strait Islander girls aged 15 in SA (with no further granularity) had had at least one dose of the HPV vaccination in 2024, and even fewer (55.7%) boys had.(153) These low proportions are of concern and warrant attention given the important role HPV vaccinations play in guarding against infections associated with a range of health conditions, particularly cervical cancer but also anal, vaginal, vulvar, penile, and oropharyngeal cancers.(154) Although there is a lack of data relating to the incidence of cervical cancer experienced by Aboriginal and Torres Strait Islander women in SA, national data indicates that the incidence of cervical cancer is nearly twice the rate for Aboriginal and Torres Strait Islander women than for non-Aboriginal women (aged 25-74).(155) This,

combined with the recognition that Aboriginal and Torres Strait Islander women reportedly participate less in national cancer screening programs,(156) speaks to the importance of ensuring young Aboriginal and Torres Strait Islander people are supported, in culturally safe ways, to have HPV vaccinations.

Insights regarding diphtheria, tetanus and pertussis vaccinations, drawn from AIR data and reported in the 2024 Annual Immunisation Coverage Report indicate that in SA in 2024, only 56.3% of 13-year-olds had received an adolescent dose of the vaccination. This proportion increased in each age group however, with 90% of 19-year-olds being vaccinated.

Meningococcal ACWY vaccine coverage, in SA, in 2024 was reported as 16.7% for 15-year-old girls, increasing to 44.3% for 16-year-olds girls and 71.2% for 19-year-old girls. For boys, the proportions were lower, with only 15% of Aboriginal and Torres Strait Islander boys having had the meningococcal ACWY vaccine at age 15 and rising to just over 60% for 18- and 19-year-old boys.

Access to services providing immunisations has been identified as a reason for poor vaccine uptake.(157,158) As one way to counter this barrier the National Immunisation Program is delivered through schools in SA. However, this means the program is highly dependent on school attendance. In the case of missed immunisations due to school absences, SA Health recommends parents take their children to be immunised elsewhere (for example at a council immunisation clinic, or GP). This puts the onus of responsibility on families who then face the same issues that the school-based strategy was designed to counter.

7.7.3 Vaccinations in adults

Influenza vaccination rates, drawn from AIR data and reported by the National Centre for Immunisation Research and Surveillance, indicate that in 2024, only 21.8% of Aboriginal and Torres Strait Islander adults aged 20–50 years of age and living in SA reported having a seasonal influenza vaccination, with the number increased to 40.0% for those aged 50–65 years of age and 62.7% for those aged over 65.(153)

Vaccination data taken from the Aboriginal and Torres Strait Islander Health Performance Framework describe that 34.0% of Aboriginal and Torres Strait Islander adults living in SA had received at least one dose of the Zostavax (shingles) vaccination at age 71 in 2022.(159) This compares to 36.5% for older Aboriginal and Torres Strait Islanders nationally, and there is no data available for Aboriginal people specific to the Adelaide PHN or non-remote SA.

7.8 Dental/Oral health

Oral health and dental care are a fundamental contributor to overall health and wellbeing, contributing to an individual's ability to eat, speak and participate in daily living activities. Poor oral health can lead to significant pain, infection and reduced quality of life. It is also increasingly recognised as a link to chronic conditions (e.g. cardiovascular disease, diabetes).(160) Nationally, it is suggested Aboriginal and Torres Strait Islander peoples are more likely to have unmet dental care needs and experience a greater burden of oral disease than non-Indigenous people.(161)

7.8.1 Oral health of adults

Recent research recognises Aboriginal and Torres Strait Islander people in SA appreciate the role oral health plays in disease prevention and overall health (including cardiovascular health) and wellbeing. (162) Having "good teeth" (understood as having a complete set of white and straight teeth) was reported as having a range of positive social and emotional benefits (including feeling self-confident, proud, and socially included). In contrast, having teeth that "did not conform to social norms" left Aboriginal and Torres Strait Islander peoples in SA feeling judged and discriminated against, and contributed to feelings of shame, embarrassment and being self-conscious, negatively impacting social and emotional wellbeing.

The 2022 Aboriginal and Torres Strait Islander Health Need Assessment reported that dental care was reported by community members as being a significant concern and these same issues also came out strongly in the 2026 community consultations. Participants in our yarns were keenly aware of how the state of people's teeth impacted self-confidence and social engagement, causing feelings of shame and not wanting to explain the cause of their poor oral health in some circumstances. Community members described wanting to access dental care but not being able to due to financial constraints or very long waiting lists for care through Nunkuwarrin Yunti or the SA Dental service. They also described an "all or nothing" situation whereby conservative dental care was not received proactively, which frequently resulted in the total extraction of the teeth when the issue became critical. These observations help contextualise statistics reported in the NATSIHS 2022–23, suggesting that only four in ten Aboriginal and Torres Strait Islander adults in SA had seen a dentist or dental professional in the previous 12 months.(68) Also, that 50% of Aboriginal adults aged 15+ living in non-remote areas of Australia have lost one or more teeth, with 4.5% having completely lost all teeth.(160)

A substantial contributing factor to low dentist visits is that services are predominantly located in the private sector in Australia(160,163) and, as such, represent a significant cost to individuals and families. These factors along with perilously described support that there are a substantial proportion (23.8%) of Aboriginal and Torres Strait Islander peoples, in SA, living with unmet dental care needs.(160) PHIDU reporting indicates that between 2017–18 and 2020–21, a total of 392 Aboriginal and Torres Strait Islander people in SA were admitted to hospital for potentially preventable acute dental conditions. (88) Although recent and more granular data specific to the unmet dental needs of Aboriginal and Torres Strait Islander people residing across Kaurna Yerta is not available, the available data suggests unmet dental needs are a pressing health concern for Aboriginal and Torres Strait Islander people in the Adelaide PHN. This was echoed by community members during the consultations in both 2026 and 2022.

7.8.2 Oral health of children

Aboriginal and Torres Strait Islander children (aged 0–17 years) in SA were, according to NATSIHS 2022–23 data, more likely to have seen a dentist or dental professional than adults (69.8% compared to 39.9%). Likely explanations for this include school-based government programs and other services like SA Dental's Aboriginal Oral Health Program that serves to provide community-based oral health education and access to dental services.

Further insight into the state of Aboriginal children's oral health and dental care specific to the Adelaide PHN or non-remote South Australian regions is limited by the lack of recent, granular data(164). Future Health Needs Assessments will likely be able to utilise data provided via the 2025–26 National Child Oral Health Study, which is due for release in 2027, to provide data insights pertaining to this. (160)

8 Chronic and other conditions

This section explores data and community insights relating to chronic, complex and other conditions. Census data from 2021 indicates that between half to two-thirds of Aboriginal and Torres Strait Islander people living in the local council areas of the Adelaide PHN do not have any diagnoses of the following conditions: arthritis, asthma, cancer, dementia, diabetes, heart disease, kidney disease, lung conditions, mental health conditions, and stroke.(22–39)

Across Greater Adelaide, over one-fifth of Aboriginal and Torres Strait Islander people reported living with one of the selected chronic conditions surveyed in the 2021 Census (Table 28). While the majority of Aboriginal and Torres Strait Islander people living across the Adelaide PHN live without these specific health concerns, it must also be noted that around one in every 10 people are living with significant multimorbidity.

Table 29 describes the proportion of people reporting each chronic condition within the Adelaide PHN region by LGA. Some notable differences are observed, with diagnoses of asthma and mental health conditions particularly variable within the region.

Table 28: Proportion (%) of people with chronic conditions in 2021, by LGA

LGA	None of the selected conditions	One condition	Two conditions	Three or more conditions	(not stated)
City of Adelaide	47.2	22.1	8.3	2.4	21.5
City of Burnside	66.1	17.2	9.1	0.0	7.0
City of Campbelltown	57.6	21.5	9.1	5.2	6.9
City of Charles Sturt	59.3	22.8	6.7	5.4	6.2
City of Holdfast Bay	63.5	21.7	9.0	4.3	2.3
City of Marion	61.3	22.3	6.6	5.6	4.0
City of Mitcham	62.6	23.9	3.9	3.7	6.4
City of Norwood, Payneham & St Peters	59.0	22.6	5.5	6.5	7.8
City of Onkaparinga	59.8	22.7	8.1	3.9	5.8
City of Playford	57.0	22.8	8.6	5.2	6.5
City of Port Adelaide Enfield	53.2	20.9	7.2	5.0	13.7

City of Prospect	63.7	21.2	7.5	4.7	4.2
City of Salisbury	57.6	22.8	8.5	5.2	5.8
City of Tea Tree Gully	56.8	24.6	9.0	2.9	6.3
City of Unley	57.2	28.4	6.2	4.6	3.6
Town of Walkerville	—	—	—	—	—
City of West Torrens	63.6	22.4	7.4	3.6	3.4
Greater Adelaide (GCCSA)	**58.2**	**22.4**	**7.7**	**4.7**	**7.1**

*No data for Walkerville

Sources: (22–39)

Table 29: Proportion (%) of people with chronic conditions in 2021, condition type by LGA

LGA	Arthritis	Asthma	Cancer (including remission)	Dementia (including Alzheimer's)	Diabetes (excluding gestational diabetes)	Heart disease (including heart attack or angina)	Kidney disease	Lung condition (including COPD or emphysema)	Mental health condition (including depression or anxiety)	Stroke	Any other long-term health condition(s)	No long-term health condition(s)	Not stated
City of Adelaide	2.9	12.1	2.1	0.0	5.6	3.5	0.9	2.1	20.4	2.1	5.3	45.1	21.5
City of Burnside	4.8	7.5	0.0	0.0	2.2	4.3	1.6	2.7	16.7	0.0	8.1	59.7	7.0
City of Campbelltown	7.2	14.2	2.5	1.1	6.3	5.4	0.0	2.0	19.4	0.9	10.8	54.0	7.0
City of Charles Sturt	7.1	13.9	1.8	0.3	7.0	4.1	1.4	2.3	16.3	0.7	8.9	55.8	6.2

City of Holdfast Bay	6.2	11.9	3.1	0.0	5.3	3.4	1.9	1.6	19.4	0.0	10.9	59.4	2.2
City of Marion	6.8	12.2	2.4	0.5	5.8	3.7	1.6	3.4	18.9	1.0	11.4	56.6	4.1
City of Mitcham	6.0	14.3	1.7	0.0	4.5	2.4	1.0	1.7	12.9	1.2	9.5	56.9	6.2
City of Norwood, Payneham & St Peters	10.1	12.4	0.0	0.0	3.7	4.1	0.0	2.8	18.4	0.0	12.9	52.5	7.8
City of Onkaparinga	6.5	15.5	1.4	0.4	4.9	3.0	0.9	2.3	18.2	0.8	12.9	53.9	5.8
City of Playford	7.0	18.3	1.1	0.9	6.1	3.2	1.1	2.7	18.1	0.9	11.0	52.8	6.5
City of Port Adelaide Enfield	6.7	14.0	1.6	0.7	6.7	3.5	1.2	2.3	15.3	1.2	8.9	49.5	13.7
City of Prospect	9.0	15.6	0.0	0.0	7.5	1.9	1.9	3.3	14.6	0.0	14.2	58.5	4.2
City of Salisbury	7.8	17.5	1.1	0.4	7.2	3.9	1.1	2.4	16.9	1.0	10.5	53.4	5.8
City of Tea Tree Gully	6.4	17.1	1.2	0.8	5.8	2.7	0.9	1.3	17.4	0.6	11.7	52.6	6.3
City of Unley	8.8	11.3	0.0	0.0	6.7	4.1	2.1	4.1	20.6	0.0	9.3	54.1	3.6
Town of Walkerville	–	–	–	–	–	–	–	–	–	–	–	–	–
City of West Torrens	7.1	13.8	1.2	0.4	6.7	3.4	0.8	1.8	14.2	0.4	10.1	59.2	3.3
Greater Adelaide (GCCSA)	**6.8**	**15.4**	**1.4**	**0.5**	**6.0**	**3.4**	**1.0**	**2.3**	**16.9**	**0.9**	**10.6**	**53.8**	**7.1**

*No data for Walkerville

Sources: (22–39)

8.1 Kidney disease

Kidney disease, specifically chronic kidney disease, is the gradual loss of kidney function over time, and can be caused through other progressive chronic conditions such as diabetes or hypertension.(165) Chronic kidney disease (CKD) represents a significant and cumulative burden for Aboriginal peoples in the Adelaide PHN. Approximately 1.0% of Aboriginal and

Torres Strait Islander people across Greater Adelaide reported kidney disease as a long-term health condition in the 2021 Census, which is comparable to the average for Aboriginal and Torres Strait Islander people in SA overall (1.2%). Table 30 provides an overview of small area-specific kidney disease across the Adelaide PHN region.

Table 30: Proportion (%) of population reporting kidney disease, by IARE (2021)

IARE	Proportion of population reporting kidney disease (%)
City of Adelaide	0.9
City of Burnside	1.6
City of Campbelltown	0.0
City of Charles Sturt	1.4
City of Holdfast Bay	1.9
City of Marion	1.6
City of Mitcham	1.0
City of Norwood, Payneham & St Peters	0.0
City of Onkaparinga	0.9
City of Playford	1.1
City of Port Adelaide Enfield	1.0
City of Prospect	1.9
City of Salisbury	1.1
City of Tea Tree Gully	0.9
City of Unley	2.1
Town of Walkerville*	-
City of West Torrens	0.8
Greater Adelaide (GCCSA)	**1.0**

*No data for Walkerville

Sources: (22–39)

Data reported by PHIDU, indicates that the rates of hospital admissions for chronic kidney conditions for Aboriginal and Torres Strait Islander people varies widely across the Adelaide PHN region (Table 31). While percentages appear low from Table 29, prevalence rate per 100,000 ranges significantly, from 224.8 in the Campbelltown–Norwood IARE to 817.6 in Adelaide–Prospect–Walkerville. For Greater Adelaide, the rate of hospitalisation for chronic kidney disease is around 400 per 100,000 (from 2019–20 to 2022–23).

Table 31: Average annual number and rate of hospitalisations for Aboriginal and Torres Strait Islander people, by IARE (2019–23)

IARE	Number	Average annual ASR per 100,000
Adelaide – Prospect – Walkerville	27	817.6
Campbelltown – Norwood	7	224.8
Charles Sturt	60	610.7
Holdfast Bay – West Torrens	15	277.6
Marion	25	432.3
Onkaparinga	68	476.8
Playford	51	281.4
Port Adelaide – Enfield	101	600.4
Salisbury	44	280.5
Tea Tree Gully	13	235.6
Unley – Burnside – Mitcham	16	395.8
Adelaide PHN	**427**	**418.9**
Greater Adelaide (GCCSA)	**440**	**400.1**

Source: (88)

Replacement or maintenance therapy for CKD focusses on transplant, peritoneal dialysis or haemodialysis. Haemodialysis is generally the most common for CKD or end stage kidney failure maintenance. Across the Adelaide PHN between 2019–20 and 2022–23 there were over 32 000 same day haemodialysis treatments for kidney disease for Aboriginal and Torres Strait Islander people (Table 32).

Table 32: Same day admission rates for dialysis for Aboriginal and Torres Strait Islander adults (2019–23, by PHN/IARE)

IARE	Number	Average annual ASR per 100,000
Adelaide – Prospect – Walkerville	1,869	58,917.0
Campbelltown – Norwood	815	24,077.1
Charles Sturt	3,778	37,748.8
Holdfast Bay – West Torrens	1,850	34,291.0
Marion	3,454	61,809.0
Onkaparinga	3,913	30,143.0
Playford	3,537	22,257.4
Port Adelaide – Enfield	7,404	44,927.8
Salisbury	3,252	22,186.5
Tea Tree Gully	1,696	32,542.3
Unley – Burnside – Mitcham	500	12,266.2
Adelaide PHN	**32,068**	**33,112.0**
Greater Adelaide (GCCSA)	**32,563**	**31,158.2**

Source: (88)

Data from the ANZDATA Registry reported through the National Indigenous Kidney Transplantation Taskforce, identifies 180 Aboriginal and Torres Strait Islander people were on kidney replacement therapy in SA in 2024 (dialysis or transplant).(166) In 2024, there were 135 Aboriginal and Torres Strait Islander people on dialysis, 45 who received a kidney transplant, and eight people on the waitlist for a transplant across the whole of SA.(166)

While this Health Needs Assessment is committed to a strengths-based approach that avoids offering comparisons between Aboriginal and Torres Strait Islander people and non-Indigenous people, it is important to recognise that the kidney health data demonstrates ongoing inequitable kidney disease burden for Aboriginal and Torres Strait Islander people at local, state, and national levels.

8.2 Diabetes

Diabetes is a chronic, non-communicable metabolic condition, associated with long-term complications including cardiovascular disease, kidney disease, vision loss, and lower-limb amputation. Strong community supports and sustained engagement with primary care are

critical for effective management, improving quality of life, reducing hospitalisations, and supporting better long-term outcomes.

Nationally, 15.5% of Aboriginal and Torres Strait Islander reported a diagnosis of diabetes, with a further 4.5% over the age of 18 being identified as being a high risk of diabetes, in the most recent NATSIHMS (2022–24). The prevalence of diabetes was greater for adult males than for females (16.7% compared to 14.3%), with prevalence increasing with age, and degree of remoteness.(71) For Kaurna Yerta specifically, Table 33 provides a breakdown of the proportion of Aboriginal and Torres Strait Islander people with a diabetes diagnosis in 2021, which was 6.0%, less than for SA as a whole (7.1%).There were also differences across Adelaide PHN council regions: only 2.2% of the Aboriginal and Torres Strait Islander people residing in the City of Burnside reported a diabetes diagnosis compared with >7% of Aboriginal and Torres Strait Islander residents in City of Salisbury and City of Prospect.

Table 33: Proportion of Aboriginal and Torres Strait Islander people living with diabetes in 2021, by LGA

LGA	Diabetes (excluding gestational diabetes)
City of Adelaide	5.6
City of Burnside	2.2
City of Campbelltown	6.3
City of Charles Sturt	7.0
City of Holdfast Bay	5.3
City of Marion	5.8
City of Mitcham	4.5
City of Norwood, Payneham & St Peters	3.7
City of Onkaparinga	4.9
City of Playford	6.1
City of Port Adelaide Enfield	7.0
City of Prospect	7.5
City of Salisbury	7.2
City of Tea Tree Gully	5.8
City of Unley	6.7

Town of Walkerville	–
City of West Torrens	7.0
Greater Adelaide (GCCSA)	**6.0**

*No data for Walkerville

Sources: (22–39)

It has also been identified by the AIHW (December 2025), that fewer than half of Aboriginal and Torres Strait Islander people in SA living with type 2 (insulin resistant) diabetes had had a chronic disease management plan prepared in the previous two years.(167) Females aged under 35 or 55+ years were more likely than their same-aged male counterparts to have had a plan prepared in the previous two years (Table 34). However, a greater proportion of males aged 45–54 had had one prepared compared to same-aged females.

Table 34: Proportion (%) of Aboriginal and Torres Strait Islander people in South Australia with type 2 diabetes with a chronic condition management plan prepared in the previous two years (2025)

Age (years)	Males	Females	Total
<35	37.9	44.5	41.9
35–44	37.1	35.8	36.2
45–54	44.0	42.8	43.2
55–64	46.8	50.3	48.8
65 and over	43.2	54.2	49.3
Total	**42.8**	**46.0**	**44.7**

Source: (167)

Table 35: Proportion (%) of Aboriginal and Torres Strait Islander people in South Australia with type 2 diabetes participating in diabetes management activities (2025)

Management activity	Males	Females	Total
Blood pressure result recorded in the previous 6 months	59.6	63.1	61.6
HbA1c test in previous six months	43.7	45.0	44.5
HbA1c test in previous twelve months	61.8	61.8	61.8

Kidney function test recorded in previous 12 months			
- eGFR only	14.5	15.7	15.2
- ACR only	2.0	1.5	1.7
- Both eGFR and ACR	45.0	43.8	44.3
- Neither EGFR nor ACR	38.5	38.9	38.8

Source: (167)

8.3 Respiratory diseases

Respiratory diseases are those affecting the airways and lungs, and include asthma, chronic obstructive pulmonary disease (COPD), occupational lung diseases and pulmonary hypertension.(168) Respiratory disease is a significant contributor to overall health need, accounting for around 9% of deaths and 8% of hospitalisations among Aboriginal and Torres Strait Islander Australians.(169) It is strongly associated with the social determinants of health, leading to the AIHW's evaluation that public health strategies addressing social determinants (such as housing) are imperative.(169) However, recent work by Bush et al.(170) suggest "it is important that while we wait for social determinants to improve, clinicians do not lose hope as effective and high-quality evidence-based respiratory service can substantially and positively improve respiratory health" (p. 6).

Data from the Aboriginal and Torres Strait Islander Health Performance Framework (last updated March 2026, and including data up until 2023) indicates that there were over 17,300 Aboriginal and Torres Strait Islander people in non-remotes areas of SA living with a respiratory disease in 2022–23.(169) This includes approximately 8,700 Aboriginal and Torres Strait Islander people living in non-remote areas of SA who had asthma.

National data indicates that females are more likely to have an asthma diagnosis than males. Nationally, nearly two thirds (65.1%) who still get asthma or have had symptoms in the previous 12 months have used medication in the previous two weeks, but over half (53.1%) did not have a written asthma action plan.(169)

Older, but specific to the Adelaide PHN region, data indicates that the proportion of Aboriginal and Torres Strait Islander people who reported an asthma diagnosis in the 2021 Census was 15.4% (Table 36). This proportion was lower in areas such as the City of Burnside (7.5%) but higher elsewhere, such as City of Playford (18.3%), City of Salisbury (17.5%) and City of Tea Tree Gully (17.1%).

Table 36: Proportion (%) of Aboriginal and Torres Strait Islander people with a diagnosis of asthma in 2021, by LGA.

LGA	Percentage of people with asthma (%)
City of Adelaide	12.1
City of Burnside	7.5
City of Campbelltown	14.2
City of Charles Sturt	13.9
City of Holdfast Bay	11.9
City of Marion	12.2
City of Mitcham	14.3
City of Norwood, Payneham & St Peters	12.4
City of Onkaparinga	15.5
City of Playford	18.3
City of Port Adelaide Enfield	14.0
City of Prospect	15.6
City of Salisbury	17.5
City of Tea Tree Gully	17.1
City of Unley	11.3
Town of Walkerville*	–
City of West Torrens	13.8
Greater Adelaide (GCCSA)	**15.4**

*No data available for Town of Walkerville

Sources: (22–39)

In 2021, the number of Aboriginal people in the Adelaide PHN region who reported they had COPD (or emphysema) was 297, representing an average annual age-standardised rate of 2.4 per 100,000 population. Rates differed between jurisdictions, with Unley – Burnside – Mitcham and Adelaide – Prospect – Walkerville having the lowest rates (1.0 per 100,000), and the area with the highest recorded rate being Playford (3.5 per 100,000) and Marion (3.4 per 100,000) (Table 37).

Table 37: Number and rate of COPD and emphysema diagnosis for Aboriginal and Torres Strait Islander people (2021, IARE/PHN)

IARE	No.	Age-standardised rate (per 100,000)
Adelaide – Prospect – Walkerville	6	1.0
Campbelltown – Norwood (part a)	20	2.6
Charles Sturt	38	1.8
Holdfast Bay – West Torrens	19	1.6
Marion	43	3.4
Onkaparinga	78	2.8
Playford	112	3.5
Port Adelaide – Enfield	79	2.4
Salisbury	78	2.5
Tea Tree Gully	15	1.3
Unley – Burnside – Mitcham	9	1.0
Adelaide PHN	**497**	**2.4**
Greater Adelaide (GCCSA)	**559**	**2.6**

Source: (88)

The Aboriginal and Torres Strait Islander Health Performance Framework (last updated March 2026, and including data up until 2023) indicates that the hospitalisation rate for respiratory system diseases, broadly, for Aboriginal and Torres Strait Islander peoples in SA between July 2021 and June 2023 was 33.2 per 1,000 people, with a slightly lower rate for males (32.2) than females (34.3). Crude rate data (again per 1,000 people) of hospitalisations for respiratory diseases for Aboriginal and Torres Strait Islander people in SA indicates that rate has increased from 30.7 and 29.9 in 2020–21 and 2021–22 to 36.5 in 2022–23.(169)

PHIDU reports more granular data pertaining to the Adelaide PHN and indicates that, between 2019–20 and 2022–23, there were 3,233 hospital admissions for respiratory diseases for Aboriginal and Torres Strait Islander people in the Adelaide PHN, not dissimilar to the number for Greater Adelaide. Table 38 details specific jurisdictions and shows the rates are lower in Holdfast Bay – West Torrens and Unley – Burnside – Mitcham, than they are in Port Adelaide – Enfield, Adelaide – Prospect – Walkerville and Charles Sturt. (88)

Table 38: Number and rate of hospital admissions for respiratory diseases for Aboriginal and Torres Strait Islander people (2021, IARE/PHN)

IARE	No.	Age-standardised rate (per 100,000)
Adelaide – Prospect – Walkerville	100	3,768.3
Campbelltown – Norwood (part a)	91	3,063.5
Charles Sturt	379	3,962.5
Holdfast Bay – West Torrens	101	2,046.6
Marion	161	2,760.9
Onkaparinga	377	2,444.2
Playford	727	3,526.3
Port Adelaide – Enfield	589	3,796.4
Salisbury	477	2,972.7
Tea Tree Gully	150	2,571.4
Unley – Burnside – Mitcham	81	2,197.6
Adelaide PHN	**3,233**	**3,136.5**
Greater Adelaide (GCCSA)	**3,397**	**3,049.0**

Source: (88)

8.4 Cancer

For Aboriginal and Torres Strait Islander people, nationally and in the Adelaide PHN, cancer remains a significant contributor to morbidity and mortality. This section presents data on cancer prevalence and cancer screening statistics. There are several notable limitations to the availability of relevant data which much be considered throughout. Firstly, the data provided through the Aboriginal and Torres Strait Islander Health Performance Framework, although updated in 2023, typically relates to data collected in or before 2019(171), predating the Adelaide PHN's 2022 Aboriginal Health Needs Assessment. Secondly, the granularity of recent cancer statistics from the AIHW (last updated in 2025) does not lend itself to exploring Aboriginal and Torres Strait Islander places and populations. (172) Thirdly, there is a dearth of SA-focused datasets in the public domain (as are available for Victoria(173) and New South Wales(174), for example).

8.4.1 Prevalence

Table 39 details Census data from 2021 that indicates 1.4% of Aboriginal and Torres Strait Islander people in Greater Adelaide had cancer or were in remission Although this proportion may seem low, it is important to recognise that Aboriginal and Torres Strait Islander peoples are 14% more likely to receive a cancer diagnosis and survival rates five years post-diagnosis are also between 20–30% lower for Aboriginal and Torres Strait Islander people than for non-Indigenous counterparts.(175,176)

Data specific to the local councils in the Adelaide PHN region are shared in Table 39. It is evident that the proportions were greatest in the City of Holdfast Bay (3.1%) and least in Salisbury and Playford (1.1%).

Table 39: Proportion of Aboriginal and Torres Strait Islander people with a cancer diagnosis in 2021 by LGA

LGA	Cancer (including remission) (%)
City of Adelaide	2.1
City of Burnside	0.0
City of Campbelltown	2.5
City of Charles Sturt	1.8
City of Holdfast Bay	3.1
City of Marion	2.4
City of Mitcham	1.7
City of Norwood, Payneham & St Peters	0.0
City of Onkaparinga	1.4
City of Playford	1.1
City of Port Adelaide Enfield	2.0
City of Prospect	0.0
City of Salisbury	1.1
City of Tea Tree Gully	1.2
City of Unley	0.0
Town of Walkerville	–

City of West Torrens	1.2
Greater Adelaide (GCCSA)	**1.4**

*No data available for Town of Walkerville

Sources: (22–39)

In the absence of SA-specific data, aggregated data from NSW, Qld, WA, NT and SA (updated in 2026, but with a 2019–23 reference period) identifies the leading causes of cancer-related deaths for Aboriginal and Torres Strait Islander peoples.(177) Lung cancer was the leading cause of death between 2019 and 2023 for both males and females, as shown in Table 40.

Table 40: Leading causes of cancer (and other neoplasms) related deaths for Aboriginal and Torres Strait Islander people in NSW, Qld, WA, NT and SA (2019–23).

Leading Cause of death (Ranked)	Males	Females
1	Lung cancer	Lung cancer
2	Liver cancer	Breast cancer
3	Colorectal cancer	Colorectal cancer
4	Cancer of unknown or ill-defined primary site	Uterine cancer
5	Pancreatic cancer	Pancreatic cancer
6	Malignant neoplasms of lip, oral cavity and pharynx	Cancer of unknown or ill-defined primary site
7	Prostate cancer	Liver cancer
8	Oesophageal cancer	Ovarian cancer
9	Leukaemia	Malignant neoplasms of lip, oral cavity and pharynx
10	Lymphomas	Leukaemia

Source: (177)

PHIDU reports that, for Aboriginal and Torres Strait Islander people residing in the Adelaide PHN region, the average annual age-standardised rate of cancer-related hospitalisations for the period of 2018–19 to 2022–23 was 1,355 per 100,000 population (Table 41).

Table 41: Number and average annual age-standardised rate of cancer-related hospitalisation by IARE, 2018–19 to 2022–23

IARE	Number	Average annual age-standardised rate per 100,000
Adelaide – Prospect – Walkerville	43	1,446.6
Campbelltown – Norwood	63	1,882.4
Charles Sturt	129	1,298.0
Holdfast Bay – West Torrens	63	1,192.2
Marion	113	1,946.8
Onkaparinga	226	1,686.5
Playford	188	1,117.3
Port Adelaide – Enfield	183	1,157.7
Salisbury	163	1,097.1
Tea Tree Gully	85	1,618.5
Unley – Burnside – Mitcham	65	1,599.8
Adelaide PHN	**1,321**	**1,354.1**
Greater Adelaide (GCCSA)	**1,504**	**1,428.6**

Source:(88)

8.4.2 Screening

Data specific to SA indicates that, in the period of 2022–23, Aboriginal and Torres Strait Islander peoples' participation in screening programs was low. This section provides screening data for breast, bowel, cervical, and lung cancer.

To detect breast cancer in women, the BreastScreen Australia Program (which targets women aged 50-74 years of age, but is open to women from age 40) offers a free mammogram every two years.(156) In 2022-23, just over one-third of Aboriginal and Torres Strait Islander women aged 60-69 (36.6%) and 70-74 (34.6%) in SA had participated in a BreastScreen Australia screening. A slightly smaller proportion of those aged 50-59 had participated (28.3%), and a substantially smaller proportion was reported for those aged 40-

49 (7.8%) and 75+ (7.7%).(178) However what these outcomes fail to capture, is that if women are not available to attend the BreastScreen clinic or bus on the scheduled days, then they miss out and need to rebook this service at another time or miss screening altogether.

The National Bower Cancer Screening Program (NBCSP) seeks to detect bowel cancer through inviting people over 50 (and younger in some cases) to participate in a screening protocol.(179) The AIHW reports that in 2023, only 1.7% of the valid screening tests returned were from people who identified themselves as Aboriginal and Torres Strait Islander. Further, they report that there is insufficient information is available to determine participation rates. As such, the participation rates offered are estimates only. The estimated participation rate for Aboriginal and Torres Strait Islander people aged 50-74 was 38% for the 2022-23 period.(156) Data specific to SA (from 2022-2023) also shows low participation rates, with only 40% of males and 14.6% of females, aged 50-74, having ever tested for bowel cancer. (156)

The National Cervical Screening Program (NCSP), through provides cervical screening to women every five years, supports early detection of precancerous abnormalities of cells in the cervix. According to AIHW, participation rate data for Aboriginal and Torres Strait Islander people is not available due to the incomplete and inconsistent ways in which Indigenous status has been recorded during screening. There is, however, some data available for women and people with a cervix who attended an Indigenous-specific primary health care service. This data indicates that, at June 2025, 43% of Aboriginal and Torres Strait Islander women and people with a cervix aged between 25–74 attending those services, had had a Pap smear in the previous five years.(156)

Aboriginal and Torres Strait Islander people face a disproportionately high burden of lung cancer, leading to the development of the National Lung Cancer Screening Program (NLCSP), launched in 2025, and which included fiscal support for National Aboriginal Community Controlled Health Organisation) to develop, alongside Aboriginal and Torres Strait Islander people and communities, culturally appropriate and respectful approaches to encourage participation in screening.(156) The most recent publicly available data predates the NLCSP and indicates that only 2.3% of Aboriginal and Torres Strait Islander adults had participated in a lung cancer screening test.(156)

Shahid et al.(180) reported a range of factors contributing to lower participation rates by Aboriginal and Torres Strait Islander people which, in turn, delayed diagnoses. These included mistrust in the health care system and professionals (linked to intergenerational impacts of colonisation), difficulties in accessing services, and affective concerns held by

individuals (such as, shame, fear, macho constructions of masculinity). Community consultations echoed some of these concerns, particularly the issues of mistrust and accessing services.

8.5 Circulatory disease

Circulatory diseases are those that affect the heart and blood vessel.(181) The AIHW recognises the connection between the burden of heart disease and the ongoing effects of colonisation, noting the role for primary health care services in early detection and management to minimise the adverse effects of heart disease.(182)

Census data from 2021, as shown in Table 42, indicates that 3.4% of Aboriginal and Torres Strait Islander people in the Greater Adelaide region reported having heart disease. The smallest proportion was reported in the City of Prospect (1.9%), while the highest was in City of Campbelltown (5.4%).More recent, but less granular, data from the NATSIHS (2022–23) reported that the proportion of Aboriginal and Torres Strait Islander people in SA with heart, stroke, and vascular diseases[18] was 7%.(68) The proportion of males with heart disease was less than for females (8.1% and 6.8%, respectively), but overall, the proportion of Aboriginal and Torres Strait Islander people with heart disease was greater in SA than the national average for Aboriginal and Torres Strait Islander people (4%).(68)

Table 42: Proportion of Aboriginal and Torres Strait Islander people with heart disease (including heart attack or angina) in 2021, by LGA

LGA	Percentage of people with heart disease (%)
City of Adelaide	3.5
City of Burnside	4.3
City of Campbelltown	5.4
City of Charles Sturt	4.1
City of Holdfast Bay	3.4
City of Marion	3.7
City of Mitcham	2.4

[18] Including, heart attack, angina, other ischaemic heart disease, stroke, other cerebrovascular diseases, oedema, heart failure, and disease of the arteries, arterioles, and capillaries.

City of Norwood, Payneham & St Peters	4.1
City of Onkaparinga	3.0
City of Playford	3.2
City of Port Adelaide Enfield	4.0
City of Prospect	1.9
City of Salisbury	3.9
City of Tea Tree Gully	2.7
City of Unley	4.1
Town of Walkerville	–
City of West Torrens	3.4
Greater Adelaide (GCCSA)	**3.4**

*No data available for Town of Walkerville

Sources: (22–39)

Table 43 shows that circulatory disease-related hospital admissions vary across jurisdictions, with higher burden identified in the northern and western regions. Lower rates of admissions for circulatory systems diseases were identified for Unley – Burnside – Mitcham and for Holdfast Bay – West Torrens. (88)

Table 43: Circulatory disease admission rates for Aboriginal and Torres Strait Islander people between 2019–20 and 2022–23, by IARE

IARE	Admissions for circulatory system diseases	Admissions for ischaemic heart disease	Admissions for heart failure
	Average annual age standardised rate per 100,000		
Adelaide – Prospect – Walkerville	1,673.4	450.5	271.9
Campbelltown – Norwood	1,659.9	645.2	318.9
Charles Sturt	2,060.2	749.9	348.7
Holdfast Bay – West Torrens	919.8	149.2	188.2
Marion	1,642.0	357.5	172.0
Onkaparinga	1,133.5	295.1	148.1
Playford	1,705.7	551.7	238.3

Port Adelaide – Enfield	2,079.0	710.8	307.9
Salisbury	1,196.4	372.7	139.5
Tea Tree Gully	1,638.0	521.9	..
Unley – Burnside – Mitcham	985.8	221.6	145.2
Adelaide PHN	**1,565.3**	**488.7**	**226.8**
Greater Adelaide (GCCSA)	**1,528.8**	**467.3**	**219.9**

Source: (88)

Cardiovascular disease have been reported as the second leading cause of death for Aboriginal and Torres Strait Islander people, nationally.(182) With respect to circulatory system disease mortality, the average annual age-standardised rate for deaths in the Adelaide PHN between 2019 to 2023 was 25.4 (per 100,000). (88)

As stated earlier, primary health service providers play an important role in identifying risk factors, offering preventative and early intervention supports,

8.6 Rheumatic fever and rheumatic heart disease

Acute rheumatic fever (ARF) is an abnormal inflammatory response to a group A Streptococcus that can damage the heart valve, permanently, leading to rheumatic heart disease (RHD)(183,184) with lifelong consequences including heart failure, arrhythmia, infective endocarditis, stroke, as well as complications during pregnancy and compromised maternal health outcomes. This is a conditional heavily influenced by the social determinants of health, whereby health impacts for individuals and communities, the economic costs are substantial.(185) ARF and RHD are preventable conditions,(186) control activities have been in operation since 1997, with screening programs across SA over the past decade (including the South Australian Childhood RHD Screening Project and the Deadly Heart Trek) facilitating identification and education efforts.(185)

Nationally, ARF and RHD disproportionately present in Aboriginal and Torress Strait Islander communities, in females, and in children.(185) In SA, the SA Rheumatic Heart Disease Control Program's 2024 Annual Report indicates that, as of 31 December 2024, there were 643 people on the RHD Register. Of the 643 patients, 88% identified as Aboriginal and/or Torres Strait Islander and 96% of those with ARF diagnoses (without RHD) were Aboriginal and/or Torres Strait Islander people (187).

8.7 Injury

Injuries, as a broad category, are one of the major causes of hospitalisation and death each year across Australia. The AIHW's 'Injury in Australia' report, indicates nationally, there were nearly 150,000 presentations to hospital emergency departments due to injury by Aboriginal and Torres Strait Islander peoples in 2023–24, and 35, 800 hospital admissions for injuries in the same period. (188) Additionally, there were nearly Aboriginal and Torres Strait Islander 650 deaths from injuries sustained nationally over 2022–23.(188) These injuries included: falls, assaults, contact with objects, transport or road traffic accidents, burns, accidental poisoning, and other intentional or unintentional causes. (188) The report also indicates that between July 2021 and June 2023, injury and poisonings were the most common causes of hospitalisations for Aboriginal and Torres Strait Islander people, nationally.

8.7.1 Emergency Department presentations due to injury

Limited injury data is available across the local government regions of the Adelaide PHN. That available through PHIDU – the number of emergency department presentations by residents of the Adelaide PHN due to injury, poisoning or other (external) causes – are presented in Table 44. Importantly, this data is related to the number of presentations rather than necessarily the number of people presenting. Proportions of the population who presented to hospital are not available. Instead, the age-standardised rate per 100,000 people has been included in the table below.

Table 44 indicates there were more emergency department presentations by people living in Onkaparinga (n = 656) and Playford (n = 689) compared to other jurisdictions, but that the Adelaide – Prospect – Walkerville (aggregated) area the highest standardised rate of hospitalisations (n = 239, followed by Onkaparinga.

Table 44: Emergency department presentations for injury, poisoning and certain other external causes for Aboriginal and Torres Strait Islander people (2022–23)

IARE	Emergency department presentations	Age standardised rate, per 100,000
Adelaide – Prospect – Walkerville	187	23,982.8
Campbelltown – Norwood	88	11,778.3
Charles Sturt	328	13,714.3
Holdfast Bay – West Torrens	125	9,482.3

Marion	213	13,942.1
Onkaparinga	656	15,935.7
Playford	689	12,719.5
Port Adelaide – Enfield	461	11,212.4
Salisbury	400	9,329.8
Tea Tree Gully	70	4,700.2
Unley – Burnside – Mitcham	100	10,360.3
Adelaide PHN	**3,317**	**12,216.6**
Greater Adelaide (GCCSA)	**3,558**	**12,158.8**

Source: (88)

Table 45 details the number of presentations (rather than the number of individuals/people presenting) and showcases that, in the Adelaide PHN, there were more presentations by Aboriginal and Torres Strait Islander people between aged 0–14 years of age (n= 1,029) and 25–44 years of age (n = 1,092) than for those aged 45–64 (n = 420) or 15–24 (n = 678). Overall, there were more presentations from those living in Onkaparinga (n = 647) and Playford (n = 666) (followed by Port Adelaide Enfield with 449) which could be reflective of the larger number of Aboriginal and Torres Strait Islander peoples residing in those jurisdictions.

Table 45: ED presentations for injury, poisoning and certain other external causes for Aboriginal and Torres Strait Islander people, by age and IARE (2022–23)

	Emergency presentations by age			
IARE	**0–14 Years**	**15–24 years**	**25–44 years**	**45–64 years**
Adelaide – Prospect – Walkerville	9	23	111	30
Campbelltown – Norwood	18	23	35	11
Charles Sturt	93	79	91	58
Holdfast Bay – West Torrens	17	27	53	20
Marion	62	49	68	26
Onkaparinga	257	158	179	53
Playford	267	109	227	63
Port Adelaide – Enfield	128	67	169	85
Salisbury	135	95	108	49
Tea Tree Gully	12	19	24	13

Unley – Burnside – Mitcham	31	29	27	12
Adelaide PHN	**1,029**	**678**	**1,092**	**420**
Greater Adelaide (GCCSA)	**1,140**	**720**	**1,139**	**452**

Source: (88)

8.7.2 Hospital admissions due to injury

Table 46 details the number of hospital admissions for injury, poisoning, and other external causes for Aboriginal and Torres Strait Islander in specific jurisdictions in the Adelaide PHN. This data indicates that there were 4,616 injury-related admissions to hospitals by people living in the Adelaide PHN for the four years 2019–23.

Table 46: Hospital admissions for injury, poisoning and certain other external causes for Aboriginal and Torres Strait Islander people (2019–23), by IARE

IARE	Admissions	Age standardised rate, per 100,000
Adelaide – Prospect – Walkerville	252	7,405.1
Campbelltown – Norwood	137	4,334.9
Charles Sturt	499	5,140.7
Holdfast Bay – West Torrens	231	4,234.2
Marion	293	4,821.6
Onkaparinga	633	4,105.5
Playford	864	4,297.6
Port Adelaide – Enfield	761	4,513.1
Salisbury	646	3,893.7
Tea Tree Gully	171	2,982.2
Unley – Burnside – Mitcham	129	3,185.0
Adelaide PHN	**4,616**	**4,331.7**
Greater Adelaide (GCCSA)	**4,835**	**4,216.8**

Source: (88)

The most recent data on Emergency Department presentations involving Aboriginal and Torres Strait Islander peoples due to injury in the Adelaide PHN region is for the year 2022–23. As is evident in Table 47, the age group with the highest number of admissions was

people aged 45–64 years (n = 2,088) followed by those aged 24–44 years (n = 1,145). Only 372 people under the age of 14 were admitted to hospital for issues relating to injury, poisoning or other external causes.

Table 47: Hospital admissions for injury, poisoning and certain other external causes for Aboriginal and Torres Strait Islander people, by age and IARE (2022–23)

	Emergency presentations by age			
IARE	**0–14 Years**	**15–24 years**	**25–44 years**	**45–64 years**
Adelaide – Prospect – Walkerville	6	46	18	82
Campbelltown – Norwood	14	20	17	74
Charles Sturt	45	79	124	255
Holdfast Bay – West Torrens	14	28	29	72
Marion	19	42	49	112
Onkaparinga	32	70	197	180
Playford	95	80	290	437
Port Adelaide – Enfield	62	114	147	442
Salisbury	62	74	195	282
Tea Tree Gully	11	23	44	106
Unley – Burnside – Mitcham	12	22	35	46
Adelaide PHN	**372**	**598**	**1,145**	**2,088**
Greater Adelaide (GCCSA)	**392**	**619**	**1,216**	**2,181**

Source:(88)

8.7.3 Road traffic

Road traffic crash data suggests Aboriginal and Torres Strait Islander peoples are over-represented in road deaths across Australia. Although Aboriginal and Torres Strait Islander peoples account for approximately 3.8% of the population, between 2012–21, 9.1% of road deaths in NSW, Qld, SA, WA, and NT were Aboriginal and Torres Strait Islander peoples. Of the 791 Aboriginal and Torres Strait Islander people who passed away due to road traffic accidents between 2012–21, just over 6% (n = 49) were recorded in SA. Those who passed were more likely to car occupants or pedestrians.(189)

Hospital admission data due to injuries associated with transport crashes are also available for the Adelaide PHN via PHIDU for the period 2019–23. This data shows that there were 371 admissions for people living in the Adelaide PHN (again, noting that this was number of

admissions, rather than number of people injured). There were more admissions from people living in Playford for transport crash injuries than for any of the other listed jurisdictions (Table 48).

Table 48: Hospital admissions for transport crash injury for Aboriginal and Torres Strait Islander people, by age and IARE (2019–23)

IARE	Admissions	Average annual age-standardised rate, per 100,000
Adelaide – Prospect – Walkerville	14	398.0
Campbelltown – Norwood	8	259.5
Charles Sturt	30	309.2
Holdfast Bay – West Torrens	16	286.4
Marion	28	446.5
Onkaparinga	41	253.8
Playford	98	468.0
Port Adelaide – Enfield	42	248.2
Salisbury	68	396.4
Tea Tree Gully	18	308.4
Unley – Burnside – Mitcham	8	196.5
Adelaide PHN	**371**	**398.0**
Greater Adelaide (GCCSA)	**393**	**334.5**

Source: (88)

8.8 Life course health conditions (eye and ear health)

8.8.1 Eye health

Eye health is widely acknowledged as being important to peoples' wellbeing, with poor eye health having a marked impact on ability to engage in social activities, employment, and education. The AIHW offers a comprehensive overview of eye health, and details both protective and risk factors, as well as environmental and socioeconomic factors that impact eye health for Aboriginal and Torres Strait Islander peoples in Australia.(190)

The AIHW reports that the proportion of Aboriginal and Torres Strait Islander people with self-reported eye or sight problems in SA in 2022-23 was 44%. This was a smaller proportion than reported elsewhere (for example, Victoria and Tasmania) but greater than all other

reported jurisdictions.(191) Hospitalisation rates for Aboriginal and Torres Strait Islander peoples in SA were also comparable to the national figures (6.5 people per 1,000 compared to 7.6 per 1,000).(192) Other positive statistics regarding eye health of Aboriginal and Torres Strait Islander people in SA is the high (91%) trachoma screening coverage for children aged 5-9,(193) and the zero reported cases of active trachoma in at-risk Indigenous communities for children aged 5-9 in SA in 2024.

There were three cases of trichiasis detected in at-risk communities in SA for adults aged over 40 in SA in 2024.(194) The location of these cases is not publicly available, and more granular detail relating to the prevalence of eye conditions in the Adelaide PHN area is not available. However, there is some PHN data available regarding to screening. Trichiasis screening coverage for Aboriginal and Torres Strait Islander peoples aged 40 and over was quite low, with only 15% coverage being reported for SA. The number and proportion of Aboriginal and Torres Strait Islander people in the Adelaide PHN who had an MBS health assessment and also had an initial eye examination by an optometrist was 1,089 people (3.9%) in 2023–24.(194)

8.8.2 Ear health / hearing

Aboriginal and Torres Strait Islander Health Performance Framework data related to 2018–19, indicates that most Aboriginal and Torres Strait Islander children in SA do not have ear or hearing problems. However, a small proportion have total or partial hearing loss (6.1%). Fewer than 1% have otitis media. Remoteness does not appear to make a substantive difference with respect to the rate of ear/hearing problems for Aboriginal and Torres Strait Islander peoples in SA, but there were more people in non-remote than remote areas with reported ear/hearing problems.(195)

Diseases of the middle ear and mastoid indicated 303 Aboriginal and Torres Strait Islander children, aged between 0 and 14 years, were hospitalised in SA between July 2017 and June 2019. Fewer Aboriginal and Torres Strait Islander people aged 15 and over (n = 88) were hospitalised for the same condition in the same time period.(195)

9 Intergenerational trauma and grief

Ongoing colonisation continues to have lasting and substantial impacts on the health and wellbeing of Aboriginal and Torres Strait Islander people living across Kaurna Yerta. The community consultations undertaken for this Health Needs Assessment highlighted the extent to which entrenched policies and processes of marginalisation persist across systems. Trauma and grief stemming from both historical and ongoing colonisation, reinforced through political, health, education, housing and other social systems, manifests in a wide range of negative health and wellbeing outcomes, including poorer self-assessed health, increased exposure to violence, and a greater likelihood of homelessness and substance misuse.(196) This can contribute to interactions with both the child protection system and justice system.

These following statistics and information have been included to draw attention to the multifaceted and complex context of intergenerational trauma and grief, and the cascading impacts on health, justice, education and wellbeing.

9.1 Interaction with child protection system

In 2023, a comprehensive report regarding child protection contact patterns for Aboriginal and Torres Strait Islander children in SA was published. This report indicated that in 2020–21, just under half (47.8%) of Aboriginal and Torres Strait Islander children in SA were notified to child services, 8.7% of children were subject of an investigation, and 5.2% reports were substantiated[19].(198)

Data reported in the 2022–23 Department for Child Protection Annual Report indicate that one quarter (24.5%) of all notifications related to Aboriginal and Torres Strait Islander children, which was a slight increase from 2021–22 reporting of 23.1%.(199) The number of Aboriginal and Torres Strait Islander children, aged 0–17 years, who were in care increased by 3.5% between 2022 and 2023, and these children represented 37.4% of all children in care.(199) Data from June 2023 suggests that 91% of Aboriginal and Torres Strait Islander children and young people in care have a current and approved Aboriginal Cultural Identity Support Tool (ACIST)[20].(199)

[19] A determination, following an investigation, of reasonable cause that a child had been, was being, or was likely to be abuse, neglected, or harmed.(197)

[20] The Aboriginal Cultural Identity Support Tool (ACIST) is part of the Department for Child Protection's strategy to ensure Aboriginal and Torres Strait Islander children who are in care have the "opportunity to build and

The Aboriginal and Torres Strait Islander Child Placement Principle has existed and been embedded in child protection legislation for over 40 years, comprising five interconnected elements: prevention, partnership, placement, participation, and connection, designed to prioritise keeping children safe in their families, communities, and cultures while supporting self-determination and ongoing cultural ties.(200) Recent reporting by South Australian Council of Social Service (SACOSS) found 40% of Aboriginal and Torres Strait Islander children were not being placed according to these principles, and that Aboriginal children were disproportionately represented in every component of the care system.(202) Of all Aboriginal and Torres Strait Islander children in care, only 56% were with relatives or in kinship care. Additionally reporting from as part of the Annual Foster & Kinship Carer Survey Summary 2024–25, indicated carers report significant strain, with many dissatisfied with the child protection system and most indicating that support payments do not cover the costs of care.(203) Caring responsibilities frequently reduce or prevent employment, contributing to low household incomes and long-term financial insecurity, particularly for women, who make up the majority of carers. (203)

In 2024, the *Holding on to Our Future (Final Report of Inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle in the removal and placement of Aboriginal children and young people in South Australia)* report was published. This report concluded that the Department for Child Protection lacked cultural responsiveness, was "unnecessarily removing disproportionate and growing numbers"(204)(p.18) of Aboriginal and Torres Strait Islander children from families and communities as a result of systemic racism and cultural bias, and that Aboriginal families and communities were not included in decision making processes. This report offered a series of recommendations relating to prevention, partnerships, participation, placements and connection. Further, this report emphasised that "underlying issues that have led to families' contact with the child protections service system have not been about the intentional harm of children" (p. 9). Instead, it recognised that contact with the child protection service system was associated with intergenerational trauma and other factors

maintain connections to family, community and culture". As a mandated requirement under the *Children and Young People (Safety) Act 2017,* the ACIST constitutes part of the care plan for Aboriginal and Torres Strait Islander children in care. It aligns with the Aboriginal Child Placement Principle(200) and aims to support children's connection with and understanding of their cultural heritage by capturing information about their family, community, and personal history, and includes documents relating to family and community members to help maintain contact and connection.(201)

including poor mental health, homelessness, poverty, domestic and family violence, and substance use.

9.2 Interaction with justice system

9.2.1 Youth Justice

Aboriginal and Torres Strait Islander people, including youth, are overrepresented in the justice system. Target 11 of Closing the Gap calls for a 30% reduction in the rate of Aboriginal and Torres Strait Islander people aged 10–17 in detention by 2031. Data for 2023–24 that reports on the average daily number of young people in detention in SA, indicates numbers were not too dissimilar for young Aboriginal and Torres Strait Islander people and non-Aboriginal people (16 and 13 respectively). However, given the relative population sizes the respective rates per 10,000 were vastly different, with 17 per 10,000 Aboriginal and Torres Strait Islander young people in detention in 2023–24, compared to less than 1 per 10,000 for non-Indigenous young people.(205)

Data related to 2024–25 indicates there has been a reduction in the rate of young Aboriginal and Torres Strait Islander people in detention in South Australia (18.1 people per 10, 000) when compared to 2017–18 (35.9 people per 10, 000) and 2018–19 (26.5 people per 10, 000). However, the 2024–25 figures (Table 49) represent an upward trend from 2020 onwards. (205)

Table 49: Detention rates for Aboriginal and Torres Strait Islander youth (10–17 years) in South Australia (2017–18 to 2024–25)

Year	Youth detention rates per 10,000
2017–18	35.9
2018–19	26.5
2019–20	21.0
2020–21	16.4
2021–22	17.1
2022–23	18.1
2023–24	17.3
2024–25	21.4

Source: (205)

In 2024–25, the number of Aboriginal and Torres Strait Islander young people (aged 10–17 years) who were under community-based supervision on an average day in SA was 97.1.(206) Data provided by the AIHW indicates that this figure represents a decrease from the previous year (118.1 in 2023–24).(207) It is suggested by the Guardian for Children and Young People that Aboriginal and Torres Strait Islander young people were less likely to be provided with diversionary responses in 2024–25 than their non-Indigenous counterparts. This is concerning because diversionary responses are recognised as "one of the most effective mechanisms for preventing deeper system involvement"(208)(p.2). A consequence of reduced diversionary responses is that more Aboriginal and Torres Strait Islander young people, are "being drawn further into the justice system"(208)(p. 2). This aligns with the significant concern that community members consulted during this Health Needs Assessment shared with the project team, describing Aboriginal and Torres Strait Islander young people being 'locked up too young'.

9.2.2 Adult justice/corrections system

Aboriginal and Torres Strait Islander adults are overrepresented in custodial settings. Factors driving this are widely recognised as existing outside the criminal justice system, with a range of social and economic determinants associated with offending. Examples include insecure accommodation, unemployment, health (hearing, cognitive, mental, physical) impairments, substance abuse, poor educational experiences and low educational attainment.(209) Aboriginal and Torres Strait Islander people are often criminalised and incarcerated for relatively low-level offences such as driving/traffic offences, theft, and public order offences.(209) Additionally, there is evidence to suggest that police disproportionately arrest and charge Aboriginal and Torres Strait Islander people, bail is more likely to denied to Aboriginal and Torres Strait Islander people, and Aboriginal and Torres Strait Islander people are more likely to be imprisoned.(210)

In the context of SA, in December 2025, the average daily imprisonment rate for Aboriginal and Torres Strait Islander adults was 2,630.4 per 100,000 adults.(211) In the 2025 December quarter at total of 372 Aboriginal and Torres Strait Islander people were sentenced and a further 476 individuals were unsentenced in full-time custody.(212) Rates for Aboriginal and Torres Strait Islander adults in SA serving community-based corrections orders was 3416.8 per 100,000 population in December 2025. (212)

9.3 Community and family safety

In 2024, ABS reporting from SA indicated there were 3642[21] Aboriginal and Torres Strait Islander people aged over 18 reported being a victim of assault.(213) There were also 185 reports of sexual assault against Aboriginal and Torres Strait Islander women in 2024 (and increase from 168 in 2023). There are concerns that many assaults go unreported(214) suggesting that the number could be substantially higher.

Nearly three-quarters of Aboriginal and Torres Strait Islander people who were assaulted were women, and a substantive majority of these instances of assault occurred in their residential home.(213) Important contextual information involves recognising these data refers to victims, those individuals who have been assaulted, not who perpetrated the assault. Given there is evidence (albeit somewhat dated) that close to three-quarters of Aboriginal and Torres Strait Islander women in Adelaide are in relationships with non-Aboriginal men,(215) it is important to acknowledge that violent behaviour is not exclusive to Aboriginal and Torres Strait Islander individuals.

The AIHW acknowledges a range of factors associated with family violence, including a gendered drivers, demographic characteristics, mental health, substance use, and access to support services. Importantly, ongoing impacts of colonisation and associated factors such as relative disadvantage, poor mental and physical health, and poor coping behaviours have also been identified as having the potential to exacerbate violence.(214)

One of the key desired outcomes of Closing the Gap is to ensure families and households are safe, with a target of achieving a reduction in family violence and abuse by at least 50% by 2031 and an aspirational goal of eliminating all family violence and abuse eventually.(216) Eliminating violence is important, not only due to the associated physical and psychological injuries but due to a myriad of other issues associated with being subjected to violence. For example, in the context of Australia, lived experience of violence is linked with contact with the justice system. This is based on reports that approximately 70-90% of women who are in or have been in custody in Australia have experienced abuse.(217) Further, globally, there is evidence that children of parents who had been exposed to violence as children were found to be at greater risk of experiencing difficulty in school and emotional-behavioural balance.(218) Further still, there is also an emerging body of research relating to “intergenerational epigenetic signature of violence”.(219)

[21] Only numbers, not proportions, were offered in this dataset

10 Family Health

10.1 Pre-pregnancy, Pregnancy and Antenatal Care

Figure 11: Painting by Maude Parker of Pee Wee Paintings, December 2021. Source (220)

Figure 11 depicts a pregnant Aboriginal woman supported by family, friends, community and service providers who work with her to offer care, protection, and reassurance through her journey of pregnancy and childbirth.(220) The community consultations undertaken for this Health Needs Assessment highlighted the importance of supporting mothers during pregnancy and after the birth of their children by Aboriginal and Torres Strait Islander women. Although improvements and gains were acknowledged, community members remained concerned about system-level barriers to accessing pregnancy-related services (for example, doctors clinics cancelling appointments and not being able to book appointments).

There were 1,196 Aboriginal and Torres Strait Islander babies born in SA's Major Cities in 2023,(221) representing a slight increase from 1,153 in 2022 and 1,121 in 2021. Aboriginal birth programs, such as Nangkita Ngartu at the Women's and Children's Hospital and Lyell McEwin, provide culturally appropriate care for Aboriginal families.(222) While Aboriginal women in Adelaide reported experiencing a range of stressors during their pregnancies, including being upset about family arguments (53%), housing problems (53%), losing loved ones (38%) and being scared about other people's behaviour (31%), program such as Corka

Bubs provide care and support, including access to counselling and legal advice for participants and demonstrate the value of integrated clinical and social support during the perinatal period.(222)

10.1.1 Maternal age

All births are reported to the SA Health Minister as part of the *South Australian Health Care Regulations 2008 – Part 5 Pregnancy Outcome Data and Statistics*. Data collation and reporting occur through Preventative Health SA's annual *Pregnancy Outcomes in South Australia* report. Table 50 details the most recent maternal age data for Aboriginal and Torres Strait Islander mothers in SA.(115)

Table 50: Maternal age of Aboriginal and Torres Strait Islander women in South Australia in 2023

Age (years)	N	%
<20	72	8.4
20–24	219	25.5
25–29	262	30.5
30–34	190	22.1
35–39	97	11.3
40–44	17	2.0
45+	<5	0.2
Total	**859**	**100.0**

Source: (115)

10.1.2 Antenatal care

There is a high degree of engagement with antenatal care by Aboriginal and Torres Strait Islander mothers in SA. Data, specific to SA (rather than to the Adelaide PHN), indicates that in 2023, 84.3% of Aboriginal and Torres Strait Islander mothers, for whom there is data, attended seven or more antenatal.(223) Older data, but data specific to Aboriginal and Torres Strait Islander women residing in the Adelaide PHN and who gave birth at or after 32 weeks of gestation, indicates that, in 2020, 82.9% attended five or more antenatal visits. While this was a substantial majority, it was slightly less than for the SA average for the same time period.(114)

10.1.3 Gestation

Nearly 87% of Aboriginal and Torres Strait Islander babies were born at term (between 37 and 41 weeks gestation) across Australia in 2023.(224) The most recent data for SA is from 2020, and indicates that most babies born to Aboriginal and Torres Strait mothers (81.6%) and Aboriginal and Torres Strait Islander babies overall[22] (84.1%) were born at term.(225)

10.1.4 Birthweights

Across Australia, most (90.2%) Aboriginal and Torres Strait Islander singleton babies born in Major Cities in 2023 were born at a healthy weight. The proportion for those born in Major Cities in SA was slightly greater (91.1%).(226) More granular data pertaining to the Adelaide PHN region is not available.

10.1.5 Breastfeeding

Breastfeeding is regarded as underpinning a healthy start for babies and provides a myriad of benefits for both mother and baby. However, most clinical teams will highlight that a fed baby, be that through exclusive breastfeeding, formula or mixed, is best. A recent qualitative study with mothers of Aboriginal babies living on Kaurna Yerta reported a clear desire from mothers to breastfeed.(227) Quantitative data relating to proportions of Aboriginal and Torres Strait Islander women breastfeeding across Kaurna Yerta are not available however. Further, data that is more recent than already reported in the 2022 Aboriginal and Torres Strait Islander Health Needs Assessment—which indicated that 77.5% Aboriginal and Torres Strait Islander babies aged 0–2 years had breastfed at some stage in their lives(228)—is also not available. What is known is that mothers of Aboriginal babies living in remote areas of SA were more likely to initiate breastfeeding and still be breastfeeding their babies at 12 weeks than mothers who lived in Adelaide.(229)

A recent South Australian study explored the breastfeeding experiences for mothers of Aboriginal babies in Adelaide. With respect to establishing and sustaining breastfeeding, they found that lack of supply, health issues (including mastitis) or discomfort, complicated pregnancies or birth, issues with baby latching, and lack of access to the baby (for example, if the baby had been admitted to special or intensive care) impeded breastfeeding. Importantly, they identified that lack of advice or support around breastfeeding had negative impacts, but that family members' and friends' positive attitudes towards breastfeeding was seen as a supportive factor. (227) This highlights the importance of social support, as

[22] where the mother may be non-Aboriginal but the father is Aboriginal

well as support from healthcare providers is also important to successful breastfeeding on Kaurna Yerta and led the authors to recommend that Aboriginal health care providers (including nurses, midwives and other health practitioners) should be encouraged and supported to complete lactation consultancy training and other courses by the Australian Breastfeeding Association.(227)

The importance of culturally informed services and support have also been highlighted, with reports that mothers attending Aboriginal Family Birthing Services in Adelaide were more likely to initiate breastfeeding and being likely to continue to breastfeed to 6 and 12 weeks postpartum than those who receiving standard antenatal care in Adelaide.(229)

10.1.6 BMI during pregnancy

Despite the limitations of BMI outlined previously in this report, Maternal BMI persists as a reported statistic. This is likely due to the impact of maternal weight (be it over- or under-weight) on health outcomes for both mothers and babies. Data provided by the AIHW indicates that, in 2023, approximately one-third (32%) of Aboriginal and Torres Strait Islander women who gave birth were at what is considered a "normal weight"[23]. More granular jurisdictional data is not available.

10.2 Early childhood

The ongoing impacts of colonisation and health inequities are clearly demonstrated by the comparatively young age structure of Aboriginal and Torres Strait Islander populations, signalling persistent marginalisation and disparities in morbidity, mortality and life expectancy. Data from the 2021 Census data indicates that, nationally, over one-third of Aboriginal and Torres Strait Islander people were under the age of 15.(230) In Greater Adelaide, specifically, there were 2,555 (10.8%) Aboriginal and Torres Strait Islander children aged 0–4 years and a further 5,329 (22.4%) aged 5–14 years in 2021.(22)

More recent, but less granular, data related to the whole of SA, indicates that Aboriginal and Torres Strait Islander children represented 5.9% of all children aged 0-5 in SA in 2025. Of those who were pre-school age, there were 3,371 Aboriginal and Torres Strait Islander children aged 3-5 years in SA (with a roughly even split between each of the ages (that is, 1,136 three-year-olds, 1,135 four-year-olds, and 1,100 five-year-olds)(231)

[23] Noting the previously identified concerns about BMI as a measurement

10.2.1 Health checks for children

About one in every seven (15.7%) Aboriginal and Torres Strait Islander children aged 0–4 years in the Adelaide PHN region participated in an annual health check[24] in 2024, which was slightly lower than the overall proportion for SA in 2024 (20%).(232) The average number of completed health checks for Aboriginal and Torres Strait Islander children aged 0–4 years in SA was 1.5. (232)

All South Australian children are offered a universal schedule of health and development checks from 0–5 years through the Child and Family Health Service (CaFHS). There is, however, limited publicly available data on participation among Aboriginal and Torres Strait Islander children specifically. While targeted supports, such as Aboriginal Cultural Child and Family Support Consultants, aim to strengthen engagement with these services,(233) it appears that policy efforts have focused on expanding the reach and uptake of health checks across the early years, rather than reporting Indigenous-specific coverage rates. This reflects a broader gap in monitoring early childhood service utilisation for Aboriginal children in both SA and metropolitan regions such as Adelaide

10.2.2 Child mortality

Infant mortality rates for Aboriginal and Torres Strait Islander babies in Australia for the period of 2020–24 were 4.3 per 1,000 live births.(234) There is no publicly available reported data on Aboriginal and Torres Strait Islander infant mortality data in the Adelaide PHN, as numbers are very low and risk identification.

10.2.3 Education & childcare

In 2025, Aboriginal and Torres Strait Islander children in SA aged 0–5 years represented nearly 6% of the SA total for this age group. Aboriginal and Torres Strait Islander children in this age group only accounted for 3.6% of those attending child care services however.(235) Nevertheless, Aboriginal and Torres Strait Islander children aged 3–5 years accounted for 6.7% of those enrolled in preschool programs, and 6.5% of all children enrolled in preschool programs in their ‘year before full-time schooling’.(235) Together, these data illustrate how formal participation in early childhood education is concentrated in the year immediately prior to school, underscoring both the progress and ongoing opportunity to strengthen earlier engagement (from age 3) in metropolitan areas such as Adelaide.(236)

[24] Specifically, MBS item numbers 715, 228, 92004, 92011, 92016, and 92023.

10.3 Elders Health, Wellbeing and Aging Well

Elders are living libraries. They are custodians of knowledge that has existed since time immemorial. They hold a central role in Aboriginal and Torres Strait Islander communities, guiding cultural continuity, education and the transmission of language, teachings and practice. Through their leadership and lived experience, Elders foster connection to Country, strengthen identity formation and nurture social and emotional wellbeing of younger generations.

Across Greater Adelaide, there are 1,650 Aboriginal and Torres Strait Islander individuals aged 55–64 years, and 1,193 aged 65 years and older. Collectively, this represents approximately 12% of the Aboriginal and Torres Strait Islander population in Adelaide and is close to that for the whole of SA (13.4%) and nationally (13.5%).(22) It should be noted that while Aboriginal and Torres Strait Islander peoples have a younger age profile than non-Indigenous Australians, the number of older Aboriginal adults is increasing steadily in metropolitan areas nationally, including the Adelaide PHN.

Older Aboriginal and Torres Strait Islander people are impacted through management of complex health conditions, such as multi- and poly-morbidity involving chronic diseases such as diabetes, cardiovascular disease and cancer, with diabetes affecting over 15% of Aboriginal adults and increasing to over 34% among those aged 55 and older.(70)

Mental health is also a significant concern, with nearly one in three (28.3%) of Aboriginal and Torres Strait Islander people in non-remote areas of SA aged over 55 years experiencing high/very high psychological distress.(70) These health inequities are strongly influenced by social determinants such as poverty, food insecurity and limited access to culturally appropriate health services.(70)

10.3.1 Dementia

The only data available surrounding dementia prevalence among Aboriginal populations nationally is from the 2021 Census. The Census reports that the proportion of Aboriginal and Torres Strait Islander people across Greater Adelaide with dementia was 0.5%, which was the same as for the state (0.5%) and slightly higher than the national figure (0.4%).(22) Despite dementia prevalence and earlier onset being greater among Aboriginal and Torres Strait Islander people compared to the non-Indigenous population, and reflecting cumulative exposure to cardiovascular disease, diabetes, head injury and social determinants over the life course, there is a lack of national reporting in this area. This lack of data and insight has been highlighted by the AIHW, who have committed to a *National*

Dementia Data Improvement Plan 2023–2034, which includes delivery of place-based dementia data for Aboriginal and Torres Strait Islander communities.(237)

Recent literature has identified some protective benefit associated with urban service access(238). However, dementia diagnoses are frequently delayed and care compromised due to a myriad of complex barriers including limited community awareness, low knowledge base of health service providers, mistrust of health system and lack of culturally appropriate services, along with denial, stigma, and fear of being moved off Country.(239), Utilisation of culturally appropriate cognitive assessment tools (such as KICA) and culturally safe post-diagnostic supports are important. As such, primary care plays a pivotal role in early identification, care coordination and supporting carers.

10.3.2 Access to aged care services

Aboriginal people access residential aged care at lower rates and later stages than non-Indigenous people.(240) Barriers include cultural safety, assessment processes and a preference for ageing on Country and within community. Lower residential aged care use reflects both barriers and strengths, including strong family support and a preference for community-based care. PHIDU analyses report that there were 642 Aboriginal clients receiving Commonwealth Home Support Packages in the Adelaide PHN region in 2023–24. Strengthening Aboriginal-led home care, flexible respite and aged care navigation services aligns with these preferences and supports ageing with dignity.

In Adelaide, Aboriginal Community Services is the largest SA provider of Aboriginal aged care, operating the only Aboriginal-specific residential aged care facility in Kaurna Yerta, located in Davoren Park. The service supports up to 33 Elders with low to high care needs, offering both short-term respite and long-term residential care. In addition, Aboriginal Community Services provides home care services to support Elders living across the Adelaide metropolitan area.

10.3.3 End-of-life and palliative care

Since previous reporting, new data addressing access to palliative care access services is limited. In 2016–17, only 1.6% of palliative-care related hospitalisations in SA involved Aboriginal and Torres Strait Islander people.(241) This underrepresentation likely reflects lack of access to culturally safe palliative and end-of-life care. Connection to Country, family, language and ceremony are central considerations for dying Aboriginal and Torres Strait Islander people and their families.(241)

Examples of excellence in this area include the South Australian Comfort Care Innovations project, led by the National Aboriginal and Torres Strait Islander Palliative Care Association and supported by the Department for Health and Wellbeing. This initiative represents a culturally grounded, system-transforming approach to improving equitable access to palliative care for Aboriginal and Torres Strait Islander peoples across metropolitan, peri-urban, rural, regional, and remote contexts. Through two concurrent, co-designed projects, the initiative addresses long-standing barriers created by Western health systems by centring cultural safety, healing-informed practice, and community leadership. Working in partnership with Elders, families, Aboriginal Community Controlled Organisations, and health services, the program prioritises listening first, building local capacity, and developing place-based solutions that respect culture, family, connection, and choice. Activities such as community visits and education workshops strengthen awareness, support informed decision-making, and encourage services to embed culturally responsive care, while the metropolitan-focused work highlights the often-overlooked challenges faced by Aboriginal people in urban settings, including fragmented care and cultural invisibility within mainstream systems. Guided by strong cultural governance and Aboriginal leadership, this work reframes Comfort Care as a holistic, life-course approach that supports dignity, wellbeing, and connection, for the journey into Sorry Business, and demonstrates that effective palliative care for Aboriginal communities requires flexible, relational, and community-led models that honour identity, spirituality, and collective ways of knowing, being, and doing.

10.4 Disability

Nationally, Aboriginal and Torres Strait Islander people (aged 15+) with disabilities experience greater difficulties in accessing health, government, financial, legal, telecommunication, and utility services than those without disabilities. Barriers identified in the most recent Aboriginal and Torres Strait Islander Health Performance Framework data were costs, logistics (including transport and distance, service availability, long waiting times) and appropriateness of services. This last category comprised experiences of being treated poorly due to being Aboriginal or Torres Strait Islander, services not being culturally appropriate, distrust, poor customer service, and language difficulties.(242)

In 2022–23, there were 19,500 Aboriginal and Torres Strait Islander people living with disabilities in non-remote areas of SA.(243) Across SA, over 4,000 Aboriginal and Torres Strait Islander peoples reportedly need assistance with core activities in 2021.(244) There were also more than 4,100 Aboriginal and Torres Strait Islander people in SA aged over 15 years of age who adopted an informal caring role (that is, providing unpaid care, help, or

assistance) to family members or others due to their disability, chronic condition or age-related issues.(245)

At end June 2025, SA had the second-highest rate of National Disability Insurance Scheme (NDIS) use by Aboriginal and Torres Strait Islander peoples (77 per 1,000 people) (following Victoria where the rate was 86 per 1,000 people).(246) At the end of December 2025, that total number of Aboriginal and Torres Strait Islander people registered as NDIS participants in SA was 4,595, representing 7% of all participants.(247)

During the consultations for this Health Needs Assessment, community members raised concerns about family members' NDIS plans. Predominantly, these concerns related to worry that funding allocations did not reflect or cover what was required to support their loved ones' needs. Community members shared that, although they wanted to care for their loved ones, caring for family members with disabilities impacted their own social and emotional wellbeing. Support for carers, especially as their loved ones transitioned from youth to adult services, was also identified as a systems-level area for improvement. These comments echo the findings from the *Wangkiny Yirra "Speaking Up" Project* as part of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.(248)

10.5 Digital Health Access

Target 17 of the National Agreement on Closing the Gap sought to ensure that Aboriginal and Torres Strait Islander peoples have an equal level of digital inclusion to their non-Indigenous counterparts by 2026. This target relates to Outcome 17 which refers to the rights of Aboriginal and Torres Strait Islander peoples to have access to information and services that support participation in informed decision-making processes.(216) Digital inclusion provides the opportunity for greater equity in access to and effective use of digital services which can include (but are not limited to) accessing telehealth and other health-related services online, engaging in online or remote learning, utilising online platforms for social and economic opportunities and so forth.(249,250)

The Australian Digital Inclusion Index (ADII) is a score, between 0 to 100 (where 100 is the highest), that is calculated based on access, affordability, and digital ability. It provides evidence to identify who (and who is not) experiencing digital inclusion, as well as tracking changes in digital inclusion over time. (251) National data for 2025 indicates there is a substantial digital inclusion gap between non-Indigenous and Aboriginal and Torres Strait Islander peoples both with regard to overall inclusion (73.9 compared to 63.4), as well as with more specific respect to access (77.2 for non-Indigenous and 64.3 for Aboriginal and

Torres Strait Islander people), affordability (70.6 compared to 57.3) and digital ability (73.8 compared to 68.6).(252)

Available ADII data does not provide sufficient granularity of detail to report specifically on the digital inclusion of Aboriginal and Torres Strait Islander peoples residing in specific areas of the Adelaide PHN. However, 2025 data indicates the ADII is greater for Aboriginal and Torres Strait Islander peoples in Greater Adelaide (76.1) than those living outside of Greater Adelaide (57.9).(253)

During the consultations undertaken for this Health Needs Assessment, community members identified telehealth appointments as being an important part of health service access. Community members acknowledged that they were not always able to navigate the technical aspects and requirements of online systems themselves, and that they looked to their younger family members to help support their access to these services. The ability to access telehealth appointments mitigated transport barriers and also provided community members with the opportunity to book an appointment with their preferred doctor (regardless of their location). This ability not only supported continuity of care, it also meant people felt confident that could select their preferred doctor (or practitioner) who they knew to be culturally safe for them. Conversely, community members also stressed the importance of non-digital communication channels and methods of contact. Relying on social media for promotion of health services and campaigns, or text messages to confirm appointments, risked exclusion of community members, especially Elders, who did not frequently use these digital platforms.

11 Needs identification and statement development

The Adelaide PHN applies a structured and transparent approach to prioritising needs statements within its Needs Assessments. Following the systematic synthesis of epidemiological data, service utilisation patterns, stakeholder consultation, and community input—such as that which constitutes the bulk of this report—findings are used to inform discrete needs statements. Each statement is framed to clearly articulate the population group, the identified service gap or health issue, and the underlying contributing factors. Prioritisation is then undertaken, considering the magnitude and severity of the issue, the level of unmet need, and the feasibility of effective intervention within the Adelaide PHN's commissioning scope.

For the current Aboriginal Health Needs Assessment, the project team developed a draft list of needs statements reflecting the dominant themes and clear community needs identified in the quantitative and qualitative data. These were reviewed by the project's Steering Committee – consisting of Adelaide PHN and Flinders University staff – and then circulated to the Adelaide PHN's Combined Councils (multidisciplinary input from clinical experts and community representatives) for review and prioritisation.

11.1 2026 key themes and needs statements

Synthesis of the various data inputs and consultations undertaken for this analysis identified the following five key themes:

1. System Capacity
2. Access and Equity of Services
3. Navigating the (Health) System
4. Social Determinants of Health
5. Health Behaviours

Two cross-cutting issues – the cultural determinants of health and the Adelaide PHN's role as a facilitator of professional and community networks – underpinned all five key themes (Figure 12).

Thirty-four needs statements were generated from these themes and presented to the Adelaide PHN's combined governance groups, discussed and ranked during an online meeting held 25 June 2026.

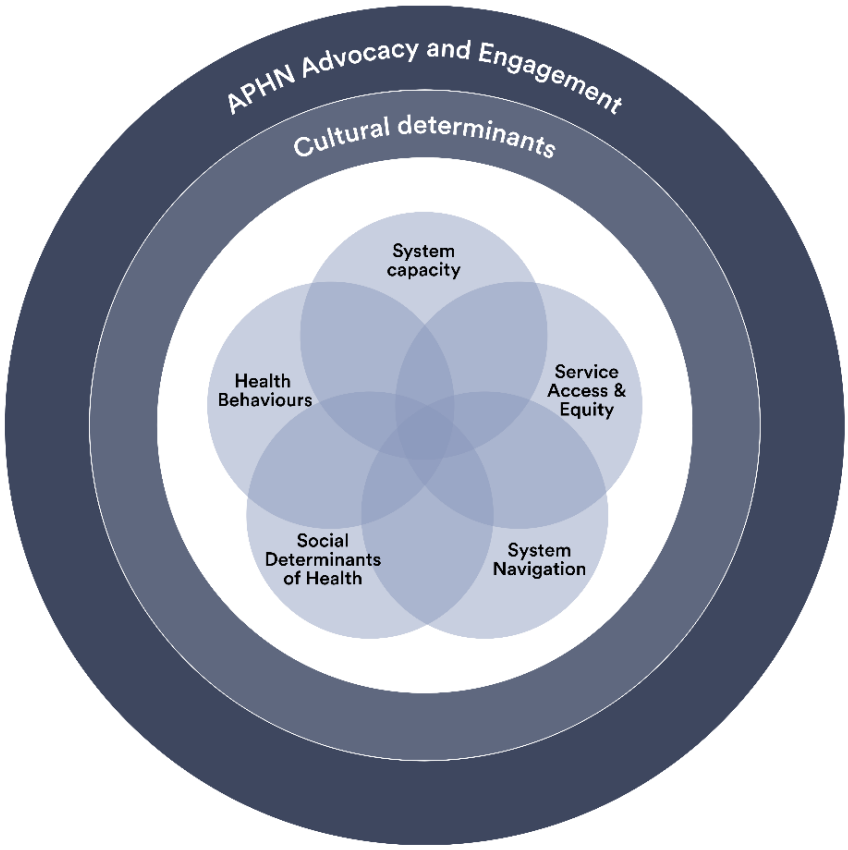

Figure 12: 2026 Aboriginal Health Needs Assessment thematic framework

11.1.1 System capacity

Draft needs statements 1–13 (below) addressed the health system and its structures as a whole and comprised several sub-themes. The availability, skills mix, and geographic spread of the health workforce required to meet population needs were grouped as *workforce capacity and distribution* issues. The organisation of services into a coherent system, including continuity of care, referral pathways, and information sharing across providers, was grouped as a *service coordination and integration* sub-theme. *Funding stability and resource allocation* issues addressed the adequacy, predictability, and alignment of funding with identified health system needs. The structures and processes for decision-making, accountability, and community leadership, including culturally appropriate governance, were grouped as *sovereignty, governance and leadership* issues.

1. Sufficient primary care, allied health, and specialist workforce to meet current and projected demand across Adelaide PHN catchment areas, with targeted supply in outer metropolitan areas, growth corridors, and areas of socioeconomic disadvantage

2. Workforce models that optimise scope of practice, including Aboriginal Health Workers and Practitioners, nurse practitioners, pharmacists, midwives and allied health workers, to reduce pressure on general practice
3. Workforce capability to respond appropriately to disclosures of violence and to support ongoing care
4. Integrated models of care that co-locate general practice, mental health, AOD, and social services to improve access and continuity of care
5. A single, clear entry pathway ("single front door") to reduce duplication, inappropriate referrals, and delays
6. Interoperable referral, triage, and care coordination systems linking primary care, hospitals, community services, and non-health sectors
7. Commissioning that supports continuity of care and long-term impact, not episodic activity, including block funding and outcomes-based payments where appropriate
8. Transparent allocation methods that direct resources to areas of highest need and unmet demand
9. Capacity to scale proven models and decommission low-value services based on consistent evaluation
10. Recognition and protection of sovereignty and self-determination in health system design, delivery, and evaluation with Aboriginal-led models where relevant
11. Clear data governance and leadership capability that ensures sovereignty of data systems, including ownership, access, and use, aligned with community priorities
12. Current, high-quality, and consistent relational data across providers to support planning, commissioning, and evaluation
13. Interoperable and integrated data systems that allow secure sharing while maintaining privacy and trust

11.1.2 Services access and equity

Eleven needs statements were drafted to address issues of health service access and equity. These include sub-themes of *health service access and availability*, the *cultural safety* and appropriateness of health services, and *growing the Aboriginal health workforce* and workforce capability.

14. Culturally safe and appropriate care embedded across all primary health services, informed by Aboriginal and Torres Strait Islander leadership and community priorities
15. Service models that recognise and respect cultural identity, kinship structures, and connection to Country within care planning and delivery

16. Commissioning approaches that prioritise and embed Aboriginal Community Controlled Organisations as preferred service provider partners where appropriate
17. Improve system-wide capability in cultural safety, including mandatory, ongoing training and reflexive practice for all staff
18. Environments, policies, and practices that actively support trust and engagement and reduce experiences of racism and support culturally safe access and continuity of care
19. Timely access—including reduced waiting times—to primary care, mental health, SEWB and allied health services across the Adelaide PHN region
20. Clear, accessible information and communication (outreach and engagement) about available services and programs across the Adelaide PHN region, using multiple platforms
21. Greater coordination between services and systems to support transitions and reduce loss to follow-up
22. Coordinated workforce planning with LHNs and RTOs to align placements, recruitment, and retention with local need
23. Targeted Aboriginal and Torres Strait Islander health workforce recruitment pipelines, including school-based pathways, vocational training, and tertiary education aligned to local workforce demand
24. Workforce data systems that accurately capture, monitor, and inform growth, retention, and distribution of the Aboriginal and Torres Strait Islander workforce
25. Increased workforce capability to consistently deliver culturally safe, trauma-informed, recovery-oriented and responsive care, supported by organisational governance that embeds clear standards, accreditation, accountability, quality improvement processes, and performance monitoring

11.1.3 Navigating the health system

Needs statements addressing support for community navigating the health system—to access health prevention and early intervention programs and easily engage with care—included:

26. Increased awareness and integration of prevention and early intervention in primary care and community settings
27. Simple navigation supports—including care coordinators, navigators, and multi-modal communication—to create clearer care pathways
28. Active identification and mitigation of barriers to help-seeking, including cost, stigma, transport, and service accessibility

11.1.4 Social determinants of health

Both the quantitative data and community consultations heavily emphasised the centrality of the social (and cultural) determinants of health. Fewer needs statements were drafted to directly address the social determinants of health than for some other themes however, due to the Adelaide PHN's limited capacity to address issues outside of the organisation's health remit. Nevertheless, Adelaide PHN's involvement to address the following needs was encouraged by community stakeholders:

29. Integrated pathways between primary health care, housing services, and social supports to address housing instability and housing-related health needs
30. Local partnerships with community organisations to support food access initiatives—including medically-appropriate options—and strategies that support nutrition knowledge alongside practical access to food
31. Community-based, trauma-informed programs that strengthen social inclusion, participation, and peer support, including targeted approaches for populations at higher risk of isolation, such as young mums, carers, people with complex needs, and people affected by family violence

11.1.5 Supporting healthy behaviours

In keeping with the strengths-based approach taken throughout this Health Needs Assessment, several draft needs statements addressed identifying models of care that were working well for the community within the Adelaide PHN area and amplifying these, as well as strengthening support for proactive healthcare and engagement with the health system across the life course:

32. Models of coordinated care across primary, maternity and community support services that reflect holistic concepts of wellbeing, including cultural, social, and emotional dimensions
33. Targeted strategies, that are culturally appropriate and utilise multimodal communication and inclusive engagement methods, to support informed-decision making about cancer and other screening and vaccination programs
34. Culturally informed, continuity-of-care antenatal services scaled, including midwifery-led and team-based models, with improved access to Aboriginal-led birthing programs

12 2026 needs statement prioritisation

The Adelaide PHN's Combined Aboriginal Councils reviewed the 2026 Health Needs Assessment data insights and the 34 draft needs statements, then ranked those considered to be of highest priority using the Mentimeter online engagement platform. Due to the large number of draft statements tabled, Council members initially ranked the statements drafted for each of the five key themes emergent from the 2026 Needs Analysis, then ranked the resulting 10 highest priorities in order of perceived priority (Figure 13). Accordingly, the final prioritisation reflects both evidence and judgement, with a focus on identifying areas where targeted investment is most likely to improve outcomes and reduce inequity. The transparency of the process enables stakeholders to understand how priorities were determined and how they inform subsequent commissioning decisions.

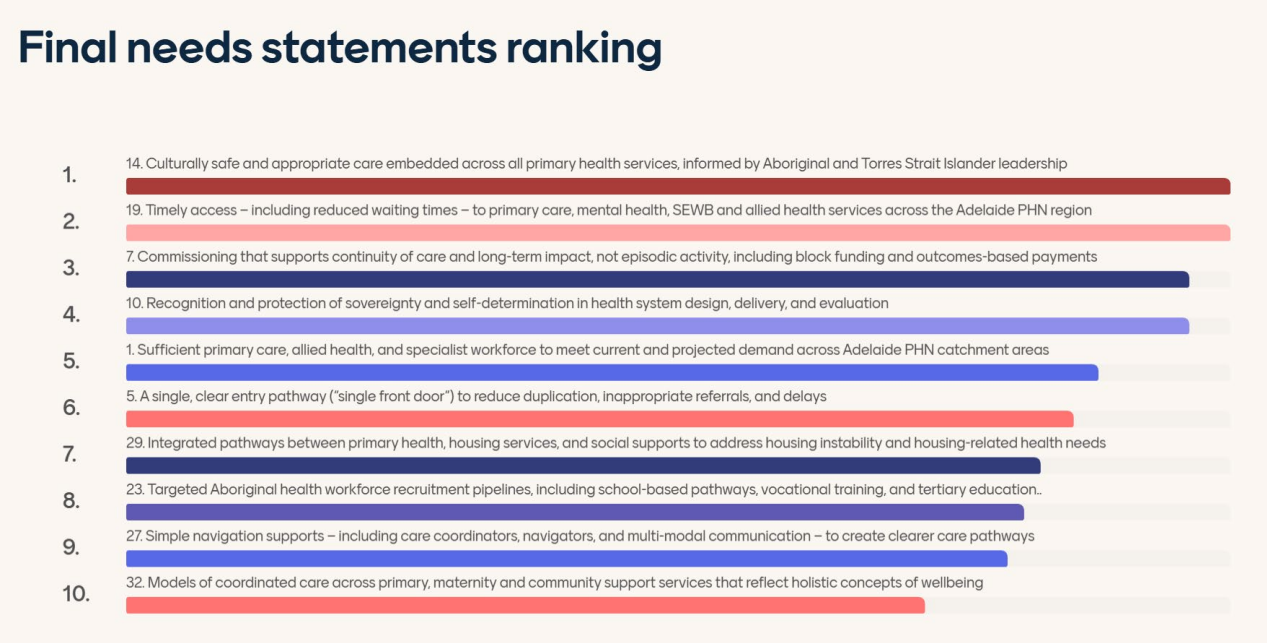

Figure 13: Adelaide PHN Combined Aboriginal Council's final 2026 Aboriginal Health Needs Statement priorities

Responses from between 22–26 council members were received for every ranking activity in the online prioritisation session. The importance of access to timely, culturally safe care—and the Adelaide PHN's capacity to lead sector- and system-level improvements to support this—was apparent in the prioritisation activity's overall outcomes.

The final order of the Needs Statement prioritisation for 2026 is as follows:

i. Culturally safe and appropriate care embedded across all primary health services, informed by Aboriginal and Torres Strait Islander leadership and community priorities.

ii. Timely access—including reduced waiting times—to primary care, mental health, social and emotional wellbeing and allied health services across the Adelaide PHN region.

iii. Commissioning that supports continuity of care and long-term impact, not episodic activity, including block funding and outcomes-based payments where appropriate.

iv. Recognition and protection of sovereignty and self-determination in health system design, delivery, and evaluation with Aboriginal-led models where relevant.

v. Sufficient primary care, allied health, and specialist workforce to meet current and projected demand across Adelaide PHN catchment areas, with targeted supply in outer metropolitan areas, growth corridors, and areas of socioeconomic disadvantage.

vi. A single, clear entry pathway ("single front door") to reduce duplication, inappropriate referrals, and delays.

vii. Integrated pathways between primary health care, housing services, and social supports to address housing instability and housing-related health needs.

viii. Targeted Aboriginal and Torres Strait Islander health workforce recruitment pipelines, including school-based pathways, vocational training, and tertiary education aligned to local workforce demand.

ix. Simple navigation supports—including care coordinators, navigators, and multi-modal communication—to create clearer care pathways.

x. Models of coordinated care across primary, maternity and community support services that reflect holistic concepts of wellbeing, including cultural, social, and emotional dimensions.

These prioritised needs statements strongly align with the issues identified in community and the existing health service system, building on existing strengths and filling gaps in service provision access and equity. They firmly position the Adelaide PHN to deliver measurable improvements in access, experience and outcomes over the next commissioning cycle.

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