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PHN Needs Assessment:

Adelaide Primary Health Network

Aboriginal and Torres Strait Islander Health

November 2022

The Adelaide Primary Health Network acknowledges the Traditional Owners, the Kaurna people whose lands their office are located on and pays our deep respect to Aboriginal and Torres Strait Islander Elders past, present and emerging.

Flinders University acknowledges the Traditional Owners and Custodians of the lands on which its campuses are located, these are the Traditional Lands of the Arrernte, Dagoman, First Nations of the South-East, First Peoples of the River Murray & Mallee region, Jawoyn, Kaurna, Larrakia, Ngadjuri, Ngarrindjeri, Ramindjeri, Warumungu, Wardaman and Yolngu people. They honour their Elders past, present and emerging.

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Acronyms

Abbreviation	Full Name
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisations
ACCFSC	Aboriginal Cultural Child and Family Support Consultants
AMIC	Aboriginal Maternal and Infant Care (worker)
CTG	Closing the Gap
LGA	Local Government Area
MBS	Medical Benefits Scheme
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NHMRC	National Health and Medical Research Council
PHN	Primary Health Network
SA	South Australia
SA3	Statistical Area Level 3
SA4	Statistical Area Level 4
The Council	Aboriginal and Torres Strait Islander Advisory Council for Adelaide PHN

1 Context, Methodology, Planning & Recommendations

1.1 Sources

Data for the Adelaide PHN Aboriginal and Torres Strait Islander Health Needs assessment was drawn from publicly available data sources listed in Table 1.

Table 1 Data sources used in report

Name of organisation	Website containing publicly available data
Australian Bureau of Statistics *ABS 2022 release of 2021 data*	https://www.abs.gov.au/
Australian Institute of Health and Welfare	https://www.aihw.gov.au/
Aboriginal and Torres Strait Islander Health Performance Framework	https://www.indigenoushpf.gov.au/
Closing The Gap	https://www.closingthegap.gov.au/
Public Health Information Development Unit (PHIDU)	https://phidu.torrens.edu.au

Prevalence data was derived from Indigenous Health Performance Framework (website initiated in 2020), which based prevalence data on National Aboriginal and Torres Strait Islander Health Survey (NATSIHS, 2018-19) and National Health Survey (NHS, 2017-18).

1.2 Indigenous Data Sovereignty and Governance

Highlights

Indigenous Data Sovereignty focusses on data autonomy across all aspects of the data journey (collection to dissemination) for Aboriginal and Torres Strait Islander communities.

Indigenous data is data in any format or medium on Aboriginal and Torres Strait Islander peoples, families and communities (1). Indigenous Data Sovereignty focusses on data autonomy across all aspects of the data journey (collection to dissemination) for Aboriginal and Torres Strait Islander communities, Indigenous Data Governance are principles, approaches and policies which allow Indigenous Data Sovereignty to be enacted (1).

This PHN Needs Assessment has focused on drawing Indigenous data predominantly from grey literature in the form of government and non-government reports, and epidemiological data repositories. It needs to be highlighted that the majority of national and bi-national data repositories in Australia were established prior to knowledge and understanding of the importance of Indigenous Data Governance for Indigenous data (1). As such these repositories

do not conform to Indigenous Data Sovereignty principles or practices. This is a significant limitation in these repositories, as while they contain Indigenous data, they do not engage Indigenous Knowledges or recognise the sovereign rights of Aboriginal and Torres Strait Islander individuals and communities in their repositories or reporting mechanisms. We have undertaken structured data framing in this PHN Needs Assessment to assist in counteracting this limitation but acknowledge that this is a significant limitation in the Needs Assessment.

1.3 Data Framing

1.3.1 Age-standardised rates

When age-standardised to Australian standard population in 2001, Indigenous mortality rate is more than double the crude mortality rate due to the difference in age distribution between the indigenous and non-indigenous population (2). While age-standardising to Australian standard population in 2001 makes the Indigenous mortality rate comparable to the non-Indigenous people's mortality rate in the same year as well as across years, these rates are more suitable for comparing changes over time and highlighting differences or similarities in outcomes between populations. These rates are not suitable when assessing the needs of the Indigenous population. We will use crude and age-specific rates for chronic diseases and death highlighting the real population need where possible instead of age-standardised rates. Age-standardised rates will only be presented when crude and age-specific rate cannot be found.

1.3.2 Absolute versus relative measures

Absolute measures were presented where possible as a real-world reflection of the current health state.

1.3.3 Geography/region

Statistical Area Level 3 (SA3) data was sought as a priority. In the absence of SA3 data, the geography specific data was sought preferentially in this order: Statistical Area Level 4 (SA4), Adelaide PHN, South Australian non-remote data, South Australia specific data, and finally Australia wide data. We acknowledge that SA3 is represented by local council boundaries which were established from Western knowledge systems. As such is not representative of Kaurna knowledges surrounding boundaries and areas of significance for community.

Table 2 Order of preference for regional data extraction for the Needs Assessment

Order of preference	Geographical area distribution	Regional data extracted
1	Statistical Area Level 3 (SA3)	Adelaide City, Burnside, Campbelltown (SA), Norwood - Payneham - St Peters, Prospect - Walkerville, Unley, Playford, Port Adelaide - East,

		Salisbury, Tea Tree Gully, Holdfast Bay, Marion, Mitcham, Onkaparinga, Charles Sturt, Port Adelaide - West, West Torrens
2	Statistical Area Level 4 (SA4)	Adelaide North, Adelaide South, Adelaide Central and Hills, Adelaide West
3	Primary Health Network	Adelaide PHN
4	Remote-non remote	South Australian non-remote
5	State	South Australia
6	Country	All of Australia

1.3.4 Comparison framework

Aboriginal and Torres Strait Islander and non-Indigenous comparison was avoided where possible. Aboriginal and Torres Strait Islander people living in Adelaide PHN was compared with Aboriginal and Torres Strait Islander people living in other parts of South Australia or Australia where possible, according to data availability.

1.3.5 Reporting timeframe

Most recent data at time of reporting was sought. Current state of disease and needs of the community were prioritised rather than change over time.

1.3.6 Strength-based approach

Strength-based approaches for the framing of Aboriginal and Torres Strait Islander health outcomes have been used to decolonise outcomes and shift from a deficit discourse and data narrative. Valuing and centring Indigenous knowledges throughout the Needs Assessment process – approach, data sources accessed, data collected, and contextualisation of outcomes are essential in strength-based approaches, along with actively recognising and addressing impacts of colonisation. For example, where possible in this report we have sought to report outcomes for Aboriginal population only against South Australia or national Aboriginal outcomes, rather than the dominant population. However, in cases where no data is available and health inequity contextualisation is required, we will report against dominant population but appropriately contextualise this with work from First Nation (global collective) scholars and researchers.

1.4 Population

Highlights

Most Indigenous Australians in the Adelaide SA4 identify as being Aboriginal (95.4%) with 2.3% identifying as Torres Strait Islander.

In South Australia, 2.4% of the population (43,000 people) identified as Aboriginal and/or Torres Strait Islander in the 2021 Census. Of these figures, 95.4% identified as Aboriginal and 2.3% as Torres Strait Islander (3).

The proportion of those identifying as Aboriginal and/or Torres Strait Islander in South Australia has grown from 2.0% in 2016, and 1.9% in 2011 (3). This increase in identification is thought to be multifactorial; through families impacted by colonial policies discovering and reconnecting, through to families and individuals feeling safer to identify.

At the time of the production of this report, region specific population data was not available across the Adelaide PHN SA3 levels. The following data is presented according to Statistical Area Level 4 (SA4) (Table 3). This covers four regions in Adelaide: Adelaide North, Adelaide South, Adelaide West and Adelaide Central and Hills. These areas cover a slightly bigger geographical area covered than the Adelaide Primary Health Network (4-7).

In the 2021 Census, Adelaide North (SA4) reported the largest number (11,400) and largest proportion (2.5%) of Aboriginal and Torres Strait Islander people. While Adelaide South (SA4) reported 5,386 Aboriginal and Torres Strait Islander people and the second greatest number, it was the third biggest proportion (1.4%) of total population in the PHN region. Adelaide West (SA4) had the second highest proportion (1.9%) of the regional population. Adelaide Central and Hills (SA4) region has the lowest count and proportion (0.8%) of Aboriginal and Torres Strait Islander people (4-11).

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Table 3 Aboriginal and Torres Strait Islander people as a numerator and all persons in the region as the denominator, by Statistical Area Level 4 in Greater Adelaide

Indigenous status all persons	Adelaide - North		Adelaide - South		Adelaide - West		Adelaide - Central and Hills		South Australia		Australia	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Aboriginal and Torres Strait Islander total	11,400	2.5	5,386	1.4	4,567	1.9	2,411	0.8	42,562	2.4	812,728	3.2
Aboriginal	10,839	2.4	5,074	1.4	4,296	1.8	2,220	0.7	40,592	2.3	742,882	2.9
Torres Strait Islander	297	0.1	152	-	129	0.1	99	0.1	994	0.1	33,765	0.1
Both Aboriginal and Torres Strait Islander	261	0.1	154	-	135	0.1	89	0.1	967	0.1	36,083	0.1
Non-Indigenous	427,938	93.9	358,096	95.5	231,958	94.9	300,098	96.1	1,669,314	93.7	23,375,949	91.9
Not stated	16,368	3.6	11,380	3.0	7,829	3.2	9,872	3.2	69,646	3.9	1,234,112	4.9

Table generated from 2021 ABS Census data (4-11). Total can be greater than 100 due to rounding. Very small percentage

1.4.1 Age

Highlights

Aboriginal and Torres Strait Islander people in Adelaide PHN have a young age distribution with a median age of 23 years.

Compared to the whole South Australian population, Aboriginal and Torres Strait Islander community in South Australia have a younger population distribution with a median age of 24 years, this median age has increased by 2 years since 2011 (Figure 1) and is the same as the national median (3). However, the median age of Aboriginal and Torres Strait Islander people living in Greater Adelaide is still 23, indicating a slightly younger population distribution in Greater Adelaide compared to the rest of the state.

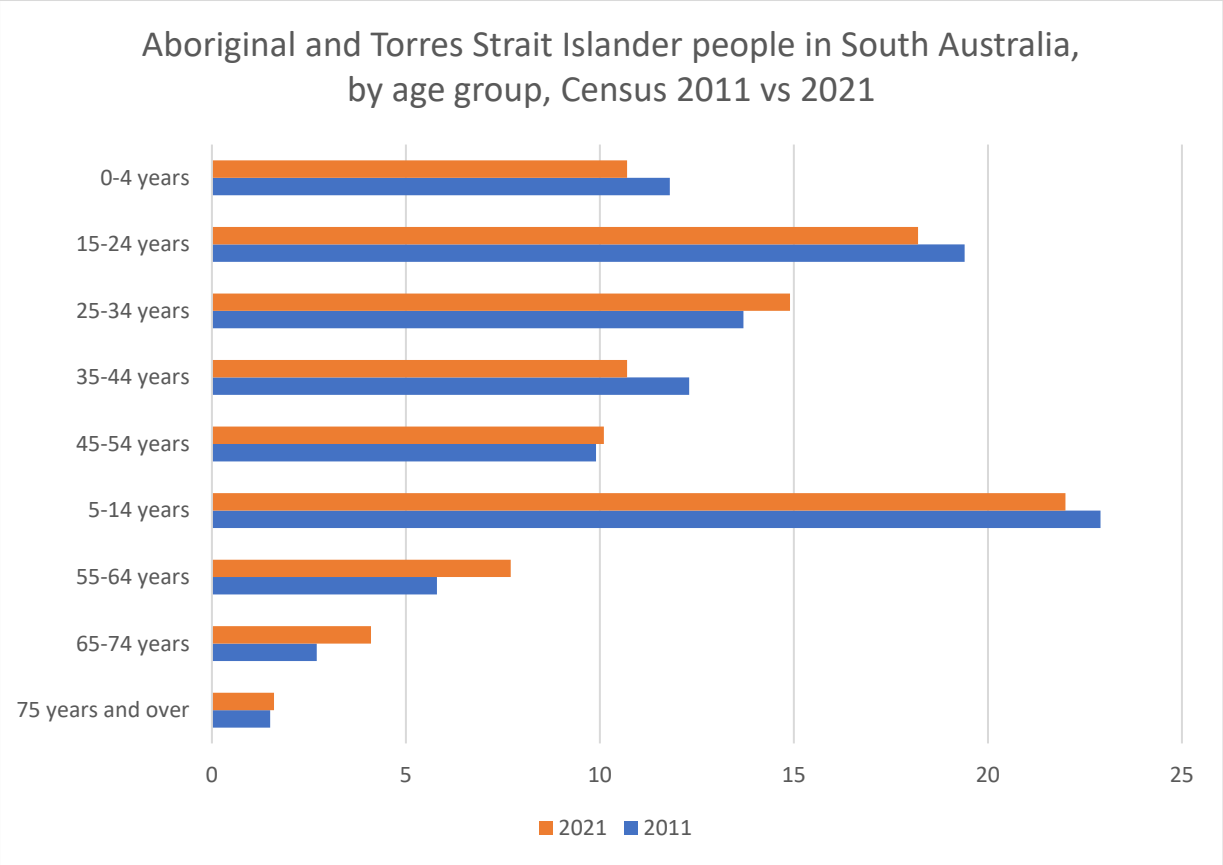

Figure 1 Aboriginal and Torres Strait Islander people in South Australia by age, 2011 and 2021

Source: Australian Bureau of Statistics, South Australia: Aboriginal and Torres Strait Islander population summary (3)

The increase in average age of Aboriginal and Torres Strait Islander people in the state was driven by a decrease in the proportion of people in the 0-24 age bracket, and an increase in the proportion of people aged 25 and over (3).

Statistical Area Level 4 data in 5-year age categories are presented in Figure 2 below.

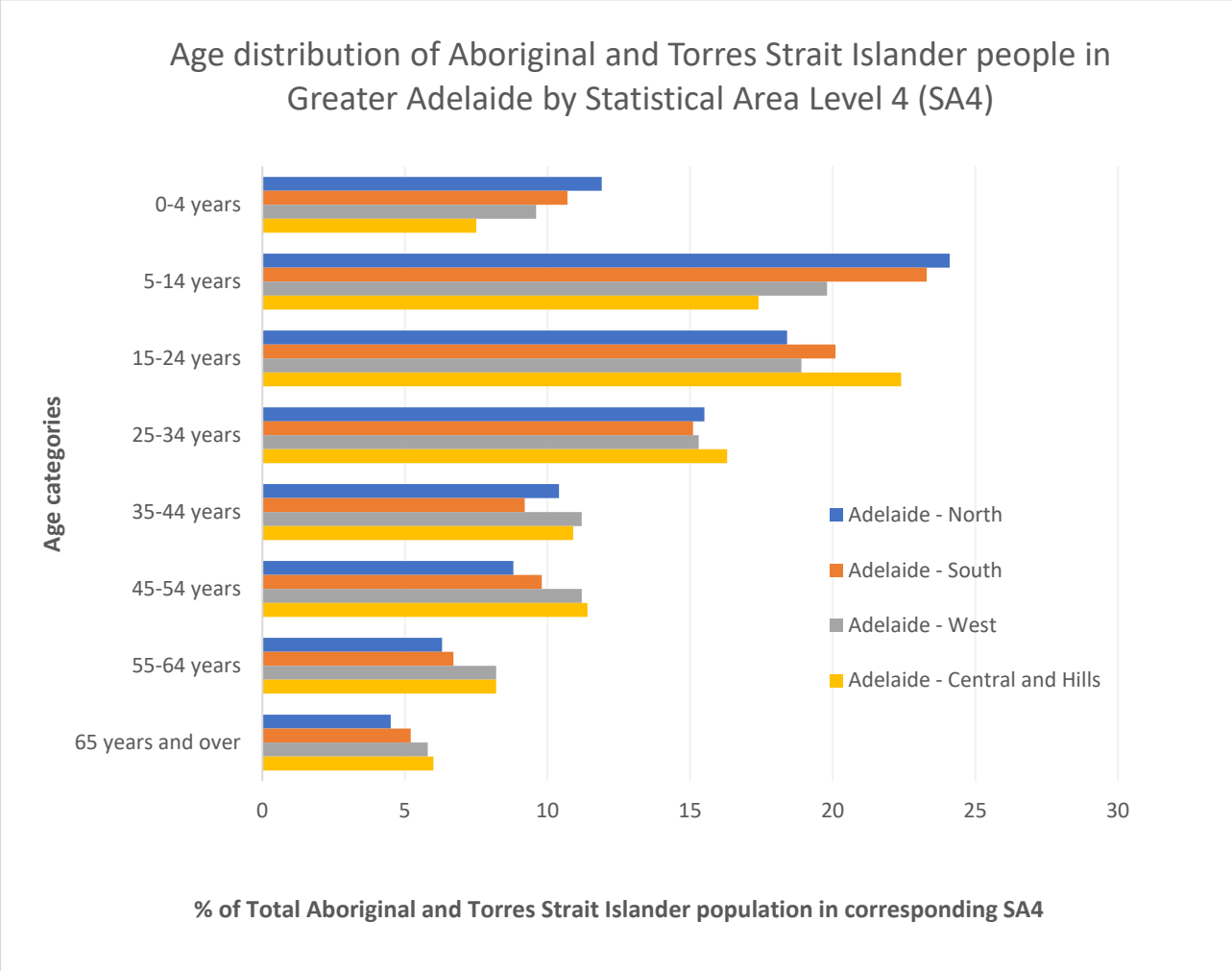

Figure 2 Age-specific rates of Aboriginal and Torres Strait Islander people in Statistical Area Level 4 within Greater Adelaide

Figure generated using ABS Census 2021 data presented as Statistical Area Level 4 data (4-7).

The area with the greatest proportion of Aboriginal and Torres Strait Islander people, Adelaide North, has the youngest age structure with median age being 22 (Figure 2: 54.4% of the total population is 24 or younger) (5). This is followed by Adelaide South with the median age being 22, and 54.1% of the population being 24 or younger (6). The median age of Aboriginal and Torres Strait Islander people in Adelaide West was 25 with 48.3% being 24 or younger (7). In Adelaide Central and Hills the median age was 26 (4).

The median age of Aboriginal and Torres Strait Islander people compared to the median age of all persons in Greater Adelaide is presented by SA4 regions in Figure 3. A younger median age in any population is an indicator of lower life expectancy. The median age of Aboriginal and Torres Strait Islander people across the Adelaide PHN SA4 regions ranged from 22 to 26 years, which compared to non-Indigenous Australians is a difference of 15 to 19 years (Figure 3). This younger median age is likely to be impacted by an array of health inequities, steaming from the ongoing colonisation, such as transgenerational trauma and grief and other chronic and complex conditions. The age difference needs to be considered when planning for service delivery.

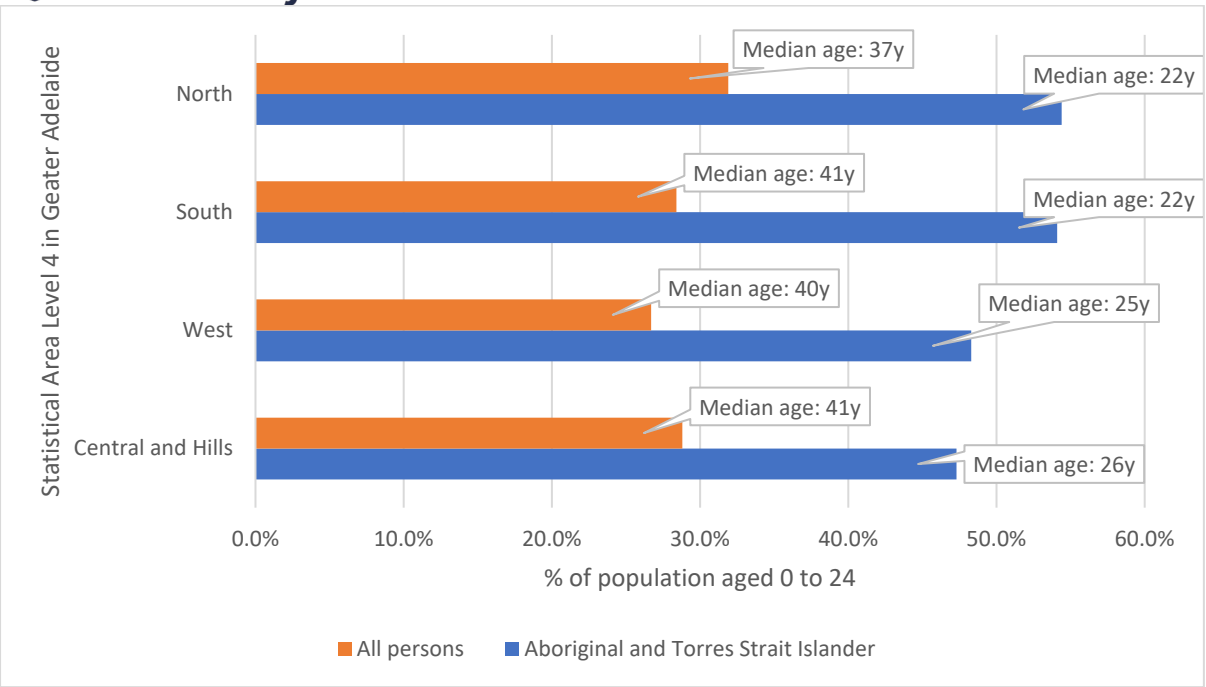

Figure 3 Proportion of young people (aged 24 and under) in Aboriginal and Torres Strait Islander people compared to proportion of young people in all people living in Greater Adelaide

Figure generated using ABS Census 2021 data presented as Statistical Area Level 4 data (4-7).

1.4.2 Place of residence

Across Greater Adelaide Aboriginal and Torres Strait Islander families reside in a range of locations. The LGAs with the highest percentage of Aboriginal and Torres Strait Islander peoples included Playford (4.2% of Local Government Area, LGA), Port Adelaide Enfield (2.5% of LGA), Salisbury (2.4% of LGA), Onkaparinga (1.9% of LGA), and Charles Sturt (1.6% of LGA)(Table 4) (3).

Table 4 Count and percentage of total Aboriginal and Torres Strait Islander South Australian population, and percentage of total Local Government Area (LGA) population (3)

2021 LGAs	Count of Aboriginal and Torres Strait Islander people	% Of the Aboriginal and Torres Strait Islander state (SA) population	% of the total LGA population
Playford	4,210	9.9	4.2
Salisbury	3,480	8.2	2.4
Onkaparinga	3,369	7.9	1.9
Port Adelaide Enfield	3,295	7.7	2.5
Charles Sturt	2,005	4.7	1.6

Based on place of usual residence. Excludes overseas visitors.

Source: Australian Bureau of Statistics, South Australia: Aboriginal and Torres Strait Islander population summary (3)

1.4.3 Housing

Highlights

The median household income has doubled for Aboriginal and Torres Strait Islander people in South Australia in the last decade.

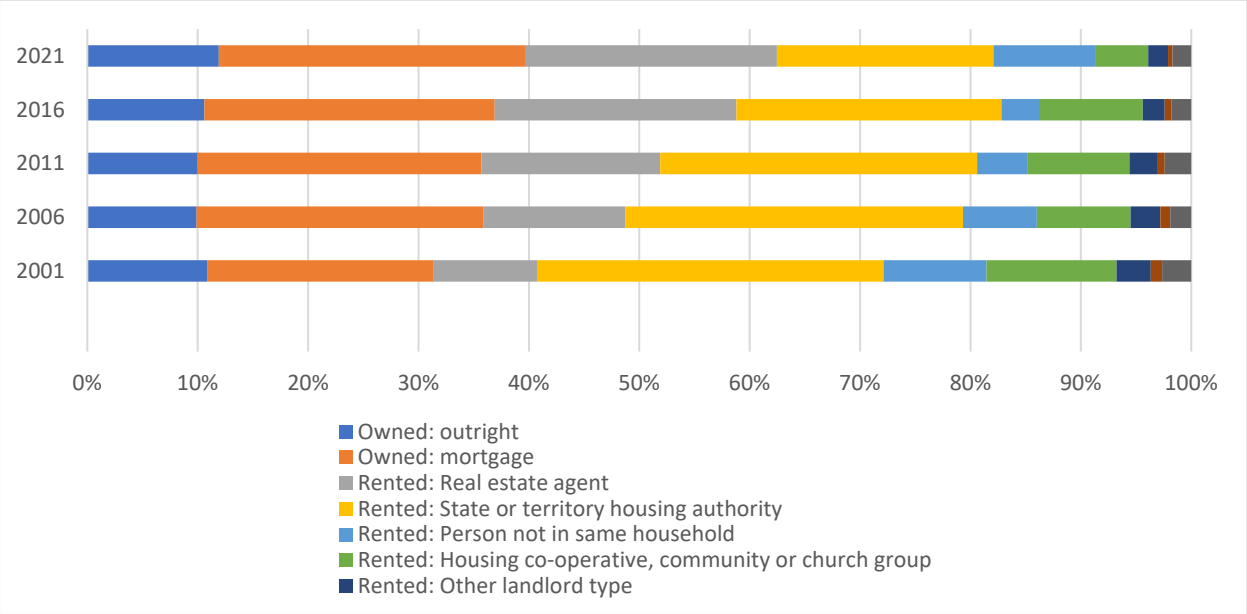

Figure 4 Tenure and landlord type in South Australia for Aboriginal and Torres Strait Islander Households

Source: ABS (12)

Tenure and Landlord type for housing in the Aboriginal and Torres Strait Islander people living in South Australia from 2001 to 2021 is presented in Figure 4. The proportion of Aboriginal and Torres Strait Islander households owning a home either outright or through mortgage has steadily increased over the last 10 years from 31.4% in 2001 to 39.6% in 2021. There has also been a steady increase in private rentals over this same period 9.4% in 2001 to 22.8% in 2021, and a decrease in social housing 31.4% in 2001 to 19.6% in 2016.

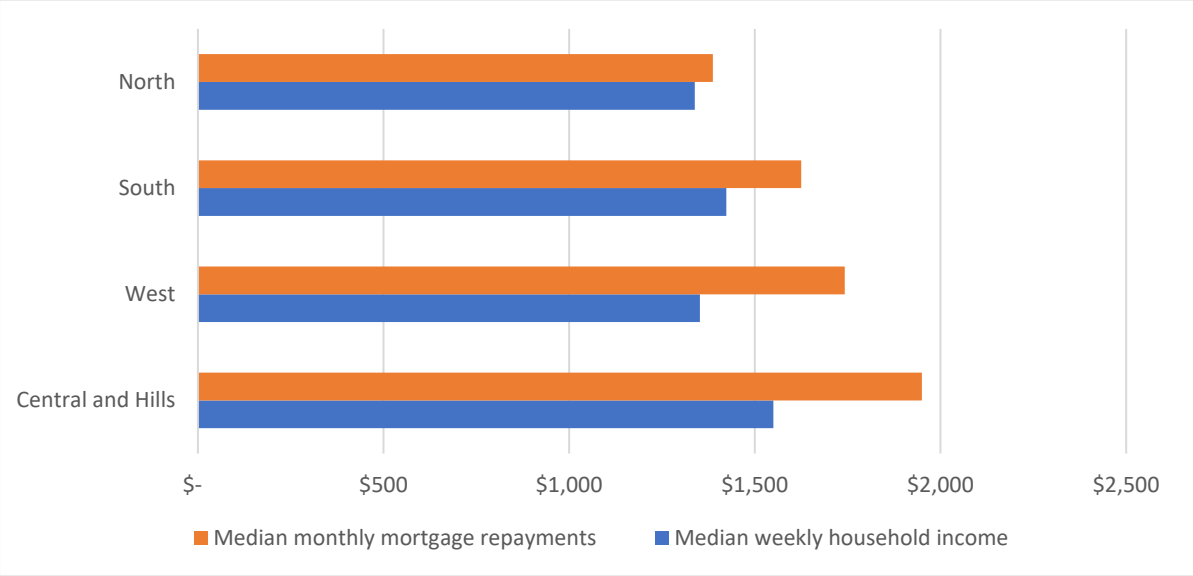

Figure 5 Median weekly household income and median monthly mortgage repayments in Aboriginal and Torres Strait Islander families

Figure generated using ABS Census 2021 data presented as Statistical Area Level 4 data (4-7).

The median South Australian weekly household income for Aboriginal and Torres Strait Islander households is presented in Figure 5. The median household income has doubled in the last 10 years, from $292 in 2001 to $716 in 2021 (12). The highest median household income was for Aboriginal and Torres Strait Islander households in SA who owned their home with a mortgage at $779 a week (12). The median in a major city was $719 from 2017-19 (13). Nationally the median monthly mortgage repayment was $1,721 and median weekly rent was $300 in 2021 (12).

Median income varied by $85 weekly across Adelaide North (SA4)($1338) and Adelaide South (SA4)($1423) (5). Similarly, median mortgage repayments varied by $238 from Adelaide North ($1387) and Adelaide South $1625, along with a $20 in median weekly rental Adelaide North($285) Adelaide South ($305) (5, 6).

Variations existed across the housing marked with between 9% to 12.7% on Aboriginal and Torres Strait Islander households reporting owning their house outright (Adelaide North 9%, Adelaide South 9%, Adelaide Central and Hills 12.7%, Adelaide West 9.1%). Owning with a mortgage varied from 24.7% to 33.1% (Adelaide North 29.9%, Adelaide South 33.1%, Adelaide Central and Hills 24.7%, Adelaide West 22.5%). Rental varied from 52.4% to 64.8% across Adelaide (Adelaide North 57.7%, Adelaide South 52.4%, Adelaide Central and Hills 59.7%, Adelaide West 64.8%) (4, 7).

1.4.4 Socioeconomic status

No SEIFA data has been published in ABS for Census 2021 data at the time of the synthesis of this needs assessment.

1.4.5 Education

Completion of year 12 or equivalent is a national priority under the Closing the Gap (CTG) targets to allow Aboriginal and Torres Strait Islander children achieve their full learning potential (14). Completion rates have steadily been increasing from 45.4% in 2006 to 63.2% in 2016 nationally, for

South Australia 39.5% in 2006 to 61.4% in 2016. There is no new data since baseline reporting in 2016, however the trajectory for 2021 is 74.1% of completions at this level. In Adelaide North (SA4), 75.4% of the Aboriginal and Torres Strait Islander people have reported to be attending or have completed up to high school, which is greater than the 2021 trajectory of 74.1%(5).

Completing a tertiary education (Certificate III of higher) for Aboriginal and Torres Strait Islander peoples 25-35 years is a national CTG priority (15). Nationally trends have increased from 25.9% in 2006 to 42.3% in 2012, and in South Australia from 23.6% in 2006 up to 39.8% in 2016, Data from 2016 on tertiary education completions is yet to be reported on the productivity commission on the CTG information repository, however the trajectory target for 2021 was 51.5% (16). Enrolment rates in South Australia for Aboriginal and Torres Strait Islander students continue to rise (170 in 2010 to 296 in 2020), with slight decreases in attrition rates (26.7% in 2016 to 22.9% in 2019)(16). Comparing tertiary education attendance or completions, Adelaide Central and Hills (SA4) had the greatest level at 26%, with Adelaide North reporting 11.7%, which is well below the national trajectory target of 51.5% (4, 5). While completion of year 12 or equivalent is meeting national trajectory areas, further programs are needed to assist transition into and completion of tertiary education.

1.4.6 Income, Employment and Work

Inequities in income were evident between Aboriginal and Torres Strait Islander people to all Australians (which includes Aboriginal and Torres Strait Islander peoples) living in the same region, such as at SA4 level, in state level (South Australia) and country wide (Australia) (see Figure 6).

In Adelaide North, the median weekly income for Aboriginal and Torres Strait Islander individuals above 15 years was $538, as a family level $1350, with median household level being $1338 (5). Over half (56%) of Aboriginal and Torres Strait Islander participants reported doing unpaid domestic work, including 28.2% providing unpaid care for children and 14.7% reported unpaid caring assistance for an individual with a disability, health condition or due to old age and 8.4% reported doing voluntary work through an organisation or group (5). It is likely that this unpaid work is underestimated given the vast array of community groups, organisations and associations specifically connected to an individual's community they volunteer for i.e. Native Title, Family Days, NAIDOC week.

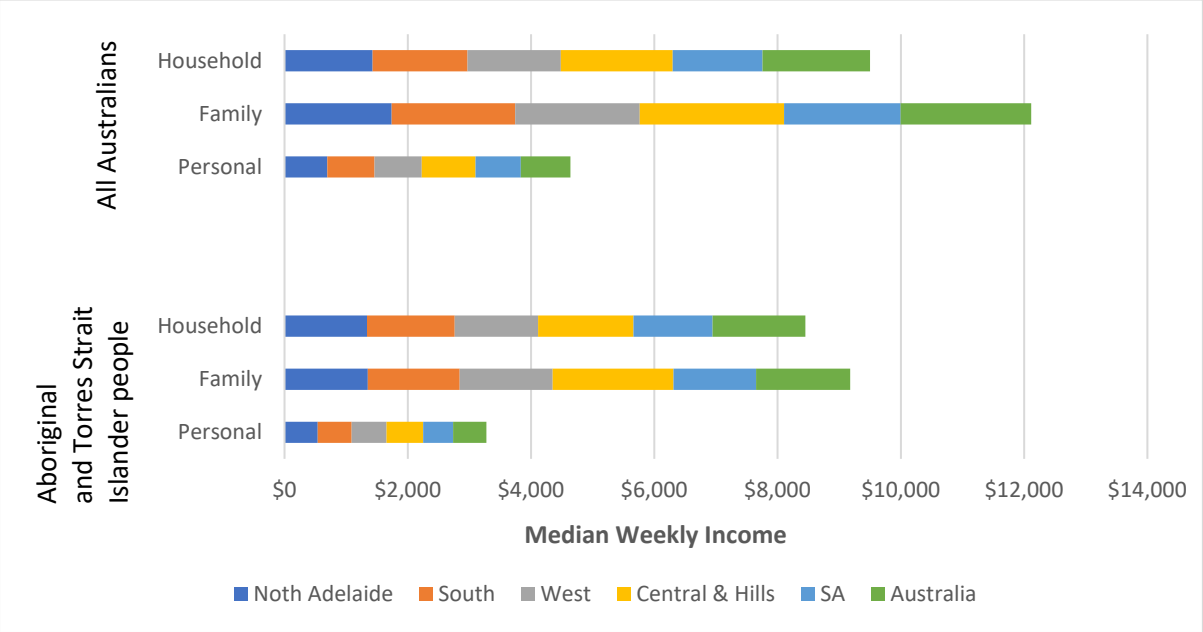

Figure 6 Median Weekly Income for all aged 15 and over, for Aboriginal and Torres Strait Islander people and for all Australians

Figure generated using ABS Census 2021 data presented as Statistical Area Level 4 data (4-7).

In Adelaide South, the median weekly income for Aboriginal and Torres Strait Islander individuals above 15 years was similar at $550, at a family level it was $1491, and household level was $1423 (6). Well over half (65.4%) of Aboriginal and Torres Strait Islander people reported doing unpaid domestic work, 30% reported providing unpaid care for children, 15% reported providing unpaid caring assistance to another person and 12.6% reported doing voluntary work through an organisation or group (6).

In Adelaide West, 57.8% of Aboriginal and Torres Strait Islander individuals reported doing unpaid domestic work, 23.8% provided unpaid care to children, 14.4% provided unpaid caring assistance to a person in need and 11.8% did voluntary work through an organisation or a group.

1.5 Multiple Dimensions of Life

Highlights

The multiple dimensions of life for Aboriginal and Torres Strait Islander people cover 5 key dimensions: physical, psychological, social, cultural and spiritual.

Health and wellbeing is a balance and harmony between 'mind, body, spirit and nature' for Aboriginal and Torres Strait Islander individuals (17). These dimensions, the balance and harmony they require are described eloquently through the work of Professor Helen Milroy a Palyku child and adolescent psychiatrist (18). Each single dimension is multilayered, intricate, and interconnected. The cultural determinants of health and wellbeing for Aboriginal and Torres Strait Islander people interact across these dimensions acting as protective factors for balance and harmony, whereas

ongoing colonisation, racism and whiteness threatens the integrity of these dimensions (18). In this next section data has been drawn to highlight these dimensions in the Adelaide PHN area.

1.5.1 Physical Dimension

Connection to country and kin is essential in providing Aboriginal and Torres Strait Islander individuals with strength, ground and protection for their identity (18). Figure 7 (connectedness to country) shows that over 60% of Aboriginal and Torres Strait Islander people identify with a clan or language group, with around 76% of respondents recognising their homelands, which is greater than the national average of 74% (18). In addition, approximately 55% of South Australian respondents are able to visit their homelands or traditional lands, which is greater than the national average for Aboriginal and Torres Strait Islander peoples (Figure 8). However, we find that less Aboriginal and Torres Strait Islander people in South Australia live on their homelands or traditional lands, which is reflective of ongoing colonisation impacts in South Australia on Aboriginal and Torres Strait Islander peoples.

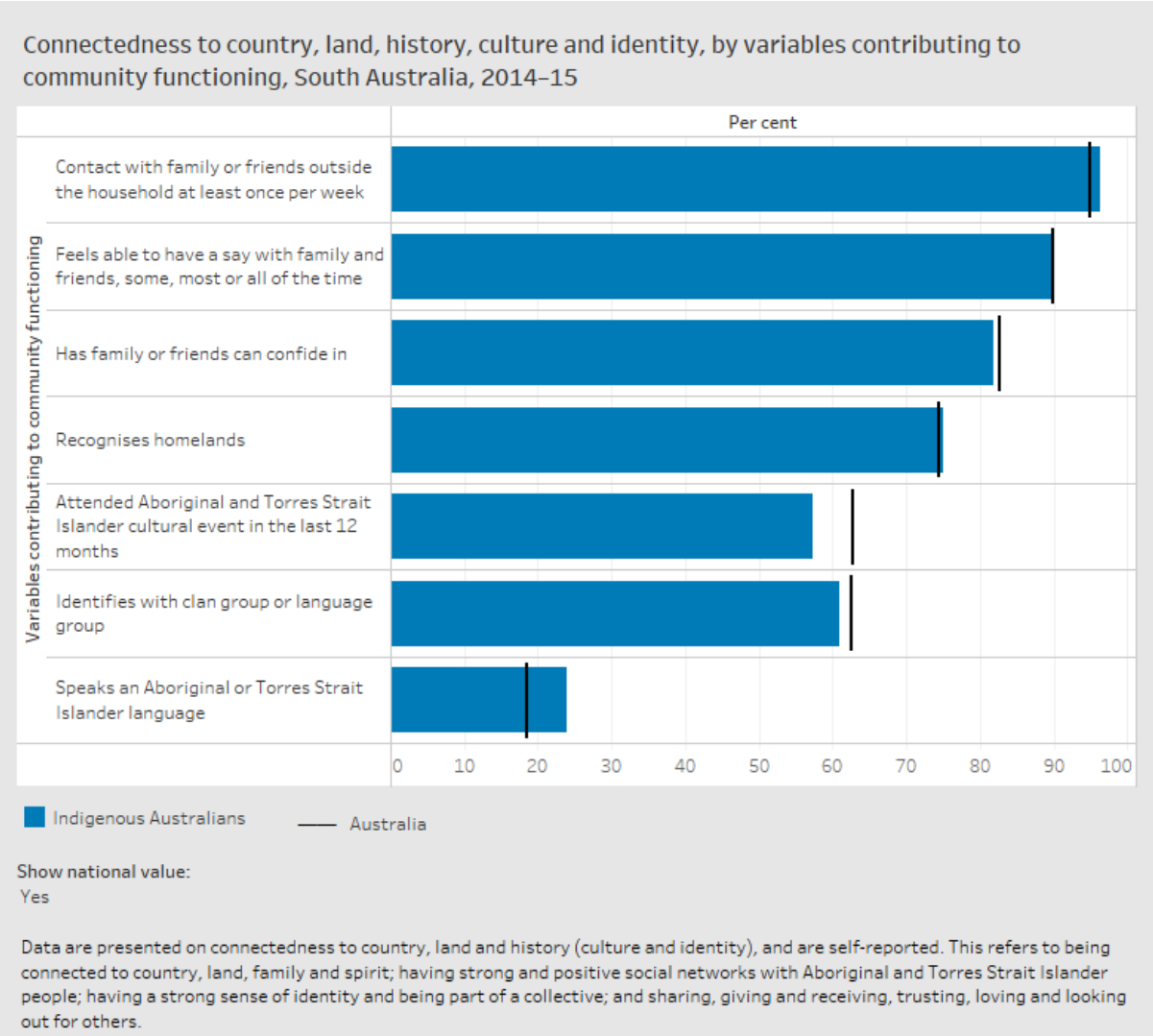

Figure 7 Connected to country, land, history, culture and identity, by variables contributing to community functioning in Aboriginal and Torres Strait Islander people in

South Australia versus Aboriginal and Torres Strait Islander people across Australia, 2014-15(19)

Source: AIHW 2020. Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (19)

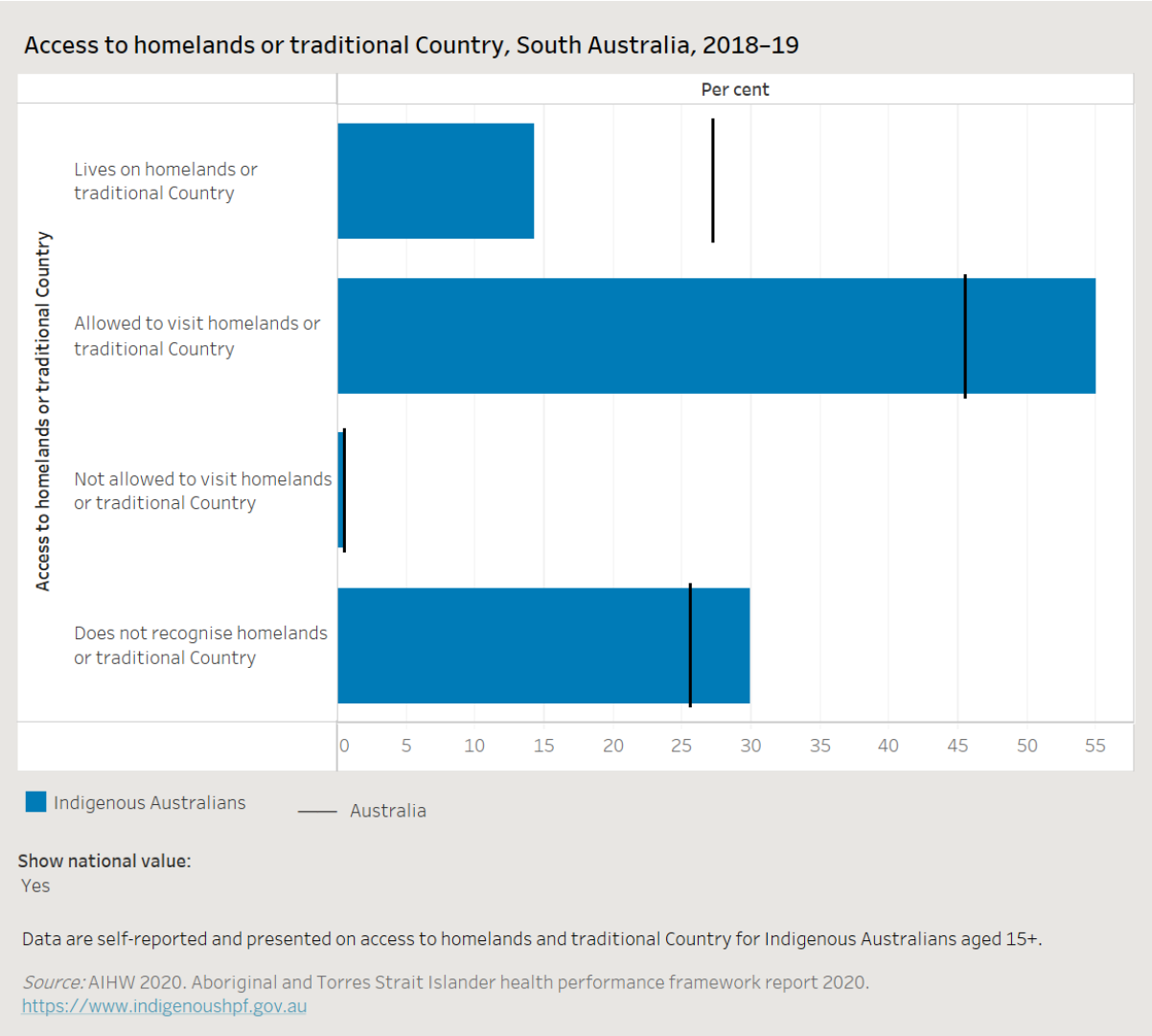

Figure 8 Access to homelands or traditional Country, South Australia, 2018-19

Source: AIHW 2020. Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (19)

1.5.2 Psychological Dimension

This dimension relates to the interconnectedness of kinship relationships, connection, obligations, responsibilities and reciprocity all in the context on one's culture and identity (18, 20). Central to this is connection to knowledge holders and teachers – Elders, senior community representatives and kin. This is critically important for children over their life course for identity development,

approximately 44% of Aboriginal children reported spending time with an Aboriginal Elder or senior community representative in the past week, 96% of Aboriginal children had participated in informal learning and teaching activities with their main carer (19).

Strong family connection and cohesion was evident (Figure 7) with over 90% of Aboriginal and Torres Strait Islander people in SA reporting contact with family and friends weekly, 90% having a say on family business and 82% of the Aboriginal and Torres Strait Islander people reported feeling they were able to confide in someone outside of the household (19). However, only 57% of Aboriginal and Torres Strait Islander people in SA reported being able to attend a cultural event in the last 12 months, which was below the national average (Figure 7).

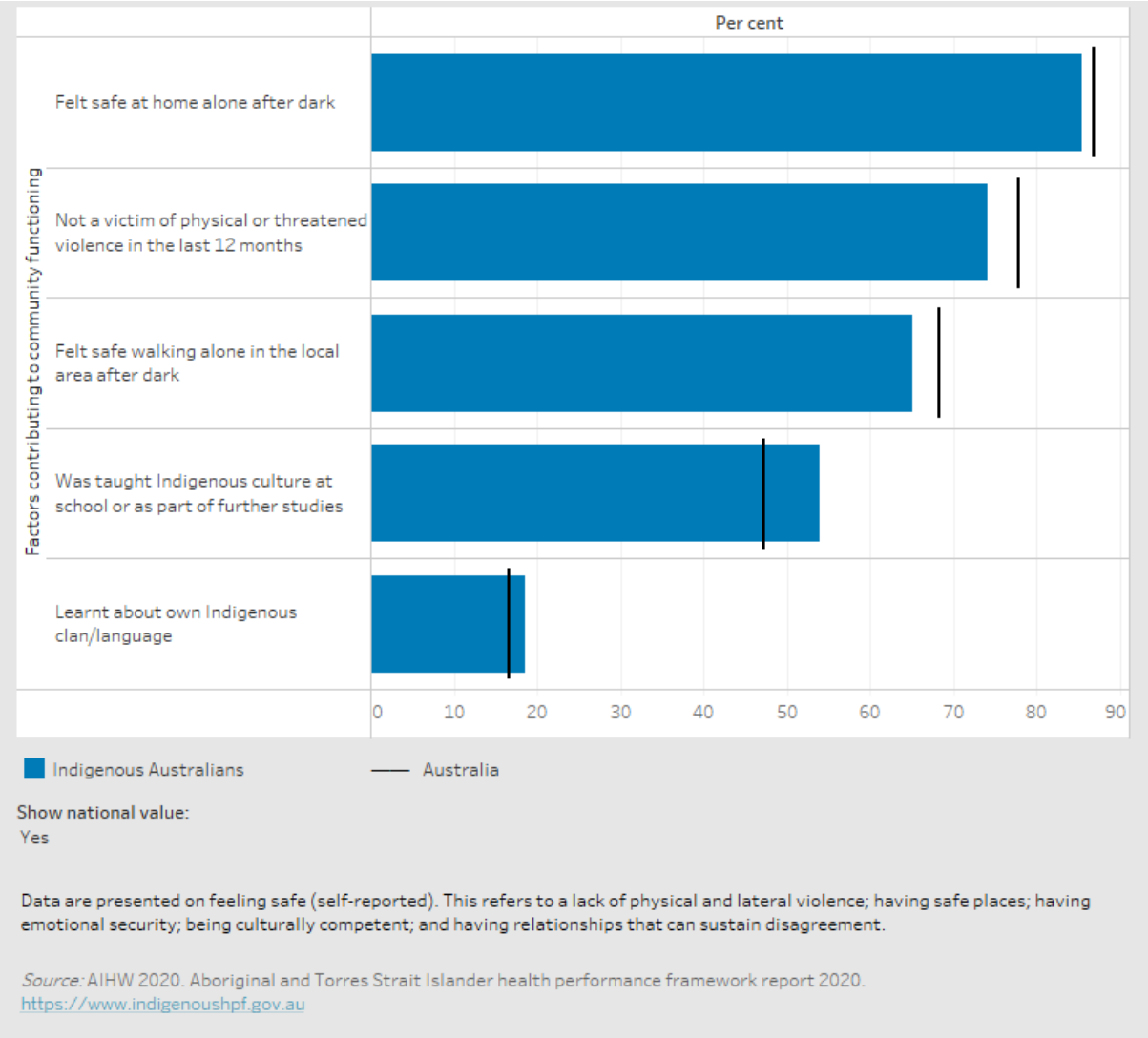

Figure 9 Feeling safe by Aboriginal and Torres Strait Islander people in South Australia versus Aboriginal and Torres Strait Islander people across Australia, 2014-15

Source: AIHW 2020. Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (19)

Feeling safe, culturally and emotionally secure and not being a victim of physical or threatened violence in the last 12 months was reported in 65% of Aboriginal and Torres Strait Islander respondents in South Australia and was below the national average, over 75% of respondents were not exposed to actions of this nature in the last 12 months (19).

1.5.3 Social Dimension

Family encompasses vast kinship networks, which are essential for identity development and passing of knowledge (18, 20). Beyond the individual the social dimension is essential for community cohesion and business. Reporting for Aboriginal and Torres Strait Islander families and household composition currently fails to encompass these important networks and is a short coming. Feedback from the Council in this area identified that there was no recognition of true family structure, in recognising the role of extended family and the pivotal role that grandparents play in caring for children. This section has focussed on household composition as defined by the ABS, a full list and explanation of ABS categories of family household composition can be found from ABS website (21).

In Adelaide there was variability in households where at least 1 person identified as Aboriginal and/or Torres Strait Islander (Table 6). One family households, consisting of one parent were the most common household type (Adelaide North: 31.9%, Adelaide South 27.4%, Adelaide West 26.8%, Adelaide Central and Hills 24.7%), followed by one family households with a couple and children (Adelaide North: 27.4%, Adelaide South 27.7%, Adelaide West 22.0%, Adelaide Central and Hills 24.7%) (4-7, 21). Other households were also common, where other included three or more family household, lone person, group, visitor only, or household with only persons under 15 years (21).

Table 5 Adelaide households with at least 1 Aboriginal and/or Torres Strait Islander person according to Statistical Area Level 4

Household with at least 1 Aboriginal and/Torres Strait Islander person	Adelaide North		Adelaide South		Adelaide West		Adelaide Central and Hills	
	Count	%	Count	%	Count	%	Count	%
One family household: Couple family with no children	738	13.7	466	16.6	347	14.9	272	20.8
One family household: Couple family with children	1,474	27.4	778	27.7	512	22.0	323	24.7
One family household: One parent family	1,718	31.9	771	27.4	624	26.8	232	17.7
One family household: Other family	117	2.2	60	2.1	71	3.0	19	1.5
Other household	1,345	25.1	731	26.1	765	32.8	22	1.6

Table generated using ABS Census 2021 data (4-7, 21). Column totals can be greater than 100 due to rounding.

1.5.4 Cultural Dimension

Culture includes connection and identity, in the 2021 census ancestry data was collected, the most common self-report Ancestry by Aboriginal and Torres Strait Islander respondents is provided in Table 6. Respondents could select more than one option in the census, which is why other ancestry is present. This information contains pertinent information on how Aboriginal and Torres Strait Islander respondents classify their Ancestry and consider their identity. The predominant Ancestry response was Aboriginal across all regions. Torres Strait Islander Ancestry included: South Australia 3.1%, Adelaide West 4.2%, Adelaide South – not reported (small numbers), Adelaide North 3.4%, Adelaide Central and Hills 5.4% (7).

Culture is grounded in country, where connection, identity and healing come from (18). The ability to engage and practice culture is central to health and wellbeing of the whole community. Language use is households is an example of connecting and practicing culture in this dimension, it was reported to be steadily decreasing over 1991-2016 (Figure 9). While English is the most reported language used in Aboriginal and Torres Strait Islander households in Adelaide and reflective of colonisation in Australia, 10.1% of households report Indigenous language use at home with 5.2% of households reporting Pitjanjatjara use (Table 4).

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Table 6 Ancestry top responses in Aboriginal and Torres Strait Islander people, self-reported in Census 2021

Ancestry, top responses in Aboriginal and Torres Strait Islander people	Adelaide - North		Adelaide - South		Adelaide - West		Adelaide - Central and Hills		South Australia		Australia	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Australian Aboriginal	9,964	87.4	4,748	88.2	4,052	88.7	1,993	82.7	37,097	87.2	695,359	85.6
Australian	4,027	35.3	2,098	39	1,501	32.9	816	33.8	13,750	32.3	277,467	34.1
English	2,195	19.3	1,112	20.6	767	16.8	525	21.8	7,433	17.5	131,618	16.2
Irish	394	3.5	224	4.2	-	-	136	5.6	1,451	3.4	31,853	3.9
Scottish	-	-	232	4.3	167	3.7	-	-	1,312	3.1	24,549	3
Torres Strait Islander	388	3.4	-	-	192	4.2	130	5.4	1,372	3.2	57,353	7.1

Table generated using ABS Census 2021 data (4-7, 21). Column totals can be greater than 100 due to rounding.

Table generated using ABS 2021 Census data(4-7). Nil = numbers not reported in ABS QuickStats. Total is not 100%, due to non-responders or ABS not reporting in Quickstats. Total can be more than 100% due to rounding up at different levels, and responders providing multiple responses.

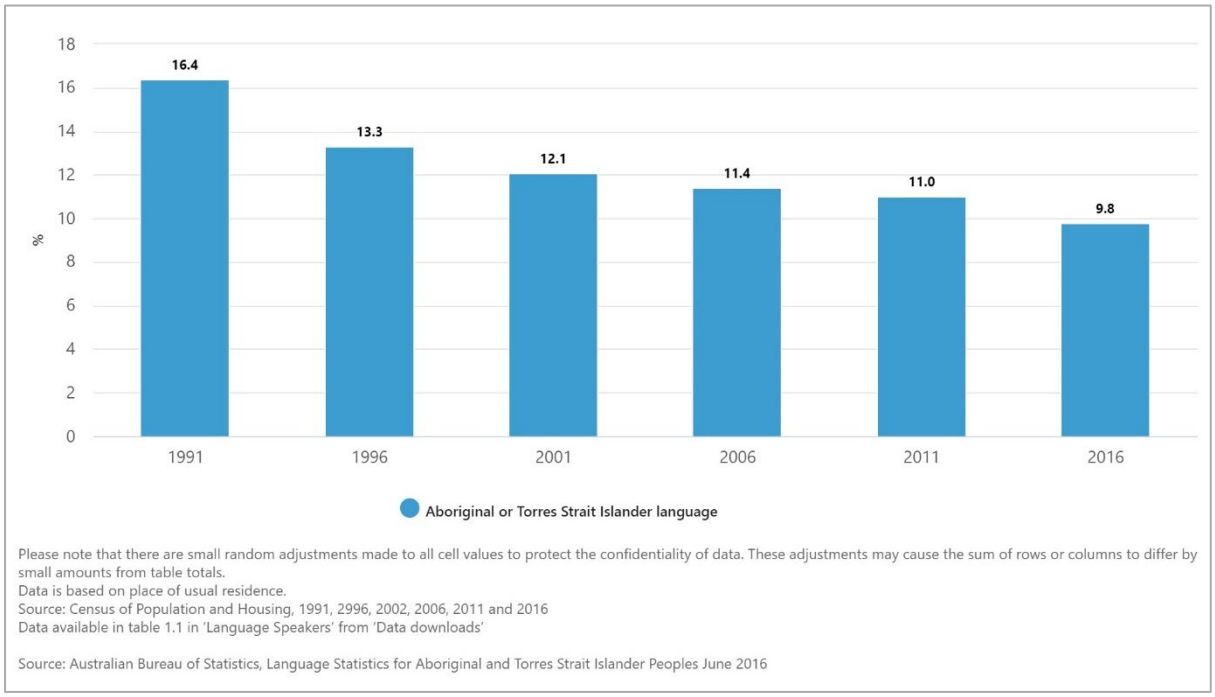

Figure 9 Aboriginal and Torres Strait Islander person who spoke an Aboriginal or Torres Strait Islander language at home, 1991 – 2016

Source: ABS data Language Statistics for Aboriginal and Torres Strait Islander Peoples June 2016

Across the greater Adelaide region some variation was exhibited in this cultural dimension. In Adelaide North, 5.6% of Aboriginal and Torres Strait Islander households reported language use at home, with Ngarrindjeri, Pitjantjatjara, Kaurna, Adnymathanha most common (5). In Adelaide South Ngarrindjeri, Pitjantjatjara, Kaurna were the most common language spoken at home, in 5.8% of Aboriginal and Torres Strait Islander households (6). The greatest level of language use for Aboriginal and Torres Strait Islander households was in Adelaide West at 9.6% of across Ngarrindjeri, Pitjantjatjara, Kaurna, Yolngu Matha languages (7). In Adelaide Central and Hills, 7.9% of Aboriginal and Torres Strait Islander households reported language use at home, with Ngarrindjeri, Pitjantjatjara, Kaurna being most common (4).

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Table 7 Australian Indigenous language used at home: top responses by Aboriginal and Torres Strait Islander people

Australian Indigenous language	Adelaide - North		Adelaide - South		Adelaide - West		Adelaide - Central and Hills		South Australia		Australia	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Aboriginal English, so described	-	-	9	0.2	-	-	-	-	77	0.2	1371	0.2
Adnymathanha	28	0.2	-	-	-	-	-	-	236	0.6	254	0.0
Australian Indigenous languages used at home	396	3.5	185	3.4	255	5.6	115	4.8	4,305	10.1	76,978	9.5
Australian Indigenous Languages, nfd	50	0.4	32	0.6	55	1.2	27	1.1	345	0.8	4,197	0.5
English only used at home	10,148	89.0	4,941	91.7	3,987	87.3	2,087	86.6	35,095	82.5	6,83,122	84.1
Kaurna	46	0.4	28	0.5	23	0.5	-	-	98	0.2	3,399	0.4
Mirning	-	-	-	-	-	-	6	0.2	10	0.0	13	0.0
Narungga	-	-	-	-	16	0.4	-	-	78	0.2	94	0.0
Ngarrindjeri	84	0.7	45	0.8	69	1.5	21	0.9	402	0.9	451	0.1
Pitjantjatjara	46	0.4	18	0.3	18	0.4	16	0.7	2,211	5.2	3,399	0.4
Yolngu Matha, nfd	-	-	-	-	-	-	5	0.2	12	0.0	1,718	0.2
Total	**10,798**	**94.6**	**5,258**	**97.5**	**4,423**	**96.9**	**2,277**	**94.5**	**42,869**	**100.7**	**7,74,996**	**95.4**

Nfd = not further defined. Table generated using ABS 2021 Census data(4-7). Nil = numbers not reported in ABS QuickStats. Total is not 100%, due to non-responders or ABS not reporting in Quickstats. Total can be more than 100% due to rounding up at different levels.

1.5.5 Spiritual Dimension

Aboriginal people are spiritual beings, part of the oldest continuing civilisations, where knowing doing and being plays a central role in spirituality (13, 14). Central to this dimension is Indigenous knowledges (knowing, being and doing), and encompasses dreaming teachings and ceremony, belonging, connectivity, beliefs and holistic healing as connected to country (13, 14, 18). Ongoing colonisation has acted to create spiritual genocide, which has impacted all Aboriginal and Torres Strait Islander families in the Adelaide PHN (13, 14). What has ensued in this process, through the resilience of Aboriginal and Torres Strait Islander peoples is a multi-dimensionality to spirituality and identity for some individuals, in part through interaction with other cultures and knowledge systems, through religion or health and healing (18). It is noted that there was limited reporting for this dimension across data sources. Feedback from community consultations with the Council reported a lack on emphasis of recovery and good news stories in this area.

> *"Holistic services guided by the social determinants of health … desire to seek alternate ways of treating people / alternative medications / practices".*

2 Outcome of Analysis – identified need, key issues and description of evidence

2.1 Self-reported health status and health literacy

Highlights

Over half of Aboriginal and Torres Strait Islander people across all SA4 regions in Adelaide reported no long-term health condition.

ABS Census 2021 asked people about long term health conditions as told to them by a doctor or nurse. The collected data represents those who sought medical treatments from doctors or nurses, those aware of their long-term conditions and those willing to report their long-term conditions in Census. Long-term health conditions reported by Aboriginal and Torres Strait Islander people living in South Australia is presented in Figure 10. Of note, mental health condition was more commonly reported by women (women vs men: 17.3% vs 11.6%), while long-term health condition was most often not reported by men (women vs men: 10.6% vs 8.7%). There was no data for individuals who identified their gender outside of male or female.

The Council recognised the difference in health literacy by gender and made several gender specific recommendations were made such as:

- Separate men's health and women's health days
- Male advocates for men's health
- More support for LGBTQI+

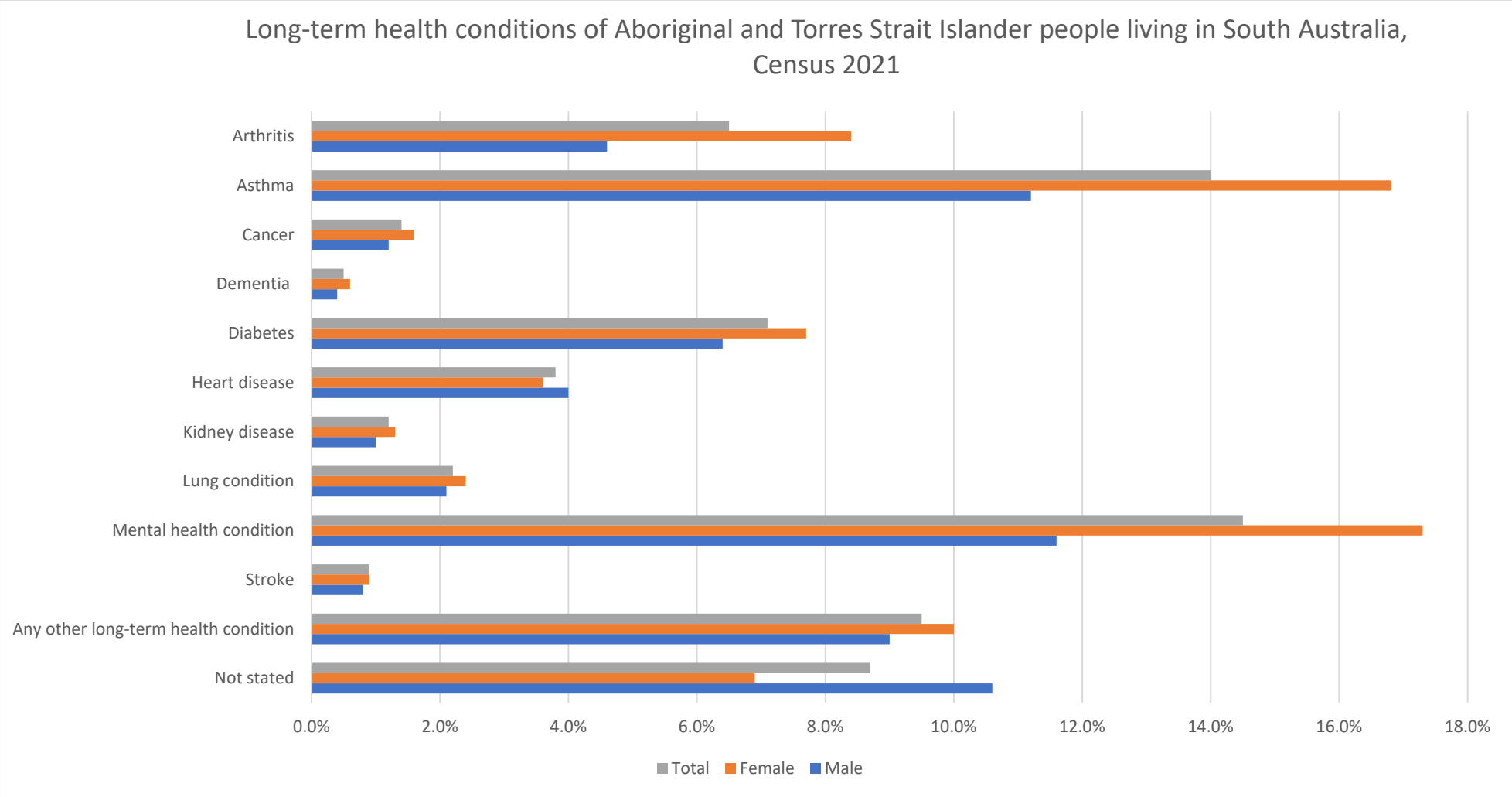

Figure 10 Long-term health conditions of Aboriginal and Torres Strait Islander people living in South Australia, Census 2021

Source: Australian Bureau of Statistics, South Australia: Aboriginal and Torres Strait Islander population summary (3)

Cancer includes remission, Dementia includes Alzheimer's, Diabetes does not include gestational diabetes, heart disease includes heart attack or angina, Lung condition includes COPD or emphysema, Mental health condition includes depression or anxiety. Table represents the number of people who reported that they have been told by a doctor or nurse that they have any of these long-term health conditions. Respondents had the option of reporting multiple long-term health conditions. Therefore, the sum of all long-term health condition responses for an area will not equal the total number of people in the area. Calculated percentages represent a proportion of the number of Aboriginal and Torres Strait Islander people in the area (including those who did not answer the long-term health conditions question).

List of long-term conditions reported by the Aboriginal and Torres Strait Islander people living in Adelaide by SA4 is reported in Table 8. In Adelaide North, 51.9% of the Aboriginal and Torres Strait Islander people reported no long-term health conditions, 16.8% reported asthma, another 16.8% reported a mental health condition, 6.2% reported diabetes and 3.4% reported heart disease (5). At least one long term condition was reported by a little over one in five, or 22.3% of the Aboriginal and Torres Strait Islander population in Adelaide North (5).

In Adelaide South, 55.1% of the Aboriginal and Torres Strait Islander people reported no long term health conditions, while 14.4% reported asthma, 17.9% reported a mental health condition, 5.1% diabetes and 3.1% reported a heart condition (6).

In Adelaide Central and Hills, 54.9% reported no long-term health condition, 13.0% asthma, 17.3% reported a mental health condition, 5.6% reported arthritis, 5.2% reported diabetes and 3.5% reported a heart disease. Of those who reported having a long term health condition 21.7% reported having one, 7.2% reported two, and 3.7% reported three or more long term health conditions (4).

In Adelaide West, 56.3% reported no long term health conditions while 14.4% reported suffering from asthma, 15.9% had mental health conditions, 6.9% had arthritis, 3.8% had a heart disease and 2.3% reported a lung condition (7). Of those individual who reported a long terms health condition 22.5% reported having one, 7.2% reported two conditions and 5% reported three or more conditions (7).

Overall, mental health condition was the most commonly reported long-term health condition, followed by Asthma, then diabetes, followed by heart disease.

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Table 8 Long-term health condition reported by the Aboriginal and Torres Strait Islander people in Adelaide by SA4

Type of long-term health condition	Adelaide - North		Adelaide - South		Adelaide - West		Adelaide - Central and Hills		South Australia		Australia	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Arthritis	814	7.1	360	6.7	316	6.9	136	5.6	2,770	6.5	50,807	6.3
Asthma	1,913	16.8	773	14.4	658	14.4	313	13.0	5,965	14.0	107,162	13.2
Cancer	138	1.2	95	1.8	81	1.8	36	1.5	603	1.4	12,927	1.6
Dementia	76	0.7	23	0.4	23	0.5	9	0.4	218	0.5	3,610	0.4
Diabetes	711	6.2	275	5.1	319	7.0	126	5.2	3,001	7.1	47,688	5.9
Heart disease	391	3.4	168	3.1	175	3.8	85	3.5	1,611	3.8	30,160	3.7
Kidney disease	118	1.0	49	0.9	57	1.2	25	1.0	497	1.2	10,053	1.2
Lung condition	264	2.3	124	2.3	107	2.3	55	2.3	951	2.2	17,552	2.2
Mental health condition	1,912	16.8	965	17.9	724	15.9	417	17.3	6,156	14.5	107,776	13.3
Stroke	96	0.8	50	0.9	50	1.1	16	0.7	363	0.9	7,059	0.9
Any other long-term health condition(s)	1,220	10.7	644	12.0	402	8.8	243	10.1	4,048	9.5	70,592	8.7
No long-term health condition(s)	5,920	51.9	2,968	55.1	2,573	56.3	1,324	54.9	23,215	54.5	462,348	56.9

Cancer includes remission, Dementia includes Alzheimer's, Diabetes does not include gestational diabetes, Heart disease includes heart attack or angina, Lung condition includes COPD or emphysema, Mental health condition includes depression or anxiety. Table represents the number of people who reported that they have been told by a doctor or nurse that they have any of these long-term health conditions. Respondents had the option of reporting multiple long-term health conditions. Therefore, the sum of all long-term health condition responses for an area will not equal the total number of people in the area. Calculated percentages represent a proportion of the number of Aboriginal and Torres Strait Islander people in the area (including those who did not answer the long-term health conditions question).

Table generated using ABS 2021 Census data(4-7). Nil = numbers not reported in ABS QuickStats. Total is not 100%, due to non-responders or ABS not reporting in Quickstats. Total can be more than 100% due to rounding up at different levels.

2.2 Risk factors and health behaviours

2.2.1 Risky alcohol consumption and other substance use

Nearly half of Aboriginal and Torres Strait Islander South Australians have self-reported engaging in risky alcohol consumption at least once in the last 12 months (22). Aboriginal and Torres Strait Islander people in non-remote South Australian were slightly more likely to report risky alcohol engagement, compared to those living in remote SA (Figure 11: 45.9% vs 44.6%, age standardised), but this rate was lower than the national rate (53.5%) reported by Aboriginal and Torres Strait Islander people. The NACCHO supports Australian guidelines to reduce health risk from drinking alcohol (23).

- Guideline 1: healthy men and women should consume no more than 10 standard drinks a week and no more than 4 standard drinks a day.
- Guideline 2: anyone under the age of 18 years should not consume alcohol.
- Guideline 3: women who are pregnant or breastfeeding should not consume alcohol.

Nationally 18% of Aboriginal and Torres Strait Islander individuals have reported exceeding these guidelines. Males (male vs females: 28% vs 10%, no non-binary data) and those living in non-remote Australia (non-remote vs remote: 19% vs 16%) self-reported to have exceeded these guidelines. Hospitalisation from a primary diagnosis of alcohol use was higher in remote South Australia compared to non-remote (19.9 per 1,000 vs 10.8 per 1000)(22).

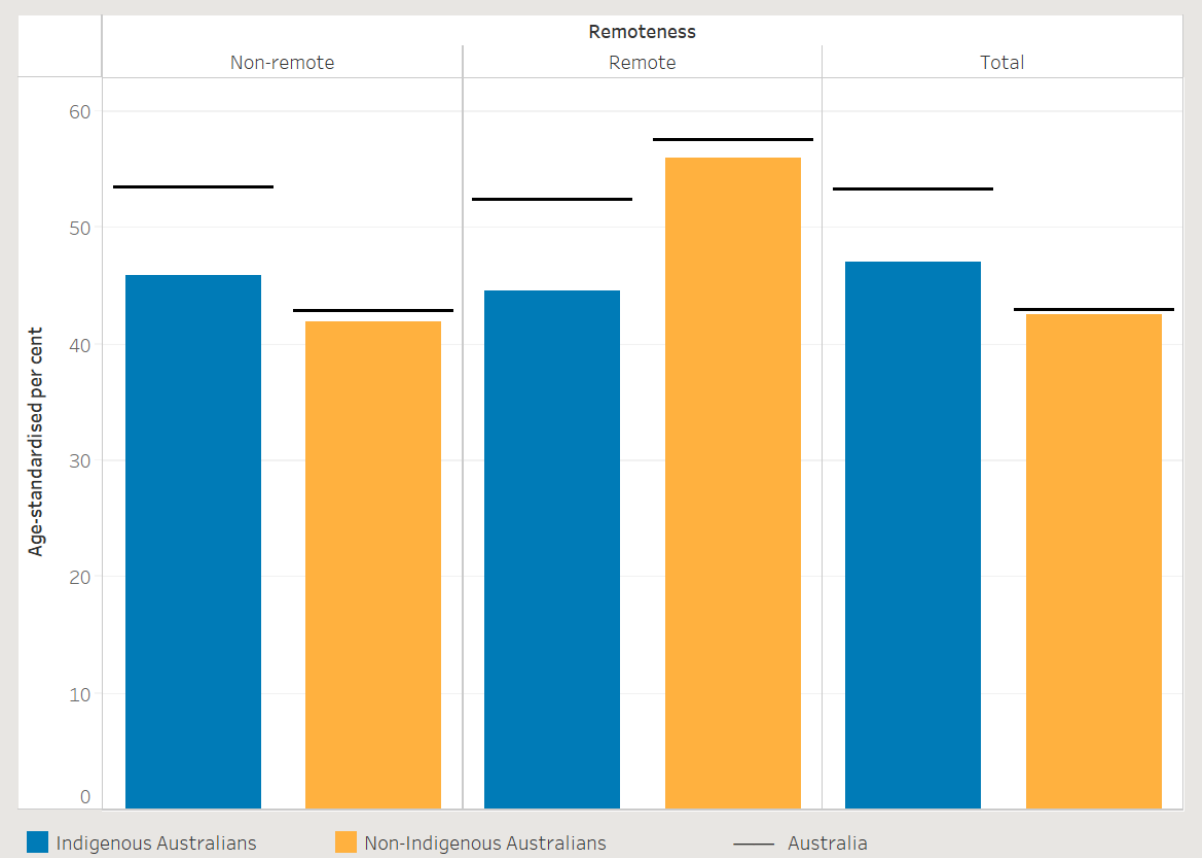


Figure 11 Self-reported risky alcohol consumption, by remoteness, South Australia, 2018–19

Source: AIHW 2020. Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

2.2.2 Smoking

Over a decade ago in Aboriginal and Torres Strait Islander communities, smoking was identified as the leading modifiable risk factor for disease burden and the gap in disease burden between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians (24). Breaking the smoking cycle in Aboriginal and Torres Strait Islander communities has the potential to improve the health inequity gap in life expectancy (24).

Current smokers are those who smoke daily, those who smoke at least once a week but not daily, and those who smoke less than weekly (25). In 2018-19, a lower proportion of Aboriginal and Torres Strait Islander people (age 15+) living in South Australia compared to the Indigenous people living in all of Australia reported currently smoking (36.9% vs 40.5%, not age-standardised) (Table D2.15.1)(24). Of note, this reflects an improvement from the self-reported current smoking rate by the South Australian Aboriginal and Torres Strait Islander people in 2014-15 (40.6% to 36.9% in 2018-19) (Table D2.15.1)(24).

In absolute numbers, 10,198 Aboriginal and Torres Strait Islander individuals from South Australia self-identified to be currently smoking in 2018-19, and 5,419 or 52.9% have reported to attempt to quit smoking in the last 12 months prior to the survey (Table D2.15.10)(24). Nationally for Aboriginal and Torres Strait Islander communities' education, employment and income remain to have a strong association with smoking prevalence, with self-reported non-smokers more likely to have completed Year 12 (72%), be employed (67%) and be in the highest income quintile (78%)(24). When comparing smoking trends and changes according to remoteness of the areas, it becomes apparent that the reduction in smoking rates in Aboriginal and Torres Strait Islander people was driven by mainly a reduction in the non-remote areas (Figure 11).

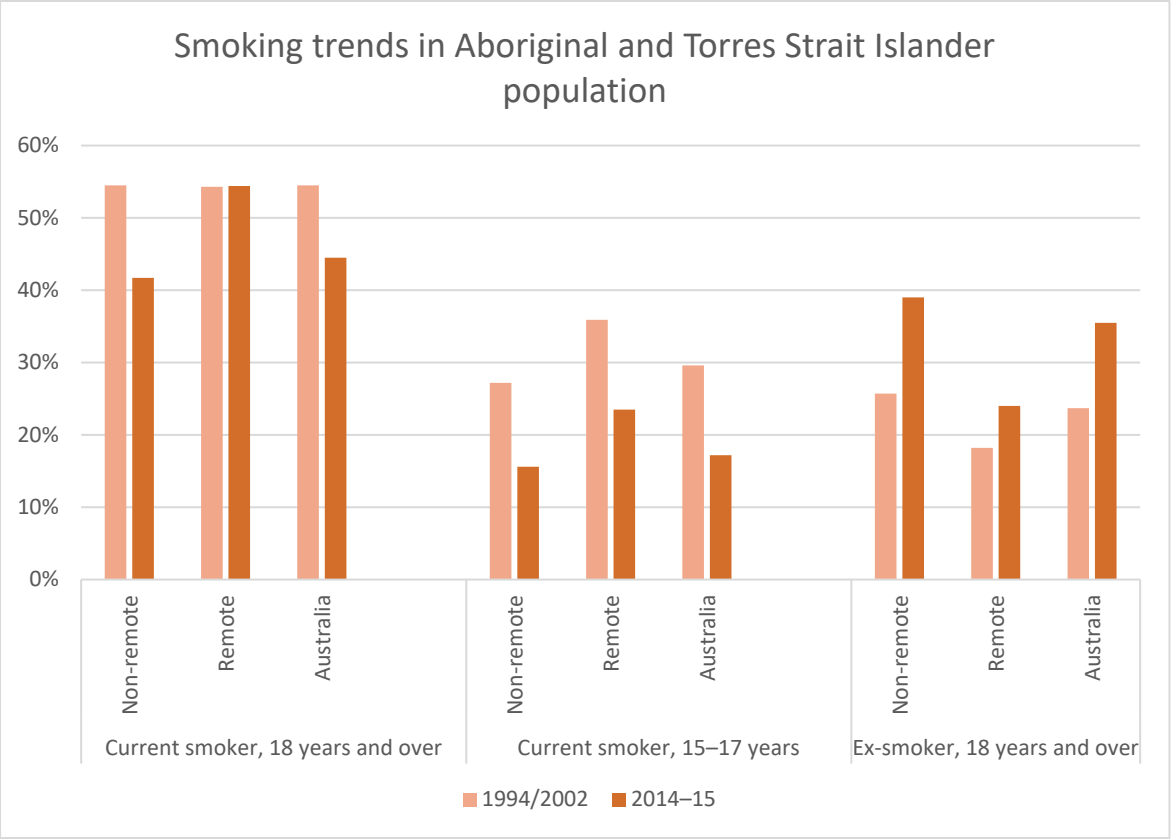


Figure 12 Smoking trends, Aboriginal and Torres Strait Islander population, selected years

Figure generated using ABS data (26)

Decreases in smoking over the last five years in the non-remote areas provides optimism in working towards decreasing disease burden for Aboriginal and Torres Strait Islander communities. Targeted community intervention programs across the life course, such as PUYU Basters, are likely to be part of this emerging change in the non-remote areas (27, 28).

2.2.3 Food security

Highlights

The Port Adelaide Council (SA3) Support for those Living on Low Income program, partners with organisations to provide access to free or low-cost food, household goods and activities working to create Food Security and decrease homelessness (29)

Food security occurs when Aboriginal and Torres Strait Islander families have physical, social and economic access to sustainable, nutritional and affordable food and remains an important issue for Aboriginal and Torres Strait Islander communities nationally. Concerns of food security have been reported in Aboriginal and Torres Strait Islander peoples in South Australia who maybe unemployed or in rental accommodation (30). Most of the literature on food Security in Aboriginal and Torres Strait Islander communities in Australia is focussed on those living in rural and remote setting,

despite the fact that more Aboriginal and Torres Strait Islander peoples reside in metropolitan settings. This is a limitation in the literature and a comprehensive picture of food security in the Adelaide PHN was not possible to be provided.

2.2.4 Obesity

In Adelaide, 4 in 5 or 79.8% Aboriginal and Torres Strait Islander people aged 18 are reported to be overweight or obese in 2018-19 (31). This rate is similar to the national level across major cities in Australia of 79.5% (31). Of the Aboriginal and Torres Strait Islander people who reported being overweight or obese, 51.3% reported being a current smoker and half (50%) also reported high to very high levels of psychological distress (31).

2.2.5 Dietary behaviour

A healthy and balanced diet has been linked to a range of positive health outcomes, such as the prevention or a delay in developing metabolic syndrome or diabetes mellites. Dietary risk factors have been found to contribute to the total disease burden for Aboriginal and Torres Strait Islander communities (32). The National Health and Medical Research Councils (NHMRC) recommended guidelines for vegetable and fruit intake include (33), 2 serves of fruit for those aged 9 and over and 5-6 serves of vegetables for those aged 9 and over. In relation to these set national guidelines, just above 10% of Aboriginal and Torres Strait Islander children in South Australia meet the NHMRC vegetable intake guidelines, an around 40% meet the fruit intake guidelines, with both being above the national average in this area (33).

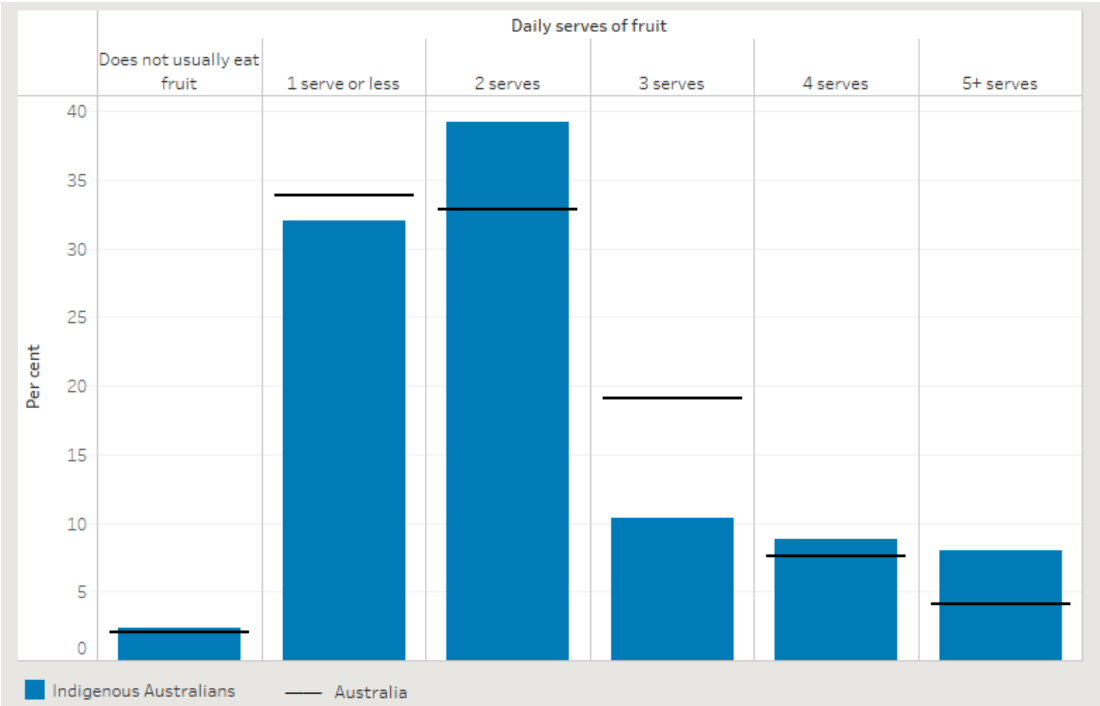


Figure 13 Daily serves of fruit consumed by Aboriginal and Torres Strait Islander people versus other Australians

Source: AIHW 2020. Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (33)

Implications from these outcomes have suggested that effort is needed to improve intake of fruit and vegetables to be in line with the NHMRC guidelines (33). However challenging factors exist in this area given the scare literature on food security for non-rural residing Aboriginal and Torres Strait Islander individuals. Additionally Indigenous knowledges surrounding dietary intake are not considered with in these studies, which is also a missing element within this area for the Adelaide PHN region.

To improve the dietary habits in Aboriginal and Torres Strait Islander people in Adelaide, the Council recommended Strength based co-design concepts such as healthy eating programs and cooking classes incorporating culture and bush tucker with traditional nutritionist and dietician working alongside traditional food bush workers.

2.2.6 Life course health conditions

Oral, ear and eye health conditions are focused on in this area.

2.2.6.1 Ear health

Nationally Aboriginal and Torres Strait Islander peoples aged 7 and over had measured hearing loss in one or both ears (34). With 4 in 5 of Aboriginal and Torres Strait Islander individuals who had measured hearing loss did not report having long term hearing loss (34). In South Australia reported ear and hearing problems in Aboriginal and Torres Strait Islander people was higher than the national rate (18.8% vs 17.3%), and also when compared to non-Indigenous Australians (18.8% vs 13.8%)(32).

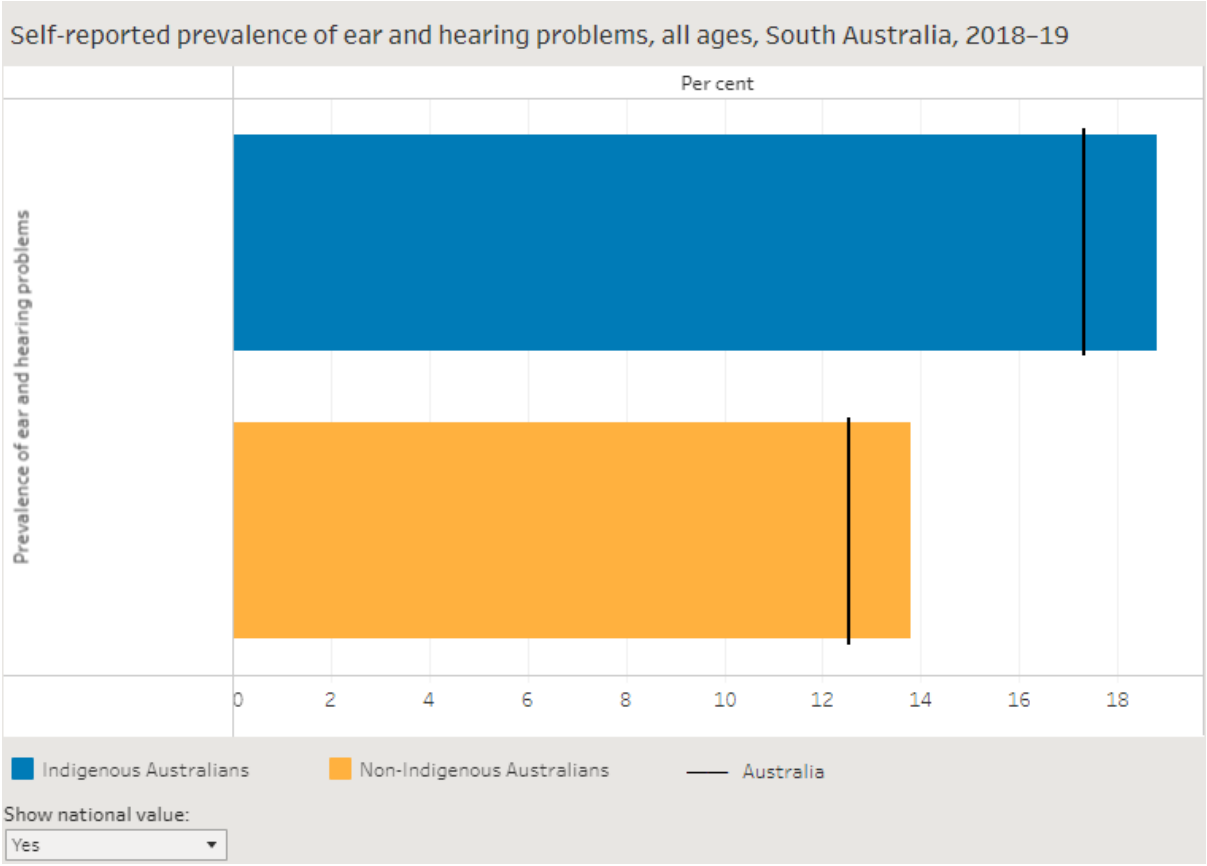


Figure 14 Self-reported ear and hearing problems by Indigenous Status, South Australia, 2018-19

Source: AIHW 2020. Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

2.2.7 Oral health

In South Australia, 5.5% Aboriginal and Torres Strait Islander people aged 15 and over reported complete tooth loss in 2018-2019, which is comparable to the national rate of 5.9% in Aboriginal and Torres Strait Islander individuals. More non-remote Aboriginal and Torres Strait Islander South Australians reported dental problems compared to individuals in remote areas (6.3% vs 2.7%) (35).

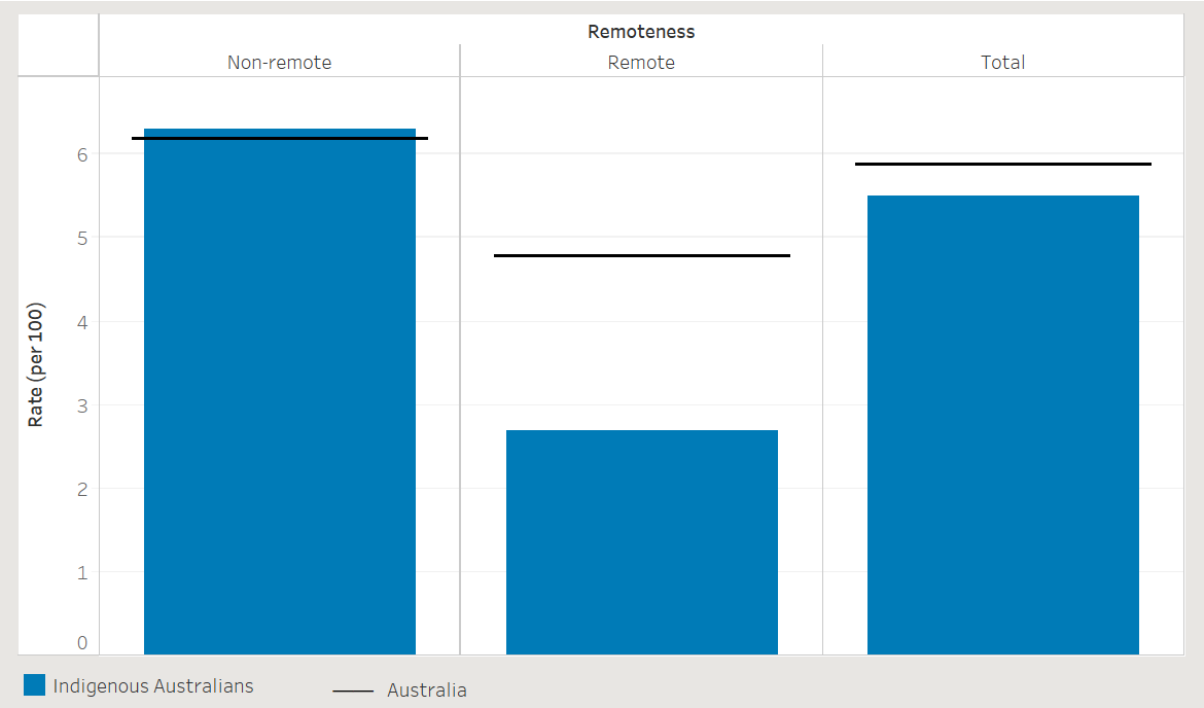


Figure 15 Dental problems, persons of ages 15+ reporting complete tooth loss, by remoteness, South Australia, 2018–19

Source: AIHW 2020. Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (35)

2.2.7.1 Eye health

Highlights

The majority of vision impairment and blindness in Aboriginal and Torres Strait Islander communities is preventable or reversable.

Vision impairment was reported in 2 out of 5 Aboriginal and Torres Strait Islander people reported eye or sight problems in 2018-19 nationally (36). With the prevalence of vision impairment being three time greater in Aboriginal and Torres Strait Islander communities than non-Indigenous communities nationally (37). The National Eye Health Survey (2016) reports that, "90% of vision impairment and blindness amongst Aboriginal and Torres Strait Islander peoples is preventable or treatable", the key causes of vision impairment are uncorrected refractive error (63.4%) and cataracts (20.2%). In 2019-20 a total of 82,211 eye examinations were conducted with Aboriginal and Torres Strait Islander patients nationally (38). Significant progress has been made in decreasing trachoma in Aboriginal and Torres Strait Islander children with the number of communities at risk of trachoma decreasing from 205 in 2008 to 65 in 2020. In South Australia there has been a slight decline in Aboriginal and Torres Strait Islander patients with diabetes having an eye health check from 45% in 2017-18 to 42% in 2019-20, these figures may have been impacted by the COVID-19 pandemic (37). While nationally cataract surgeries have increased for Aboriginal and Torres Strait Islander patients, weight times are still inequitable with Aboriginal and Torres Strait Islander patients having a median weight time of 124 days as compared to 82 days for non-Indigenous Australians for 2018/19 (37).

2.3 Indigenous health checks

Highlights

The 'Ways of Thinking, Ways of Doing' is an example of how cultural respect has been embedded into routing daily clinical practice in South Western Sydney, with a key focus on cultural mentors in the clinical environment.

Indigenous health checks are intended to ensure regular and comprehensive health checks for the Aboriginal and Torres Strait Islander people and play an important role in preventative Primary Health Care. The Indigenous Health Check involves an assessment of the patient's physical, psychological and social wellbeing (39). The check can be used as an opportunity to provide brief interventions for a range of health behaviours. It can also assess what education, allied health care, preventive health care and other services can be offered to the Indigenous patients (39). The health checks can be claimed every 9 months. Patients in the community are eligible for Medicare Benefits Schedule (MBS) Items 228 and 715, while patients in Aged Care Facilities are eligible for MBS items 93470 and 93479. Furthermore, MBS telehealth items (92004, 92011, 92016, 92023) were introduced in March 2020, in response to COVID-19 and associated restrictions (40).

2.3.1 Total Indigenous health checks

During the last priority setting workshop, the Aboriginal Health Priority Group (41) emphasised the need to improve Indigenous health checks for adults and children (42). The most recent Adelaide PHN Needs Assessment for Aboriginal and Torres Strait Islander people ranked all PHNs according to the proportion of Indigenous Health Checks completed, and Adelaide PHN was found to be at 21 out of all 31 PHNs (42). Analysis of the most recent MBS data for the current Needs Assessment shows (43) that the Adelaide PHN has not improved in its position from 21 out of 31 (Figure 16). Only 1 out of 5 people or 21% of Aboriginal and Torres Strait Islander people in Adelaide have received at least one Indigenous health check in the last financial year. In South Australia it can be speculated that COVID-19 and COVID-19 related health behaviours has impacted on these results. During the last financial year many restrictions were still in place regarding healthcare access, and a strong emphasis being placed on COVID-19 vaccinations prior to the easing of restrictions.

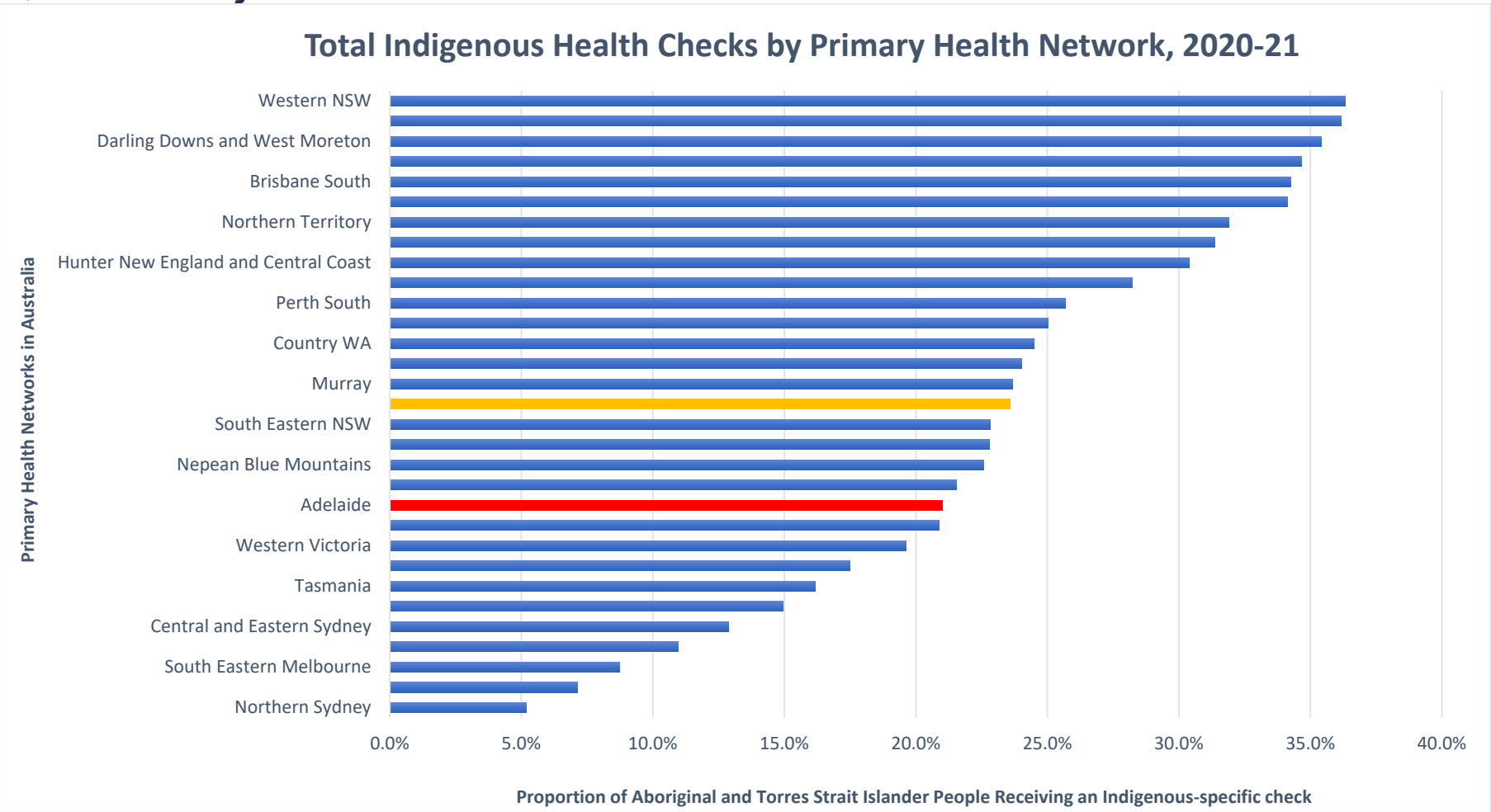


Figure 16 Total Indigenous Health Checks by Primary Health Network, 2020-21

Figure generated from extracted data in the AIHW analysis of Indigenous Health Checks and Follow Up data tables (43).

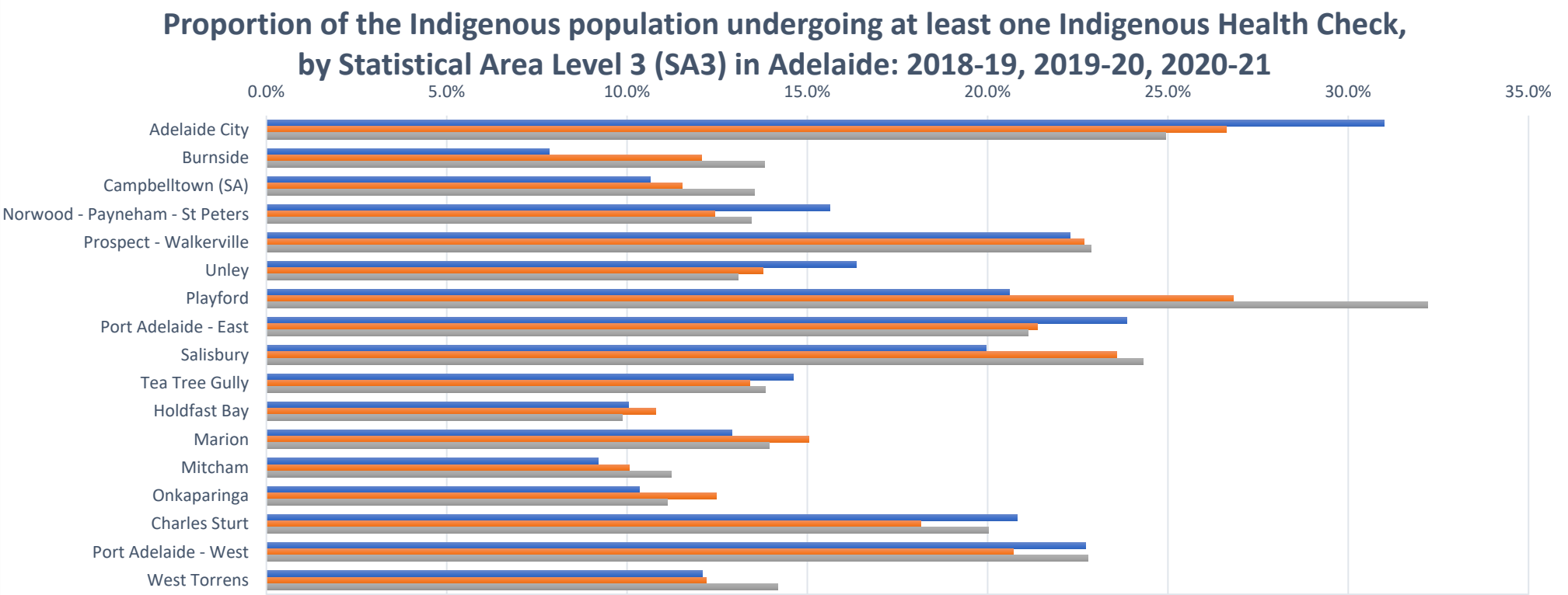
The proportion of Aboriginal and Torres Strait Islander individuals undergoing at least one Indigenous health check (either telehealth or face-to-face) varied across SA3 regions in Adelaide. There was also yearly variation between the financial years of 2018-19 (pre-pandemic), 2019-20 and 2020-21 (See Table 9). The proportion of the population undergoing at least one Indigenous Health Checks is presented in Figure 16.

Table 9 Face to face, Telehealth and Total Indigenous Health Checks Adelaide SA3 regions over three financial years

		2018-19		2019-20		2020-21	
SA3 Name	**Telehealth status**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Adelaide City	**Total**	**129**	**31.0%**	**114**	**26.6%**	**111**	**24.9%**
	Face-to-face	129	31.0%	110	25.5%	106	23.8%
	Telehealth			-	-	-	-
Burnside	**Total**	**14**	**7.8%**	**21**	**12.1%**	**25**	**13.8%**
	Face-to-face	14	7.8%	21	11.6%	25	13.8%
	Telehealth			-	-	-	-
Campbelltown (SA)	**Total**	**39**	**10.6%**	**43**	**11.5%**	**52**	**13.5%**
	Face-to-face	39	10.6%	42	11.1%	50	13.0%
	Telehealth			-	-	-	-
Norwood - Payneham - St Peters	**Total**	**44**	**15.6%**	**35**	**12.4%**	**39**	**13.4%**
	Face-to-face	44	15.6%	35	12.4%	37	12.8%
	Telehealth	-	-	-	-	-	-
Prospect - Walkerville	**Total**	**62**	**22.3%**	**65**	**22.7%**	**67**	**22.9%**
	Face-to-face	62	22.3%	65	22.7%	60	20.5%
	Telehealth	-	-	-	-	-	-
Unley	**Total**	**34**	**16.4%**	**29**	**13.8%**	**28**	**13.1%**
	Face-to-face	34	16.4%	28	13.1%	28	13.1%
	Telehealth	-	-	-	-	-	-
Playford	**Total**	**864**	**20.6%**	**1,154**	**26.8%**	**1,421**	**32.2%**
	Face-to-face	864	20.6%	1,093	25.4%	1,032	23.4%
	Telehealth			72	1.7%	418	9.5%
Port Adelaide - East	**Total**	**436**	**23.9%**	**401**	**21.4%**	**406**	**21.1%**
	Face-to-face	436	23.9%	389	20.7%	363	18.9%
	Telehealth			14	0.7%	45	2.3%

Salisbury	**Total**	**704**	**19.9%**	**851**	**23.6%**	**892**	**24.3%**
	Face-to-face	704	19.9%	775	21.5%	746	20.3%
	Telehealth			82	2.3%	158	4.3%
Tea Tree Gully	**Total**	**162**	**14.6%**	**152**	**13.4%**	**159**	**13.8%**
	Face-to-face	162	14.6%	145	12.8%	145	12.6%
	Telehealth	-	-	7	0.6%	13	1.1%
Holdfast Bay	**Total**	**31**	**10.0%**	**34**	**10.8%**	**32**	**9.9%**
	Face-to-face	31	10.0%	33	10.2%	30	9.3%
	Telehealth	-	-	-	-	-	-
Marion	**Total**	**176**	**12.9%**	**210**	**15.0%**	**199**	**13.9%**
	Face-to-face	176	12.9%	197	14.1%	177	12.4%
	Telehealth	-	-	15	1.0%	23	1.6%
Mitcham	**Total**	**40**	**9.2%**	**45**	**10.1%**	**51**	**11.2%**
	Face-to-face	40	9.2%	44	9.8%	46	10.1%
	Telehealth	-	-	-	-	-	-
Onkaparinga	**Total**	**350**	**10.4%**	**431**	**12.5%**	**391**	**11.1%**
	Face-to-face	350	10.4%	413	12.0%	375	10.7%
	Telehealth	-	-	18	0.5%	17	0.5%
Charles Sturt	**Total**	**435**	**20.8%**	**389**	**18.1%**	**439**	**20.0%**
	Face-to-face	435	20.8%	377	17.6%	413	18.8%
	Telehealth	-	-	14	0.7%	28	1.3%
Port Adelaide - West	**Total**	**470**	**22.7%**	**439**	**20.7%**	**491**	**22.8%**
	Face-to-face	470	22.7%	424	20.0%	459	21.3%
	Telehealth			18	0.8%	34	1.6%
West Torrens	**Total**	**93**	**12.1%**	**96**	**12.2%**	**114**	**14.2%**
	Face-to-face	93	12.1%	93	11.8%	108	13.4%
	Telehealth	-	-	-	-	6	0.7%

Table generated from extracted data in the datatables of Indigenous Health Checks and Follow ups (43). Some numbers are not published due to small numbers. Per cent is proportion of the Aboriginal and Torres Strait Islander people undergoing at least 1 Indigenous Health Check as a proportion of the Aboriginal and Torres Strait Islander population in the specified SA3 region.



	West Torrens	Port Adelaide - West	Charles Sturt	Onkaparinga	Mitcham	Marion	Holdfast Bay	Tea Tree Gully	Salisbury	Port Adelaide - East	Playford	Unley	Prospect - Walkerville	Norwood - Payneham - St Peters	Campbelltown (SA)	Burnside	Adelaide City
2018–19	12.1%	22.7%	20.8%	10.4%	9.2%	12.9%	10.0%	14.6%	19.9%	23.9%	20.6%	16.4%	22.3%	15.6%	10.6%	7.8%	31.0%
2019–20	12.2%	20.7%	18.1%	12.5%	10.1%	15.0%	10.8%	13.4%	23.6%	21.4%	26.8%	13.8%	22.7%	12.4%	11.5%	12.1%	26.6%
2020–21	14.2%	22.8%	20.0%	11.1%	11.2%	13.9%	9.9%	13.8%	24.3%	21.1%	32.2%	13.1%	22.9%	13.4%	13.5%	13.8%	24.9%

Figure 17 Proportion of the Indigenous population undergoing at least one Indigenous Health Check, by Statistical Area Level 3 (SA3) in Adelaide: 2018-19, 2019-20, 2020-21

Figure generated from extracted data in the datatables of Indigenous Health Checks and Follow ups (43).

There were observable site-specific patterns in the Indigenous Health Check rates across the SA3 regions, such as Playford and Burnside saw a steady increase over the years (Playford: 20.6% to 32.2%, Burnside: 7.8% to 13.8%), despite COVID-19. The Indigenous Health Checks in Adelaide city had a steady decline (31.0% to 24.1%), while the indigenous Health Check rates in some areas consistently low. When the Council were asked about the site-specific rate differences, the feedback was that the Aboriginal and Torres Strait Islander people can be transient when searching for a health care provider and reputation is a big factor in deciding which site is accessed for healthcare needs.

2.3.2 Indigenous health checks by age categories

Analysis of data shows Aboriginal and Torres Strait Islander people in South Australian above 55 years were most likely to receive an Indigenous Health Check (31.5%), followed by those in the 0 to 4 age category (24.1%) (Figure 18). The higher numbers in the older (age 55+) Aboriginal and Torres Strait Islander people could be due to the Closing the Gap co-payment program, for individuals who have or are at risk of developing a chronic condition. Indigenous Health Checks are built into vaccination appointments and follow up as part of Child and Health Services, which is likely to contribute to higher rates in the 0-4 years age category. When the MBS categories are broken down to face to face (MBS items 715, 228) and telehealth (92004, 92011, 92016, 92023), the pattern continued for those receiving face to face Indigenous Health checks, and the telehealth Indigenous Health Check rate was 3% and below for all age categories (Figure 18).

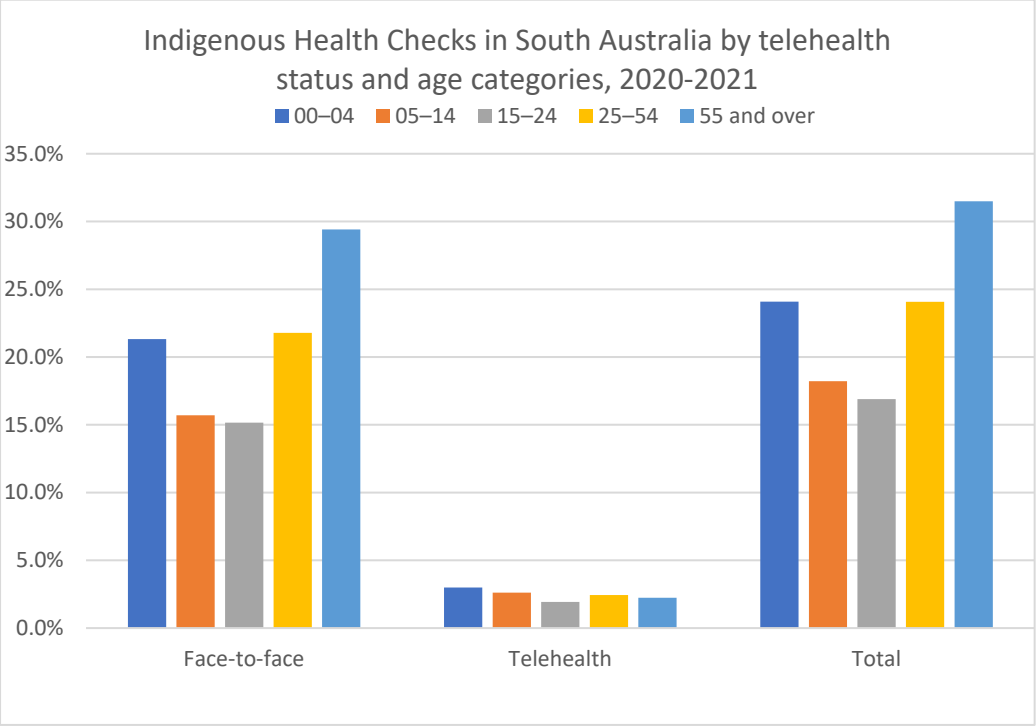


Figure 18 Indigenous Health Checks in South Australia by telehealth status and age categories, 2020-2021

Figure generated from extracted data in the datatables of Indigenous Health Checks and Follow ups (43).

In Adelaide PHN a total of 4,200 or 17.9% of Aboriginal and Torres Strait Islander people accessed Indigenous health checks face to face (Item numbers 228 and 715). This rate was lower than the national average of 22.3% in major cities. The Council made comment that more education and understanding that 715 can be accessed through mainstream health services.

> *"Health promotion and education that (715) health checks can be accessed through mainstream services".*

2.3.3 Indigenous health checks and National Implementation Goal

There is a National Implementation Goal for Indigenous Health Checks which varies according to age groups (44) to track progress. The National Implementation Goal by 2023 is presented along with current rates in South Australia and Australia in Figure 19. Nationally Australia is not on track to meet its national Indigenous Health Check targets across all age groups (45-47), and South Australia is also lagging behind.

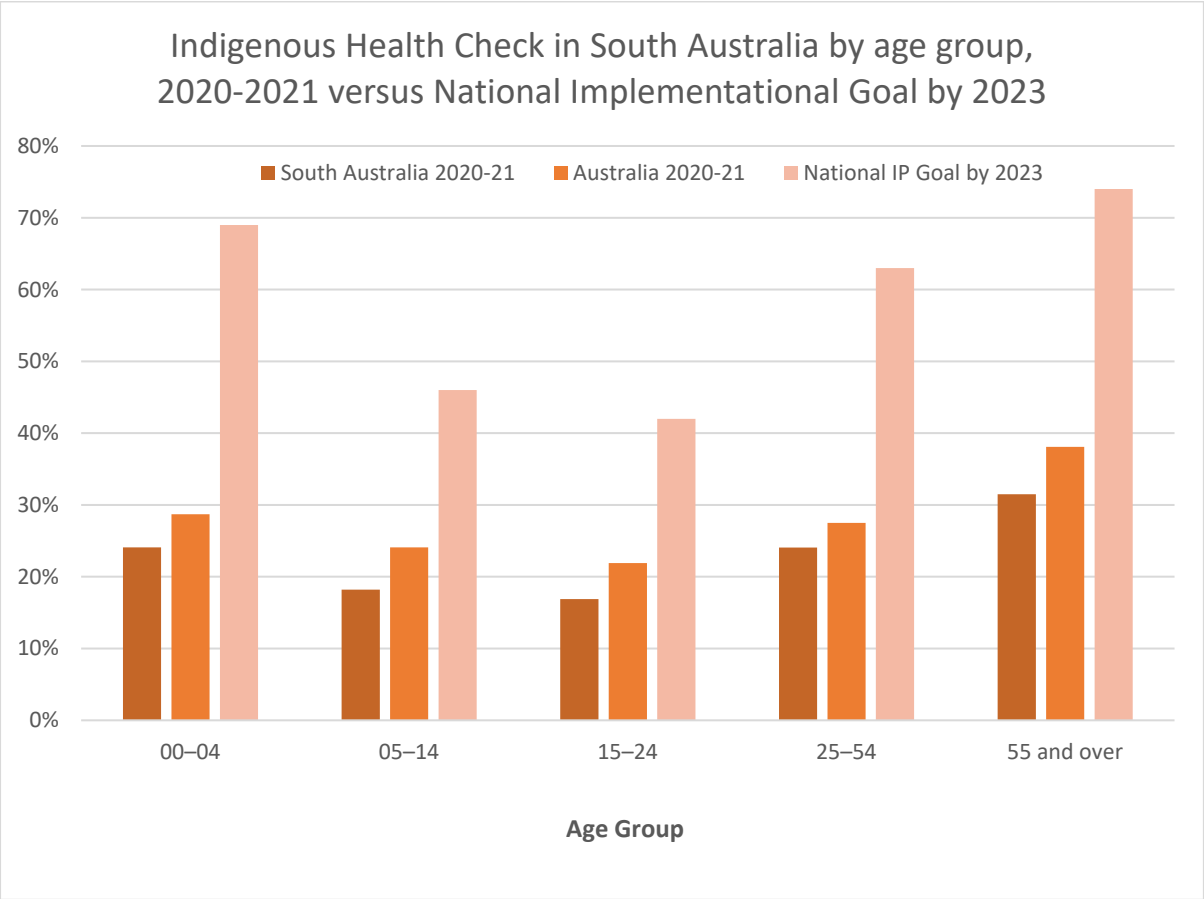


Figure 19 Indigenous Health Check in South Australia, across Australia and the National Implementation Goal

2.3.4 Indigenous Health Check: Feedback from the Council

Community consultations with the Council surrounding the low uptake of Indigenous Health Checks in the Adelaide PHN highlighted the need for change so that they were patient centred.

> *"A male attended a health check and was questioned about the safety and wellbeing of his children and the state of his relationship with his ex-wife rather than his current health assessment."*

Similar outcomes have been reported in urban regions of Australia from health professionals undertaking Indigenous Health Checks, where they felt that sections of the check were inappropriate and invasive (48).

Additionally, the Council identified that the overall cultural safety of Indigenous Health Checks and service providing it was of significant concern for Aboriginal and Torres Strait Islander individuals and families, along with education and awareness of the checks.

> *"Word of mouth and reputation of services within the community impact peoples decision to access services, for example, one site is not welcoming for Aboriginal people and staff are rude, lack of sensitivity"*

Indigenous health check uptake has already been identified to be impacted by awareness, along with a lack of understanding and appreciation by health professionals (49). Working closely with community leaders to address cultural respect in the clinical setting is of utter most importance to assist in uptake of Indigenous Health Checks.

> *"Increase community awareness, many Aboriginal community members are unaware that they are entitled to health checks."*

The 'Ways of Thinking, Ways of Doing' is an example of how cultural respect has been embedded into routing daily clinical practice in Southwestern Sydney, with a key focus on cultural mentors in the clinical environment (50). Indigenous Health Checks play an important role in early prevention, detection and intervention of a range of chronic and complex conditions for Aboriginal and Torres Strait Islander patients and are important in decreasing burden of disease. All health services undertaking Indigenous Health Checks should be addressing cultural safety and respect in their clinicals to maximise opportunity and uptake.

2.4 Chronic and complex conditions

Community consultation with the Council examining chronic and complex conditions was undertaken more broadly with Aboriginal Reference Group members for the Adelaide PHN. While overall there was good feedback on a range of services offered to Aboriginal and Torres Strait Islander individuals, for instance through Sonder with their approach to connect and offer continuous support, members still felt that services very much operated in a silo-based framework not meeting specific health and wellbeing requirements for community. Certainly, there was a call for more integrated care, improved interventions, and more education (service providers) which should be co-designed with community.

"There is a need for more champions or ambassadors, seeing people connecting more with specific people rather than services. Family and community support is valued more than services (shame). Change is hard because it is about identity."

2.4.1 Diabetes

Highlights

South Australia is above the national average for blood glucose monitoring in Aboriginal and Torres Strait Islander patients.

Age-standardised diabetes prevalence for Aboriginal and Torres Strait Islander people living in non-remote SA was higher than the prevalence of diabetes in Aboriginal and Torres Strait Islander people living in non-remote places across Australia, 18.5% vs 15.4% (51). Across Australia, the age standardised rate of diabetes in Aboriginal and Torres Strait Islander males was higher than their female counterparts (17.7% vs 16.7%) (51), there was no data on non-binary or gender-neutral people. From Figure 20, out of all the states and territories for the crude prevalence of Diabetes for Aboriginal and Torres Strait Islander people, South Australian was the third highest (20.2%), after Western Australia (24.0%) and Northern Territory (21.8%) (51). Nationally, age-specific diabetes prevalence was highest in Aboriginal and Torres Strait Islander peoples above 55+ years (35.5%) as more than 1 in 3 Aboriginal and Torres Strait Islander Australians in the ≥ 55+ age group had diabetes (51). One in five people aged 45 – 54 years and one in ten in the 35 to 44 year age group of South Australian Aboriginal and Torres Strait Islander people had diabetes (51).

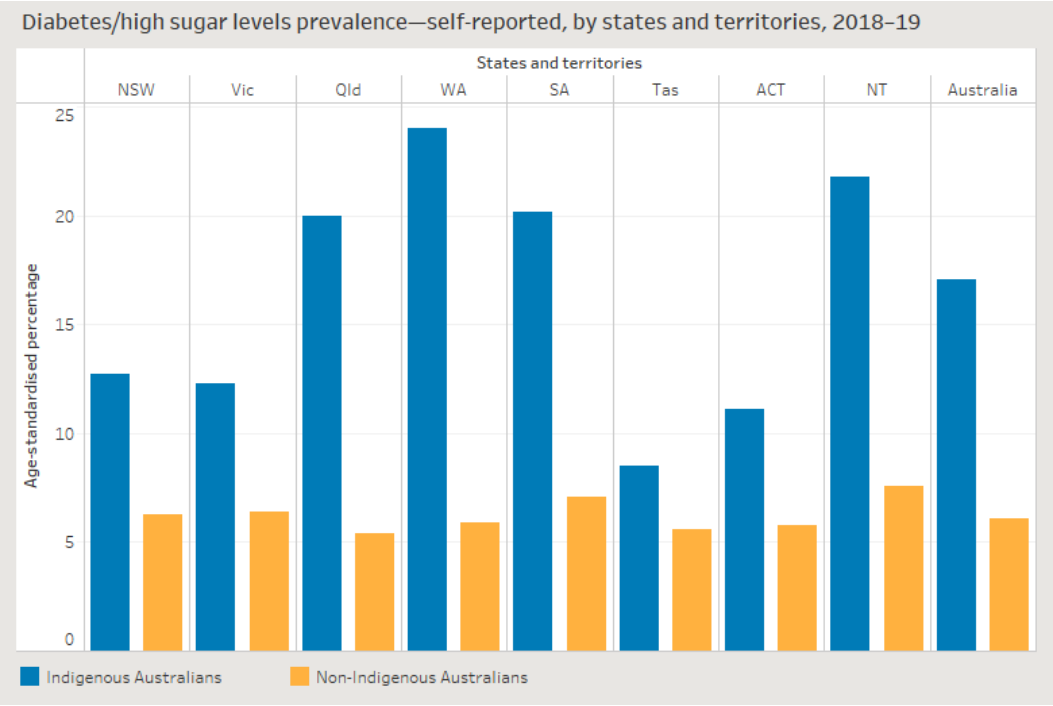


Figure 20 Prevalence of Aboriginal and Torres Strait Islander people with Diabetes.

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

When it comes to actions taken in the last 12 months to manage diabetes or high blood glucose, SA Aboriginal and Torres Strait Islander patients received better care than Aboriginal and Torres Strait Islander Aboriginal and Torres Strait Islander people nationally (52), for example in the 12 months prior to the survey in 2018-19:

Blood glucose checked in 94.6% of SA Aboriginal and Torres Strait Islander diabetic patients to 92.7% of Aboriginal and Torres Strait Islander patients nationally

- Feet reviewed in 79.4% of SA Aboriginal and Torres Strait Islander diabetic patients vs 77% nationally
- HbA1C test in SA Aboriginal and Torres Strait Islander diabetic patients 75% vs 72.6% nationally (52).

The same trend was evident 2 weeks prior to the survey:

- Insulin use for management in 35.3% of SA Aboriginal and Torres Strait Islander diabetic patients vs 26.4% nationally
- Taking medication for their diabetes in 76.5% of SA Aboriginal and Torres Strait Islander diabetic patients vs 68.4% nationally.

However 67.6% of SA Aboriginal and Torres Strait Islander patients were involved in a diabetes lifestyle related preventive actions (i.e. diet, weight loss and exercise) compared to 74.6% Aboriginal and Torres Strait Islander people nationally (52). Additionally, diabetes detection in Aboriginal and Torres Strait Islander patients remains largely opportunistic through annual Indigenous health checks (see section 2.4.1), and there was no local or state reporting for Aboriginal and Torres Strait Islander communities on diabetes strategies recommended by Diabetes Australia – bariatric surgery, very low-calorie diets and ketogenic eating plans (53).

2.4.2 Respiratory disease

Aboriginal and Torres Strait Islander communities nationally continue to be impacted by respiratory disease; asthma, chronic obstructive pulmonary disease (COPD), pneumonia and invasive pneumococcal disease (54) (Figure 21). Burden from respiratory disease remains more prevalent in Aboriginal and Torres Strait Islander peoples than non-Indigenous peoples and accounts for 9% of non-fatal disease burden and 5.8% of fatal disease burden for Aboriginal and Torres Strait Islander Australians (54).

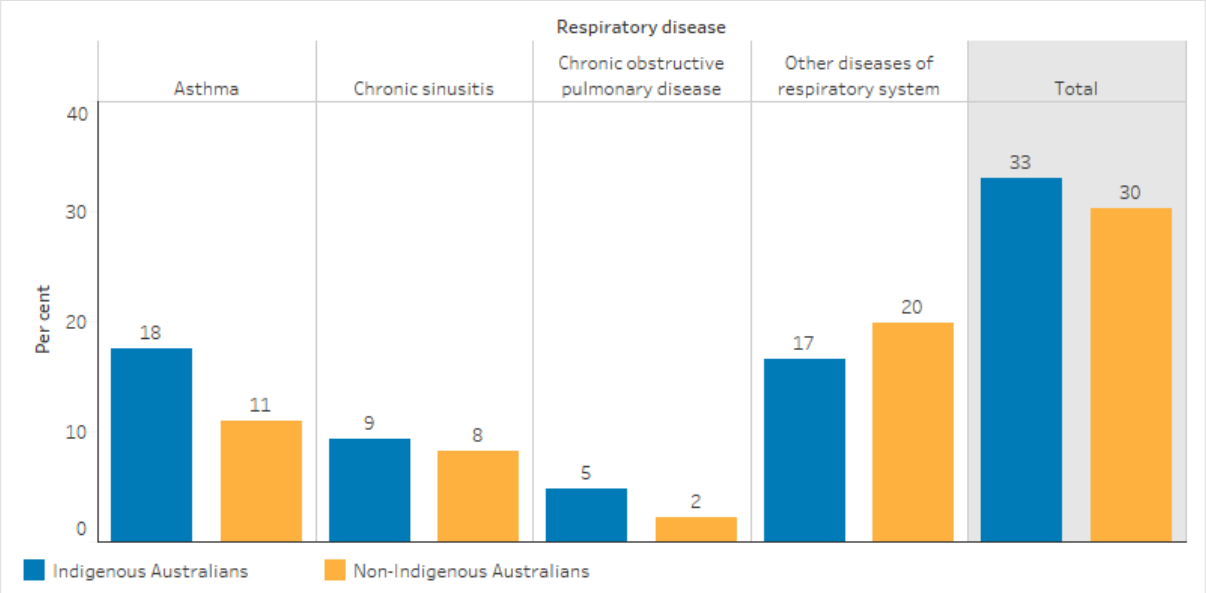


Figure 21 Prevalence of respiratory disease in Aboriginal and Torres Strait Islander people and non-Indigenous Australians by respiratory disease type, 2018-19

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

Age-standardised respiratory disease prevalence in Aboriginal and Torres Strait Islander people living in non-remote SA was slightly higher than the prevalence in Aboriginal and Torres Strait Islander people living in non-remote places nationally, 39.0% vs 36.5% (Figure 22).

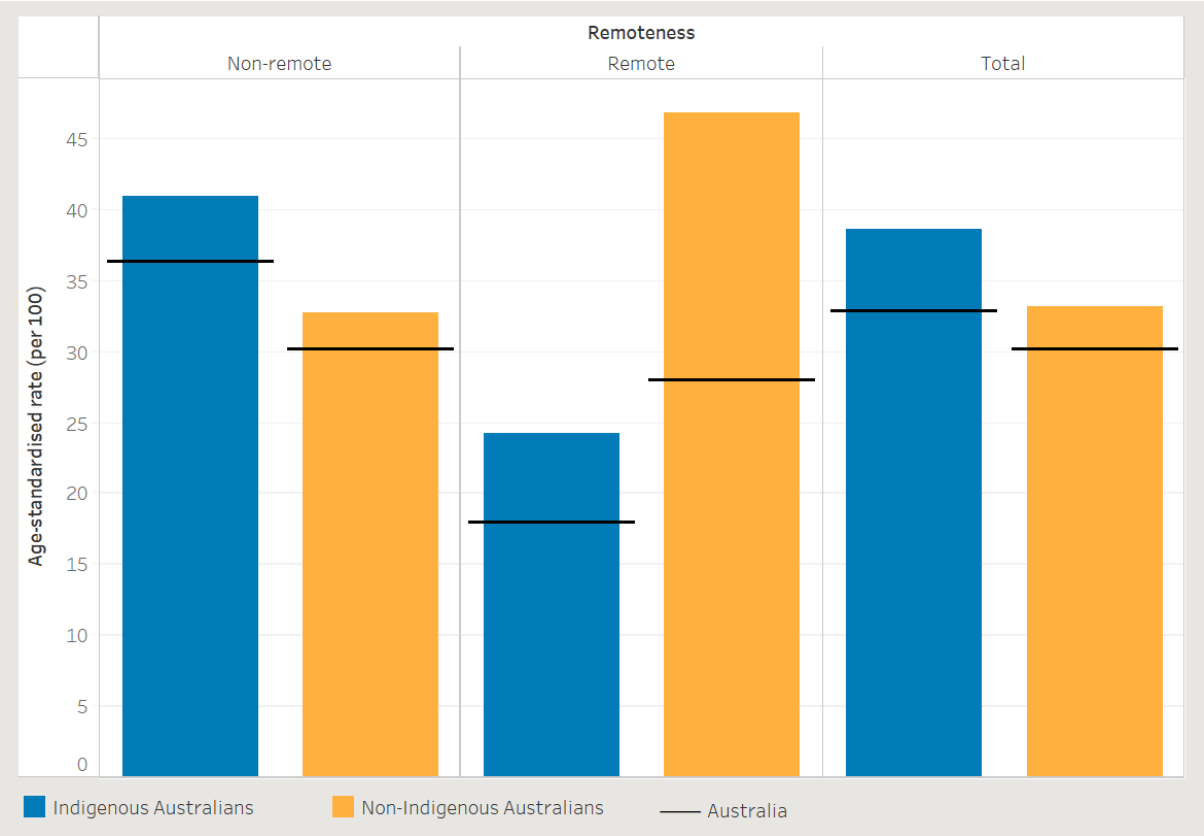


Figure 22 Prevalence of respiratory disease—self-reported, by remoteness, South Australia, 2018–19

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020(54)

Across Australia, the age standardised rate of respiratory disease in female Aboriginal and Torres Strait Islander people was higher than their male counterparts (37.2% vs 28.3%)(54), no data was reported for non-binary or gender neutral individuals. Aboriginal and Torres Strait Islander Australians above 55+ years had a much higher prevalence of respiratory diseases compared to their non-Indigenous counterparts (46.6% vs 35.3%), however this gap is not as significant as in other age groups (54). Respiratory disease mortality for SA Aboriginal and Torres Strait Islander peoples is 38 per 100,000, with the highest mortality rates being for COPD, pneumonia and asthma (54).

2.4.3 Cancer

Between 2015-2019, 23% of total deaths in Aboriginal and Torres Strait Islander people was due to a type of cancer, and this rate is increasing (55). A population study in NSW revealed that compared to non-Indigenous Australians, Aboriginal and Torres Strait Australians were less likely to receive cancer treatment after cancer diagnosis (56). Literature suggests an increase in screening participating and improved early detection (57), improved diagnosis and access to treatment (56) can all lead to the removal of disparity in cancer for First nations people. The Aboriginal Advisory Council in Adelaide PHN also provided similar feedback surrounding cancer screening, awareness for early detection. There was also feedback that the Cancer Council in SA had been undertaking community

engagement more than prior years. There was also feedback surrounding the significant impact of transgenerational trauma and grief, and how this can manifest into poor health outcomes such as cancer. Funding concerns surrounding cancer were also raised, in terms of access to financial assistants to decrease how much Aboriginal and Torres Strait Islander families were having to pay out of their own pocket for healthcare. This also transitioned over into the overall affordability of living.

> *"It is costly to be eating healthy, it is significant. This impacts on household budgets, cheaper to eat unhealthy food."*

2.4.3.1 Breastscreen

Across Australia, the breast cancer screening rates in Aboriginal and Torres Strait Islander women are low in every age group (Figure 23). Only around two in five Aboriginal and Torres Strait Islander women participate in BrestScreen (58). In South Australia, Aboriginal and Torres Strait Islander women in every age group have a lower BreastScreen participation rate compared to other Aboriginal and Torres Strait Islander women across Australia (Figure 23), except in women aged 75+ years.

Community consultations with the Council in this area have highlighted that impacting factors for these rates are likely to be the busy and important caring roles that females play in Aboriginal and Torres Strait Islander families, through caring for family, kin and the elderly. Additionally, screening for community often occurs when the BreastScreen bus visits local or nearby health clinics, long delays in being seen on the day through to only being conducted over a few days at one location, could also be contributing factors to low participation rates. Access to BreastSceen services for Aboriginal and Torres Strait Islander women is a national policy feature of BreastScreen Australia (58). Co-designed programs with Elders and Senior community representatives have been recommended to increase these BreastScreen participation rates.

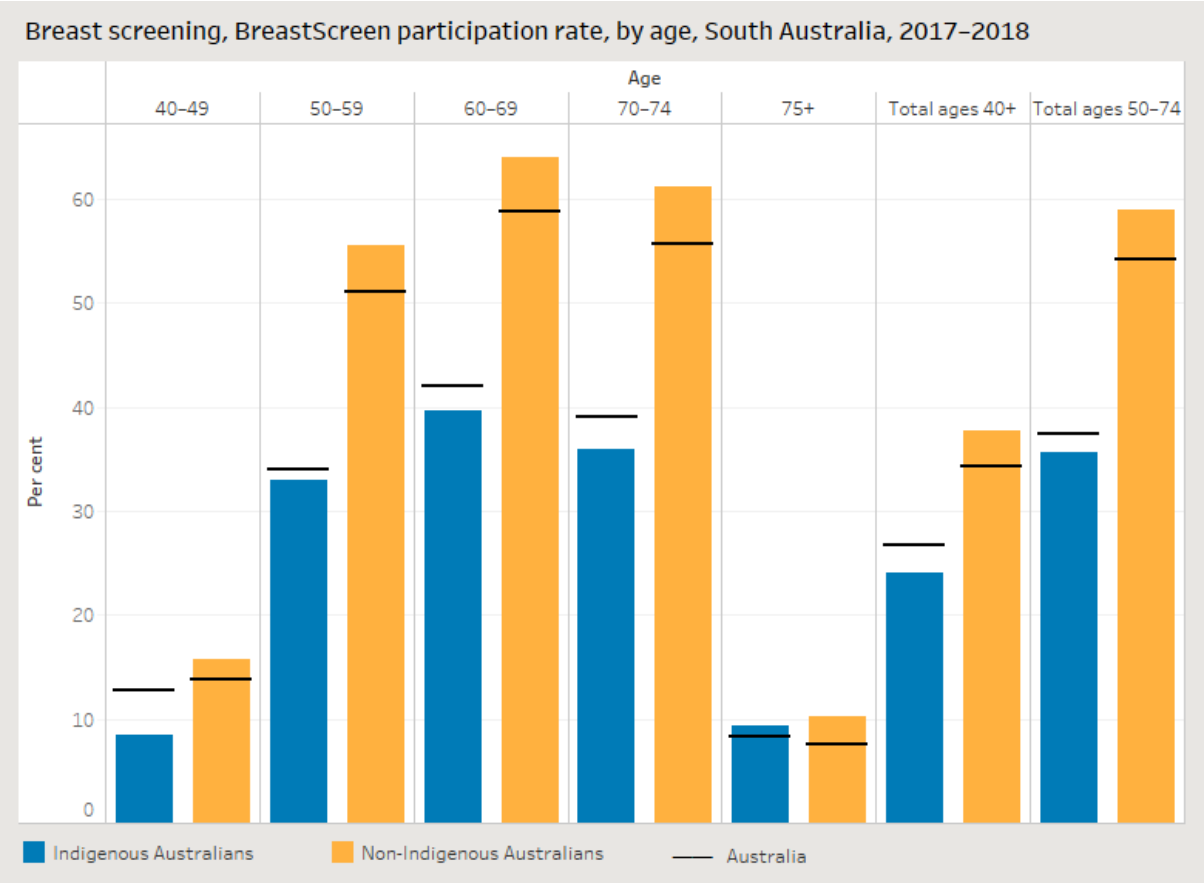


Figure 23 Breast screening, Breastscreen participation rate, by age, South Australia 2017-2018

Figure source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (59).

2.4.3.2 Cervical cancer screening

Cervical cancer screening rates for Aboriginal and Torres Strait Islander women living in South Australia as reported in 2018-19, compared to national rates in Aboriginal and Torres Strait Islander women is presented in Figure 24. Aboriginal and Torres Strait Islander women in South Australia have comparable cervical cancer screening rates (89.5%) to Aboriginal and Torres Strait Islander women nationally (89.8%).

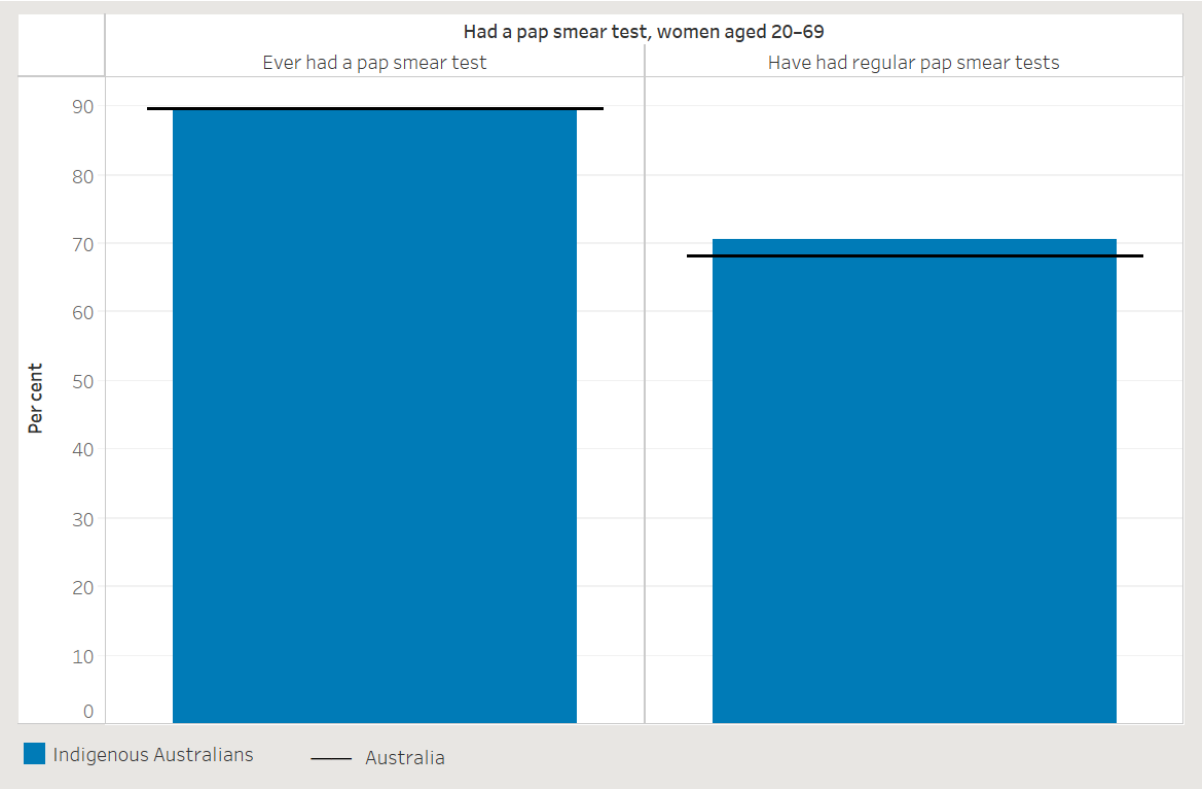


Figure 24 Cervical cancer screening through pap spear in Aboriginal and Torres Strait Islander women in South Australia, 2018-19

Figure source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (59). (59)

2.4.3.3 Bowel cancer screening

Highlights

Screening for bowel cancer in Aboriginal and Torres Strait Islander men in South Australia is significantly higher than the national average.

Bowel cancer screening rates in Aboriginal and Torres Strait Islander men living in South Australia is much better than screening rates in other Aboriginal and Torres Strait Islander people living across Australia as shown in Figure 25 (49% vs 23%), however bowel cancer screening rates in Aboriginal and Torres Strait Islander women living in South Australia are much lower than the national average for Aboriginal and Torres Strait Islander women Figure 25 (6% vs 20%) (60).

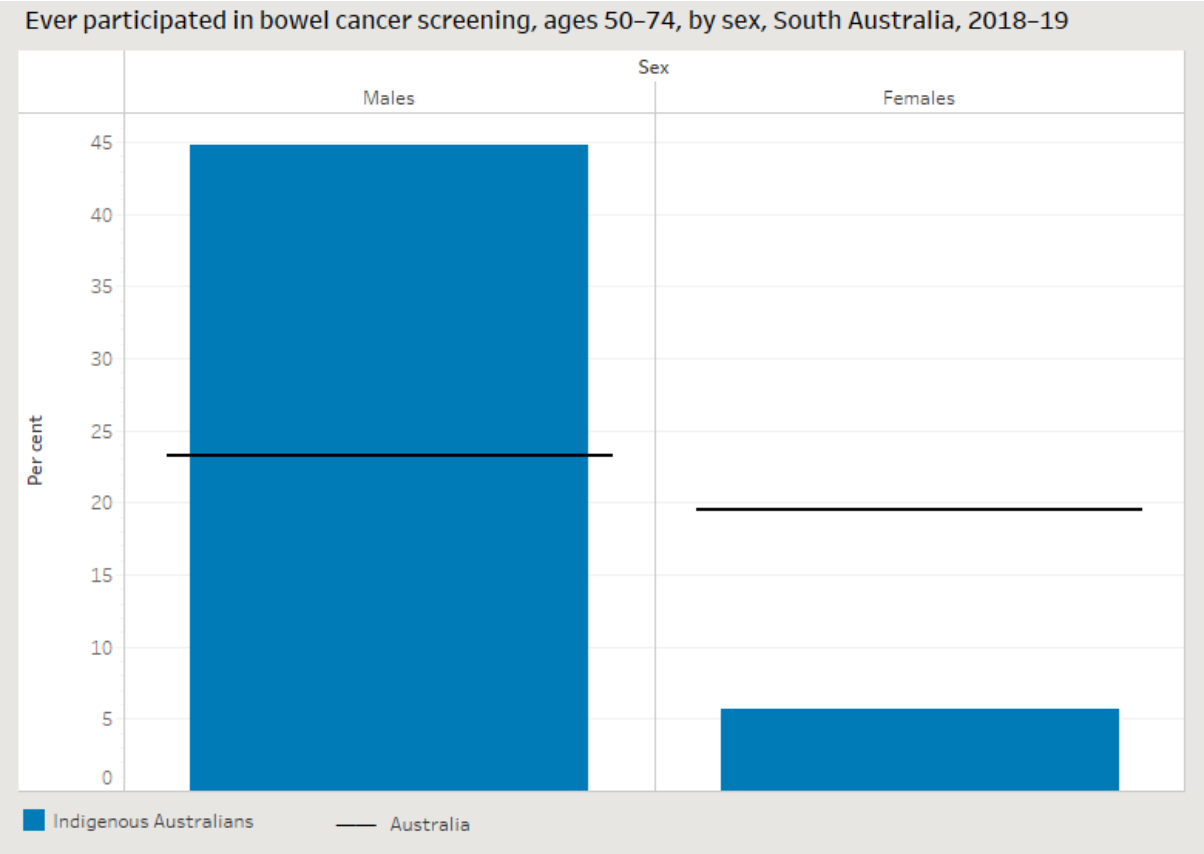


Figure 25 Ever participated in bowel cancer screening, ages 50-74, by sex, South Australia, 2018-19

Figure source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (60).

The Council also explained the excellent screening participation in bowel cancer screening to be a result of designated project works on male health through Cancer SA where screening could be encouraged in a culturally safe environment for a male only audience. To improve other cancer screening rates in all sexes, the Council advised for the need of *"more health days focusing on women's health and men's health"*.

2.4.3.4 Strength based co-design to increase cancer

The Council suggested there needed to be more concerted effort on education of cancer with project officers (including social workers, nurses, outreach workers) to work with the community. Strength based co-design concepts were suggested such as health eating programs and cooking classes incorporating culture and bush tucker with traditional nutritionist and dietician working alongside traditional food bush workers.

2.4.4 Kidney disease

Highlights

The AKction (Aboriginal kidney care together – improving outcomes now) is a collaborative project which aims to enable Aboriginal kidney patients to improve kidney care and support in South Australia (61).

The self-reported prevalence of chronic kidney disease in Aboriginal and Torres Strait Islander people living in non-remote South Australia was slightly lower than for Aboriginal and Torres Strait Islander people in non-remote locations nationally (2.3% vs 2.8%), Figure 26. Overall, Aboriginal and Torres Strait Islander females reported a higher prevalence of chronic kidney disease than Aboriginal and Torres Strait Islander males (4.1% vs 2.6%)(62), with no data for non-binary or gender neutral individuals.

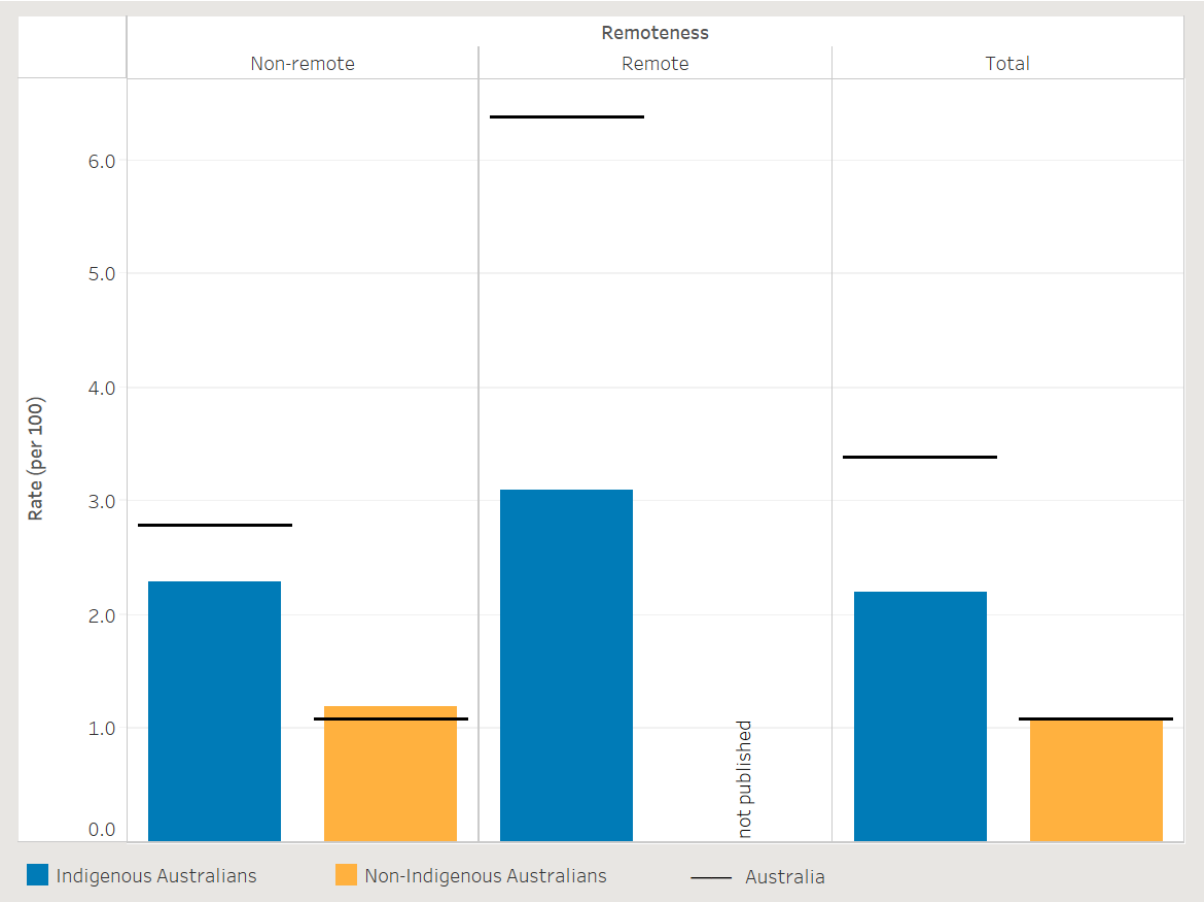


Figure 26 Self-reported chronic kidney disease prevalence by remoteness, South Australia, 2018-19(62)

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

Between 2015 to 2017 chronic kidney disease diagnosis accounted for 3.1 per 1000 of all hospitalisations (crude rate) for Aboriginal and Torres Strait Islander patients (62). With 2 per 1000 of all hospitalisations being male and 4.2 per 1000 of all hospitalisations being female received a principal diagnosis of chronic kidney disease (62). Age-specific hospitalisation rates for Chronic kidney disease, found more South Australian Aboriginal and Torres Strait Islander individuals compared to Aboriginal and Torres Strait Islander nationally were hospitalised for chronic kidney disease at ≥65 years (12.9% vs 9.4%), but this rate lower in all other age categories (55-64 yrs: 8.6% vs 12.5%, 45 – 54 yrs: 6.6% vs 7.6%)(62).

Australia wide, Aboriginal and Torres Strait Islander Australians with end-stage kidney disease were less likely to receive a kidney transplant when compared to non-Indigenous Australians (13% versus 87%)(62). This is an ongoing reported and documented inequity in kidney transplantation for Aboriginal and Torres Strait Islander peoples, which continues to impact on disease burden (63). Presently only small gains in this area are being reported with slight increases in kidney transplantation or being active on the transplant waitlist, which could be contributing to a 36% reduction kidney disease mortality for the Aboriginal and Torres Strait Islander people between 2010 and 2019 in. (62, 64). The National Indigenous Kidney Transplantation Taskforce continue to work action work in this area for improvement (64).

2.4.5 Circulatory disease

In non-remote South Australia, the age-standardised rate of circulatory disease in Aboriginal and Torres Strait Islander people was slightly lower than the total rate in Aboriginal and Torres Strait Islander people nationally (Figure 27: 19.9% vs 22.5%), but higher than non-Indigenous non-remote South Australians (Figure 27: 19.9% vs 15.4%) (65).

Aboriginal and Torres Strait Islander females (age>2 years) had a slightly higher age-standardised rate of circulatory disease compared to Aboriginal and Torres Strait Islander males (24% vs 22%). More than half (56%) of Aboriginal and Torres Strait Islander Australians above 55+ years of age reporting having a circulatory disease (65).

Circulatory disease accounted for 23% of all deaths in Aboriginal and Torres Strait Islander communities, making it the second leading cause of death for Aboriginal and Torres Strait Islander people in 2015 to 2016.

Although, from 2010 to 2019, the circulatory disease mortality rate for Aboriginal and Torres Strait Islander people decreased by 18%, there was no major change in the gap between circulatory health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous people.

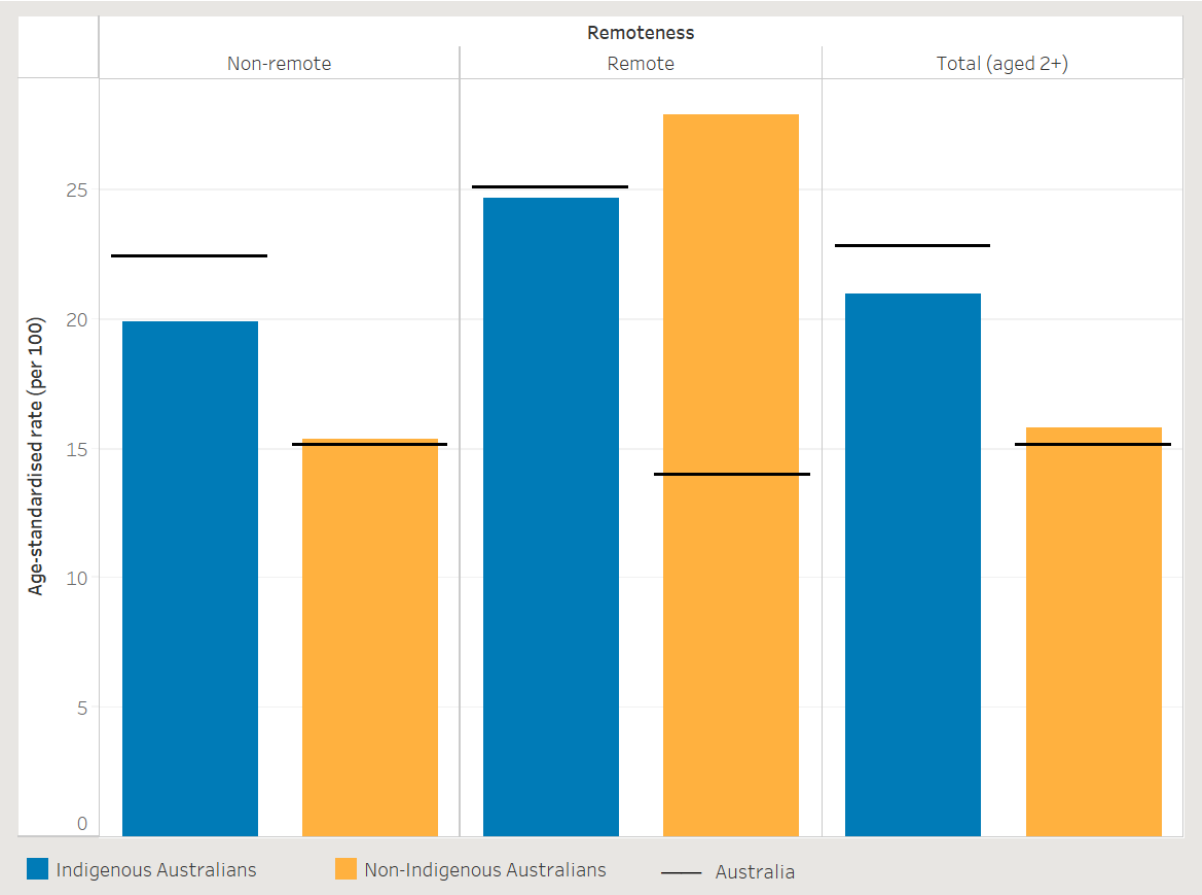


Figure 27 Prevalence of circulatory disease—self-reported, by remoteness, South Australia, 2018–19(65)

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

2.4.6 Rheumatic fever and rheumatic heart disease

Aboriginal and Torres Strait Islander Australians had a disproportionately higher representation (87%) in the total numbers of individuals with rheumatic heart disease (RHD) in QLD, WA, SA and NT, with 17 out of 20 cases of RHD being an Aboriginal and Torres Strait Islander person (66). RHD was most commonly diagnosed in the 5-14 years of age as presented in Figure 28 (66) and in females (54 per 100,000 vs 31 per 100,000) as presented in Figure 29, which is also the most commonly impacted age group reported in the literature (67). In non-remote South Australia, between 2015 and 2017, there were a total of 28 hospitalisations due to acute rheumatic fever or chronic rheumatic heart disease (66). Recent progression studies on RHD, have found death or non-fatal complications occur in around one-fifth of uncomplicated cases for patients <35 years (67). Internationally RHD is a recognised indicator for socioeconomic deprivation, impacted frequent streptococcal bacterial infections (throat or skin) and inadequate access to healthcare, even in high income countries this condition impacts the most marginalised (68). This is a treatable condition through administration of antibiotics and monitoring to stop progressions, community co-designed initiatives are needed to strengthen, and tailor make community specific approaches to combat RHD.

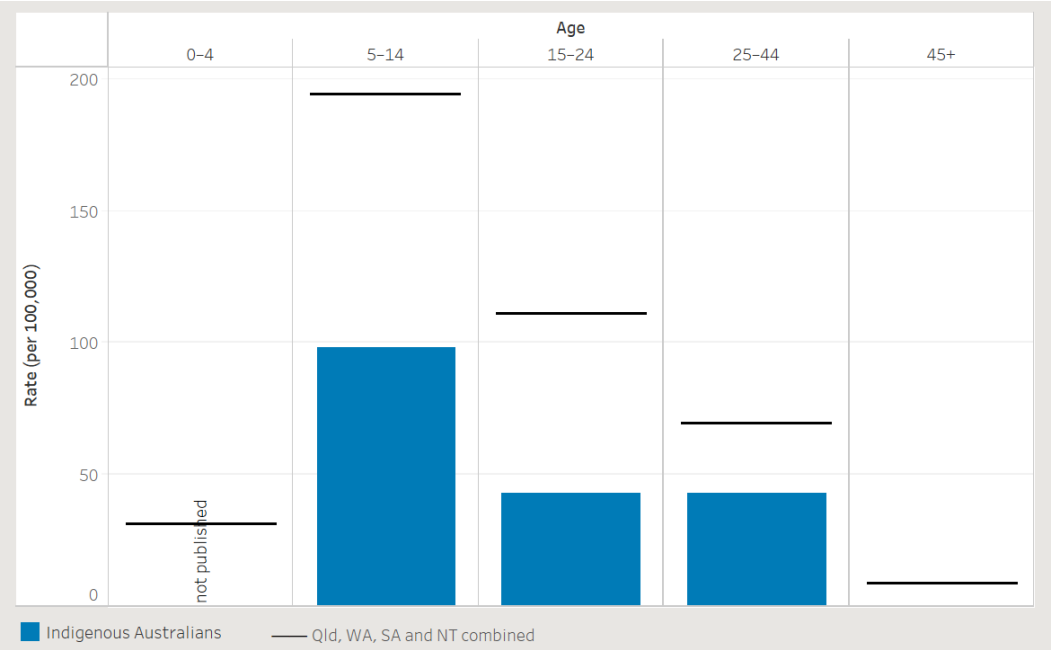


Figure 28 Incidence of acute rheumatic fever, by age, in Aboriginal and Torres Strait Islander children and all Australian children, 2014-2018

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (66)

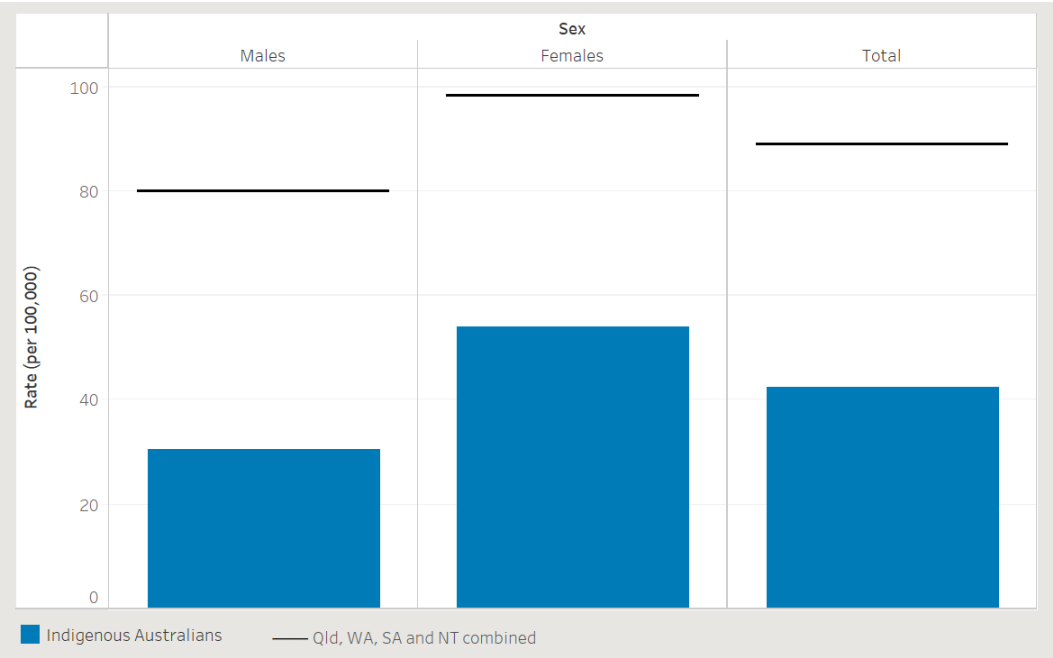


Figure 29 Incidence of acute rheumatic fever, by sex, South Australia, 2014-2018

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (29)

2.4.7 High blood pressure

Aboriginal and Torres Strait Islander Australians had a higher prevalence of high blood pressure when compared to non-Indigenous Australians in every age group, with the biggest difference (48% vs 34%) being in the 45 to 54 years of age group as seen in Figure 30 (69). High blood pressure is a health condition which can significantly impact and amplify the intensity of other health conditions.

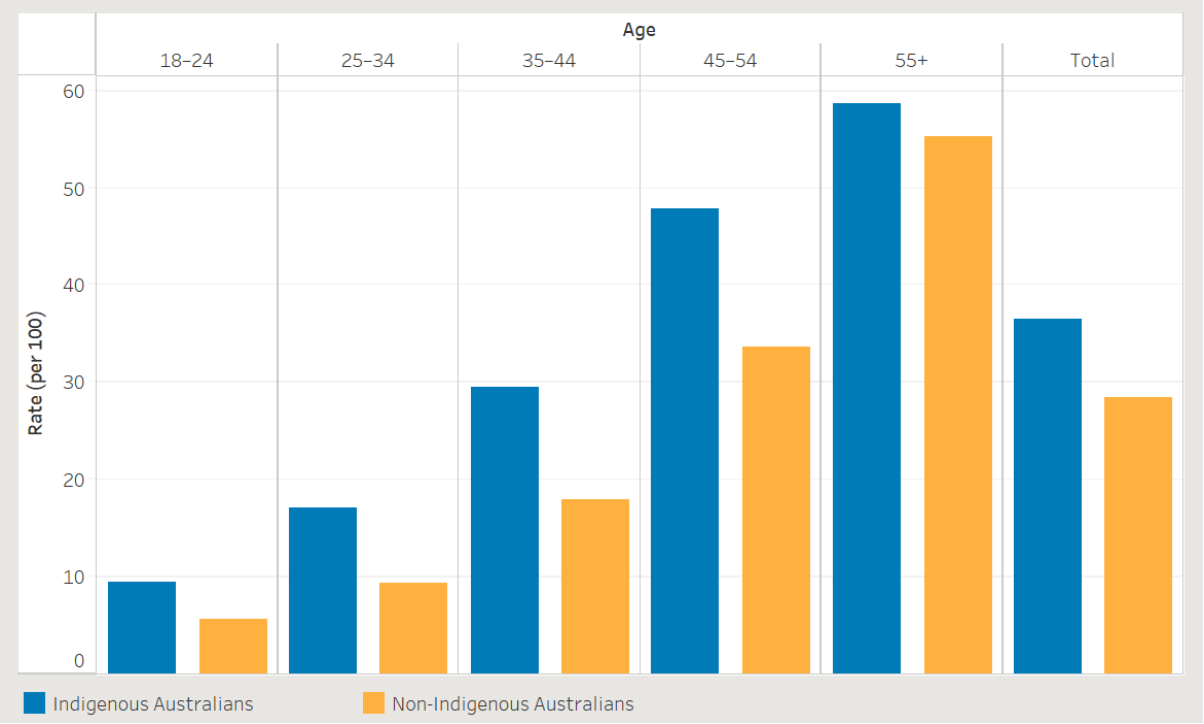


Figure 30 Prevalence of high blood pressure, by age, 2018-19

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (69)

When compared to Aboriginal and Torres Strait Islander people nationally, those living in non-remote South Australia had a higher prevalence (Figure 31: 36% vs 43%).

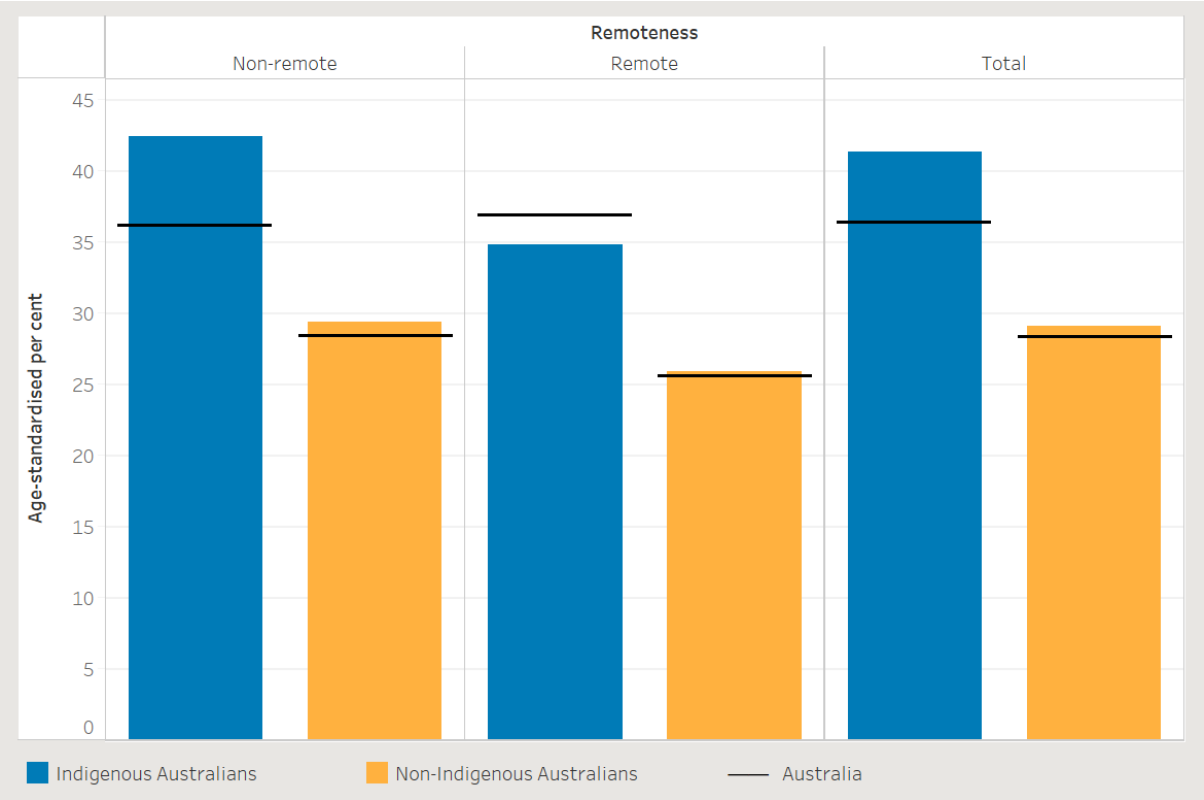


Figure 31 Prevalence of high blood pressure-self-reported and measured, by remoteness, in South Australia, 2018-19

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (69)

2.4.8 Injury

Injuries as a term covers a range conditions, from unintentional injuries; road traffic, burns, drowning, falls, poisoning, through to intentional injuries; intentional harm, suicide, neglect, or physical violence. Nationally injuries are the third leading cause of death for Aboriginal and Torres Strait Islander communities, they account for 12% of the total disease burden and rates are twice that of non-Indigenous Australians (70). The leading cause of injury in Aboriginal and Torres Strait Islander communities is suicide, which will be reported under its own separate heading, followed by road traffic accidents (19%), poisoning (18%), assault (7.8%) and falls (4.5%) over 2015-19 (70).

In South Australia hospitalisation rates for Aboriginal and Torres Strait Islander people who have sustained an injury remains above the national average 48.5 vs 41.7 per 1,000 hospitalisations (Figure 32)(70). In South Australia falls injuries account for the highest rate of hospitalisations (11.9 per 1,000) for Aboriginal and Torres Strait Islander people, but it is below the national average in this area (Figure 33) (70).

Great caution does need to be undertaken with interpretation of this data as currently Aboriginal and Torres Strait Islander injury data and reporting is lacking on a national, state and local level.

For instance, many injury related registries, such as the Australian Trauma Registry, do not report on Aboriginal and Torres Strait Islander status, currently there is no national registry for crash related data. With this in mind, there is likely to be an under representation for the true burden of injury.

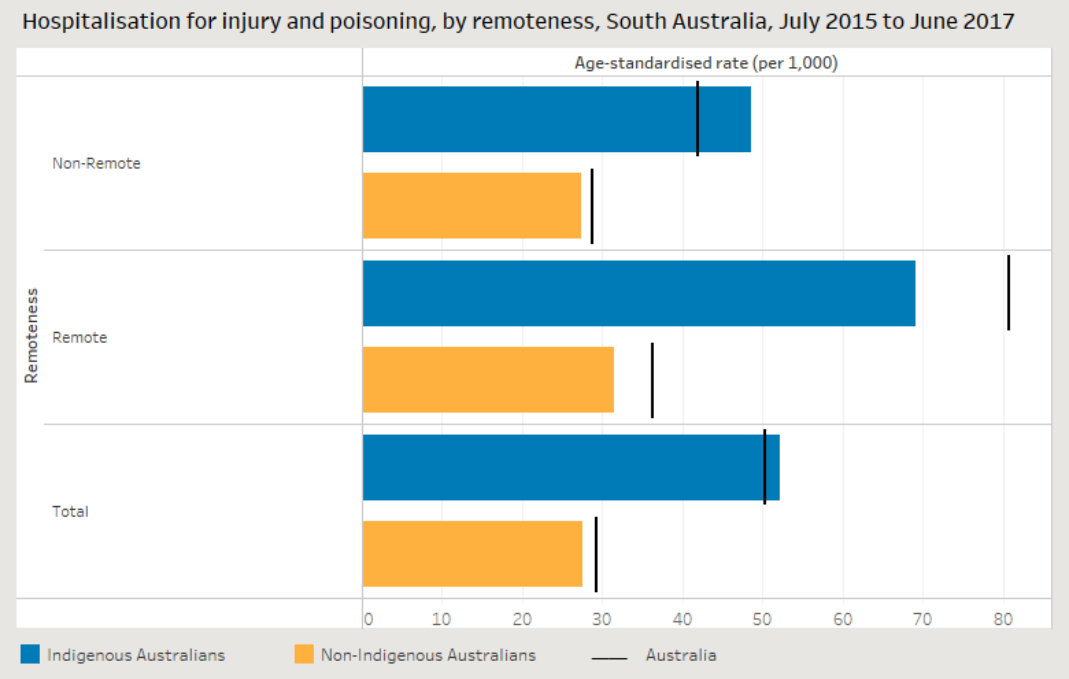


Figure 32 Hospitalisation for injury and poisoning, by remoteness, South Australia, July 2015 to June 2017

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (70).

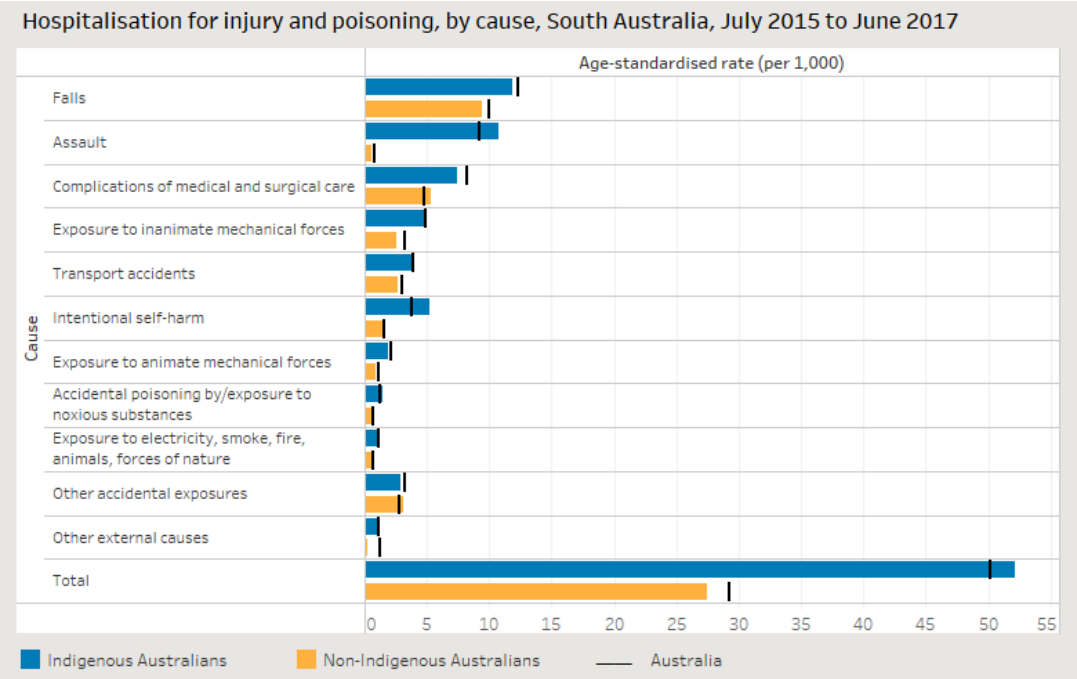


Figure 33 Hospitalisation for injury and poisoning, by cause, South Australia, July 2015 to June 2017

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (70).

2.5 Transgenerational trauma and grief

The 2018-19 National Aboriginal and Torres Strait Islander Health Survey gave insights to impacts of transgenerational trauma and grief. Ongoing colonisation through displacement and the forced removal of children from families is still evident through the over-representation of Aboriginal and Torres Strait Islander children in the child protection system, youth justice system and adult imprisonment. It is also manifested through an increased risk of mental health conditions, risk of self-harm and interpersonal violence. Discussion with the Council identified that service delivery and access for transgenerational trauma and grief was an ongoing issue, while mainstream services are available for access they do not identify with the specific nature and cause of trauma and grief from a cultural perspective. Specific training on narrative/yarning approaches to care, along with cultural hubs for support were suggested to improve access and support. Access to support sooner rather than later was also identified, with community feedback suggesting services and referral access through telehealth or online.

2.5.1 Child protection system

The rate of Aboriginal and Torres Strait Islander children on care and protection orders has significantly increased in the last decade (2009 to 2018), going from 24 to 62 per 1,000 population (71). The rate of Aboriginal and Torres Strait Islander children in out-of-home care has also increased from 35 to 53 per 1,000 during the same period (71). In South Australia, Aboriginal and Torres Strait

Islander children on care and protection orders are over-represented, as compared to the national Aboriginal and Torres Strait Islander level and that of non-Indigenous children in South Australia (Figure 34), and this rate has increased over the past decade (71).

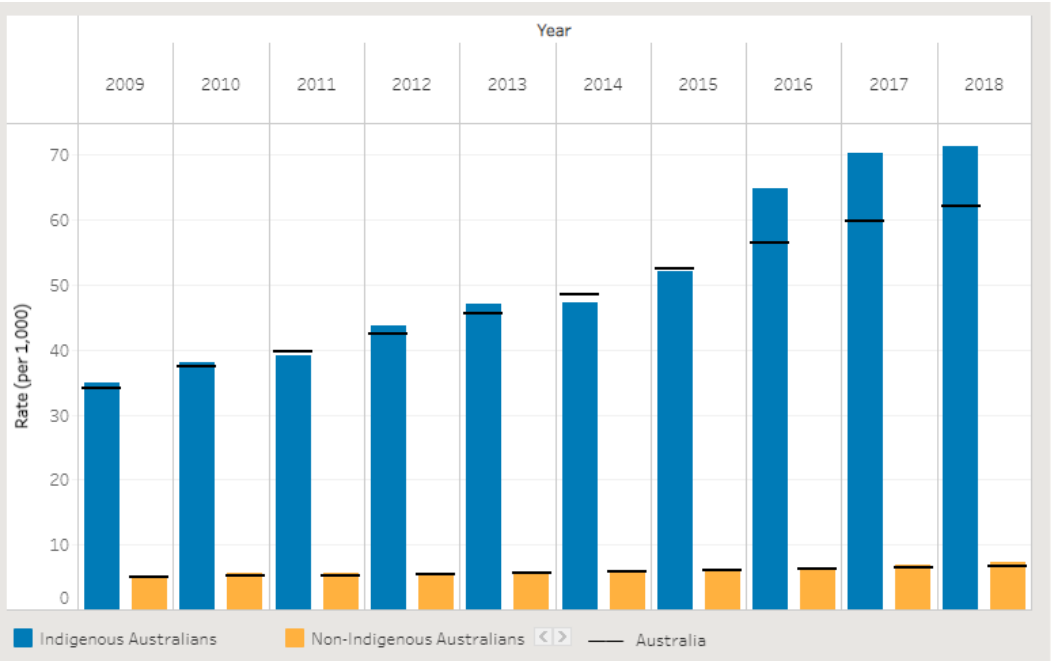


Figure 34 Children on care and protection orders in South Australia, 2009-2018

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (71).

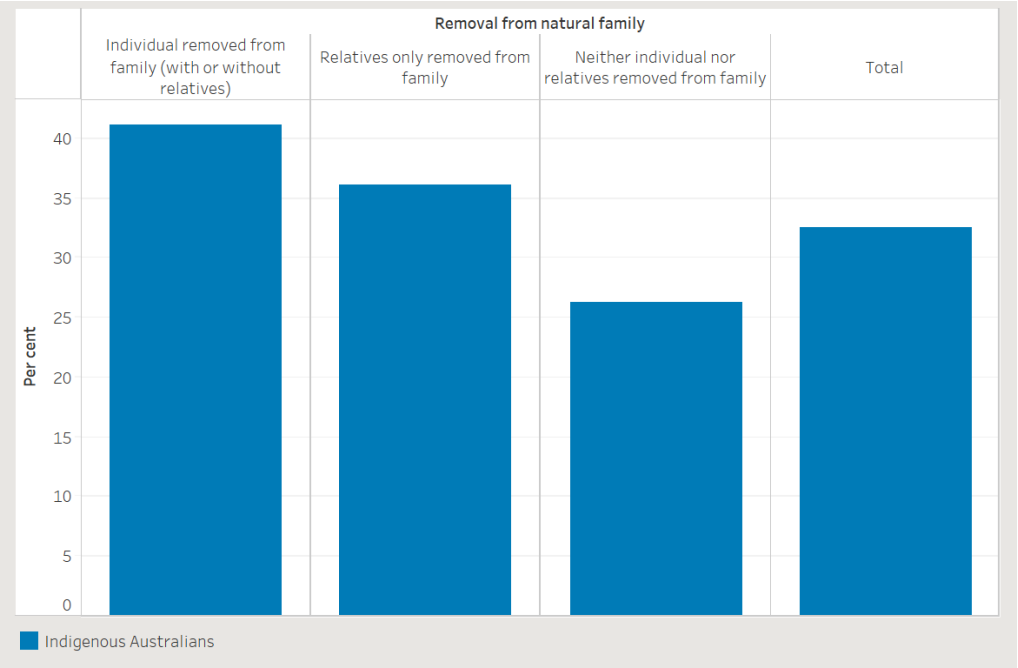


Figure 35 High levels of psychological distress in Aboriginal and Torres Strait Islander people, by removal from natural family, 2018–19

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

From Figure 35, the Aboriginal and Torres Strait Islander people who were removed from their natural family (either with or without relatives) experienced high levels of psychological distress (41% vs 26%) (72). Further, even if individuals themselves were not removed, but they have experienced the removal of a relative, they reported having high level of psychological distress compared to those who were not (36% vs 26%)(72). Concerns regarding the overrepresentation of Aboriginal and Torres Strait Islander children in the child protection systems are long standing, and continue to form the cultural genocide impacting Aboriginal and Torres Strait Islander families through cultural and family breakdowns, family and partner violence, mental distress and drug and alcohol misuse (73, 74). Ensuring that Aboriginal and Torres Strait Islander children are not overrepresented in the child protection system is a key target for the National Agreement on Closing the Gap with a specific target to reduce this rate by 45% by 2031 (75) and strategic community

centric action in required to improve these outcomes (Figure 36– below) (16).

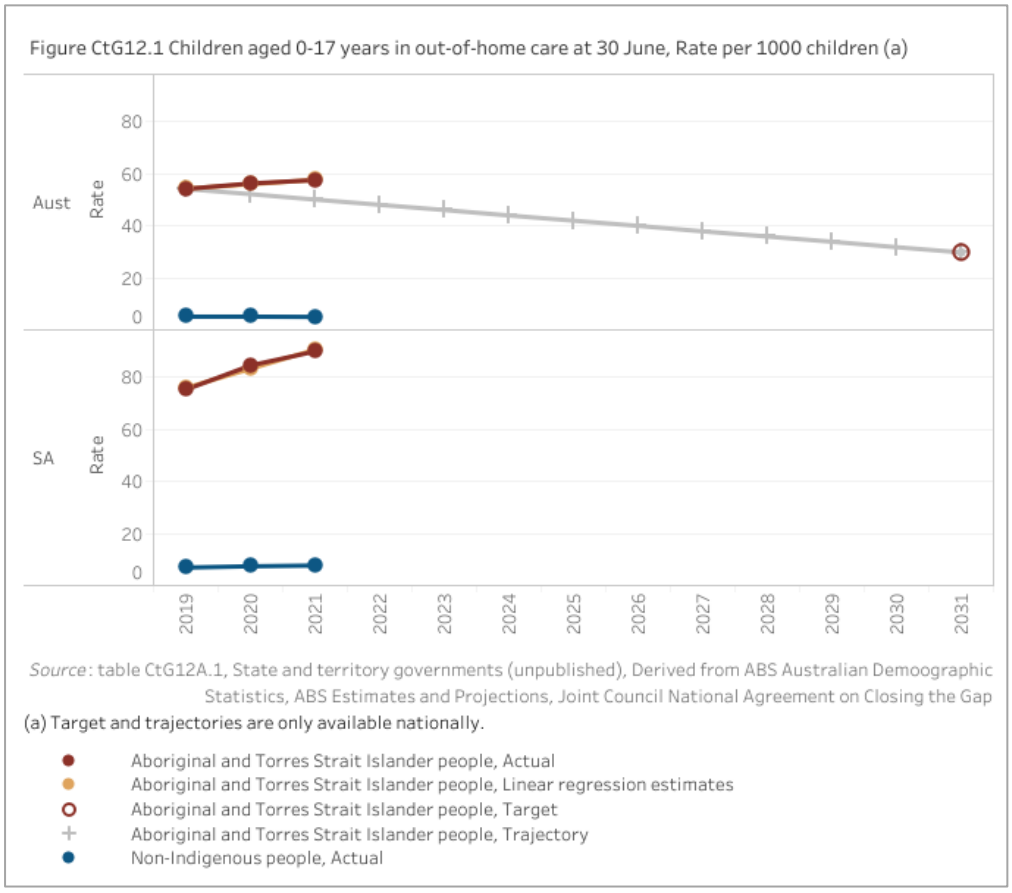


Figure 36 Aboriginal and Torres Strait Islander Children and non-Indigenous Children aged 0 to 17 in out-of-home care in South Australia and Australia, 2019 - 2021, Rate per 1000 children

Source: Closing the gap (16)

2.5.2 Youth justice

The rate of Aboriginal and Torres Strait Islander young people (aged 10 to 17) under the youth justice system fell by 26% from 2009-10 to 2019-20, when compared to non-Indigenous young people, however, Aboriginal and Torres Strait Islander young people were still 16 times more likely to be under youth justice supervision on an average day, in 2019-20 as compared to non-Indigenous young people (76). The rate of Aboriginal and Torres Strait Islander young people under youth justice supervision in South Australia has been variable over the last few reported years, however, with some improvement since the first reported period in 2006-07 (Figure 37) (76). However, improvements in this area are required to reduce this rate by 30% by 2031 to meet the National Agreement on Closing the Gap in for this indicator (Figure 38) (77).

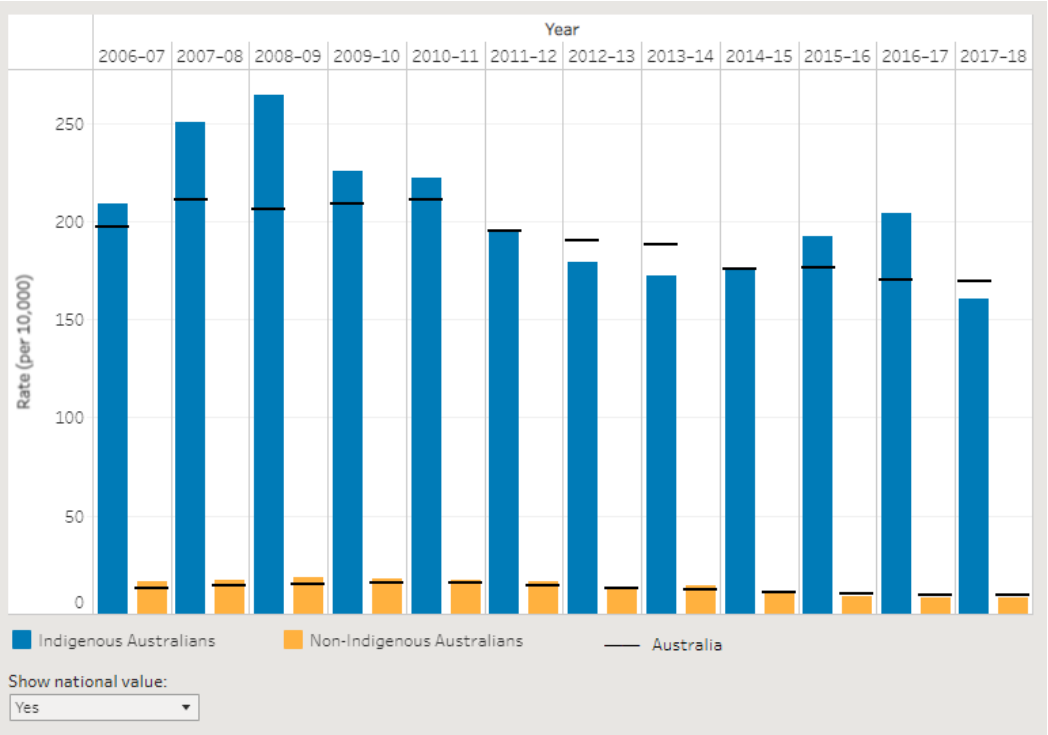


Figure 37 Youth justice, young people under supervision in South Australia, 2006-07 to 2017-18

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (76)

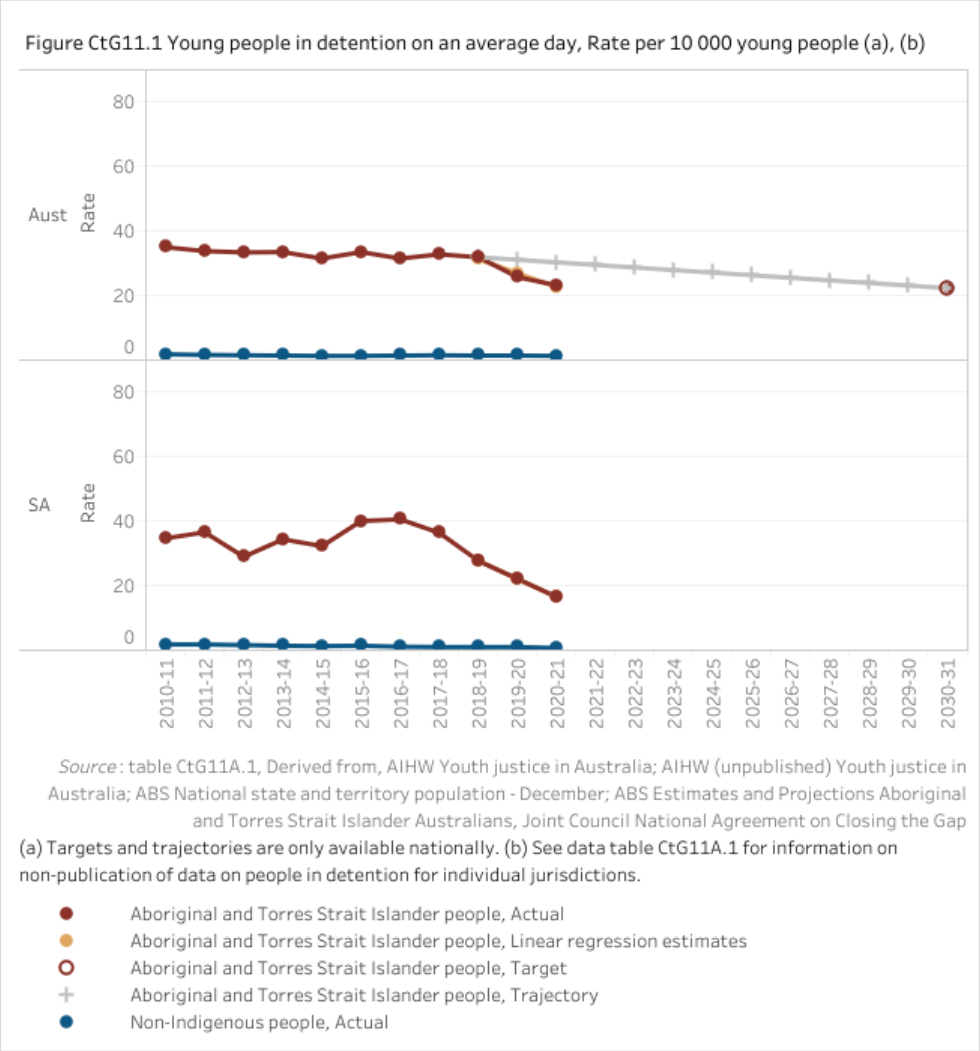


Figure 38 Aboriginal and Torres Strait Islander young people and non-Indigenous young people in detention on an average day in South Australia and Australia, Rate per 10 000 young people

Source: Closing The Gap (77)

2.5.3 Adult imprisonment

In the year 2019 alone, nationally Aboriginal and Torres Strait Islander adults were 12 times more likely to be imprisoned than non-Indigenous adults (76), and this rate has increased over time (76). South Australian Aboriginal and Torres Strait Islander adults were imprisoned at an even higher rate when compared to both the national imprisonment rate of Aboriginal and Torres Strait Islander Australian adults, as well as the non-Indigenous South Australian adults (Figure 39) (76). When age standardised to the 2001 Australian population, for every 100,000 people, an additional 309 Aboriginal and Torres Strait Islander adults were imprisoned when compared to the overall Aboriginal and Torres Strait Islander Australian population, and an additional 2,214 Aboriginal and Torres Strait Islander adults were imprisoned when compared to non-Indigenous population in South Australia (76). This is unjust and reinforces the inequitable outcomes impacting on Aboriginal

and Torres Strait Islander individuals, their families and communities. The National Agreement on Closing the Gap has set a target to decrease this rate by 15% by 2031 Figure 40, and significant action and investment is needed in South Australia to ensure that rates of imprisonment do not increase (78).

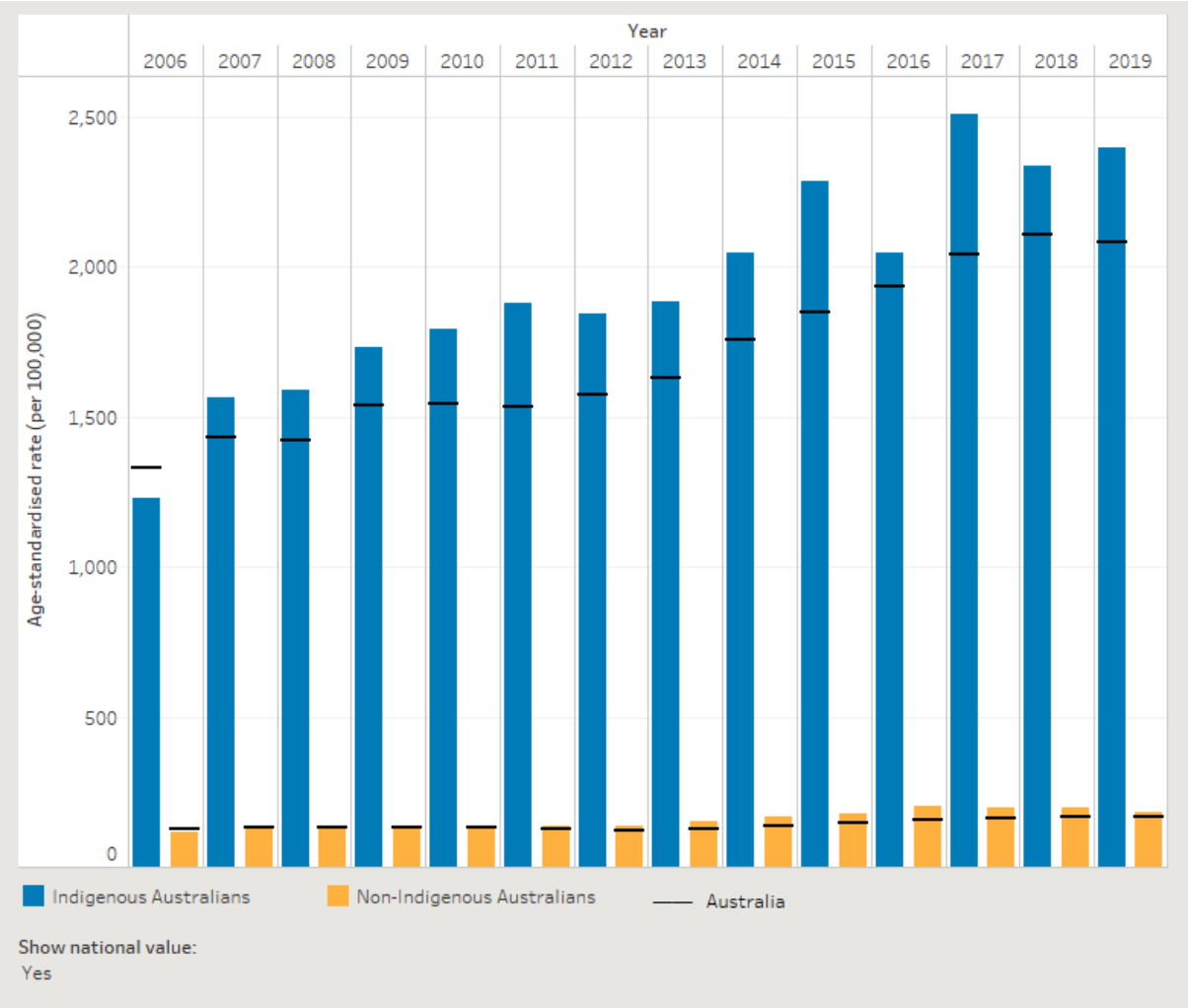


Figure 39 Adult imprisonment of Indigenous and non-Indigenous Australians in South Australia vs national rate, 2006 to 2019

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

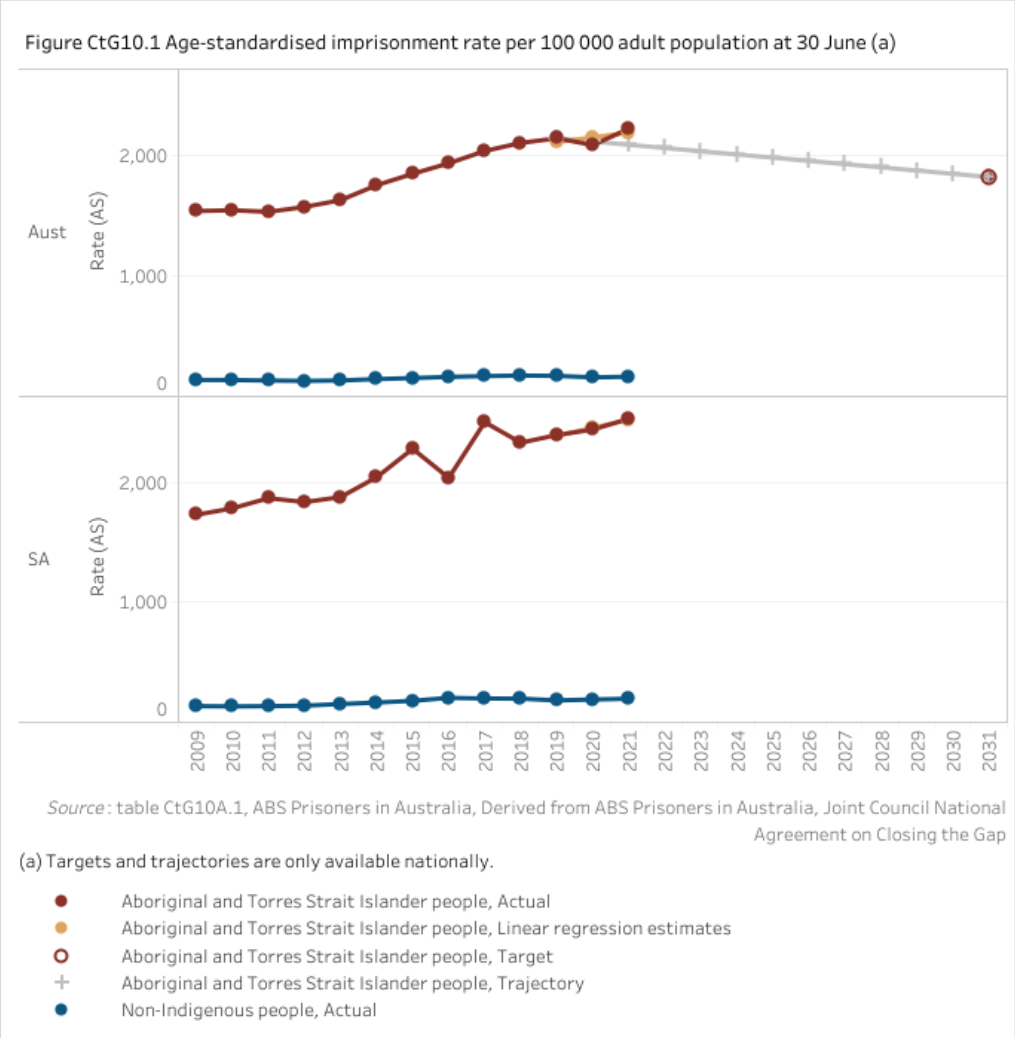


Figure 40 Age-standardised imprison rate per 100 000 adult population, Aboriginal and Torres Strait Islander people and non-Indigenous people in South Australia and Australia

Source: Closing The Gap (78)

2.5.4 Mental Health

As noted in section 2.1, ABS Census 2021 (3-6) asked people about long term health conditions as told to them by a doctor or nurse. The collected data represents those who sought medical treatments from doctors or nurses, those aware of their long-term conditions and those willing to report their long-term conditions in Census. The most reported long-term condition by the Aboriginal and Torres Strait Islander people living in South Australia was mental health conditions (Figure 10). There was gender difference between the reported rates by males and females (Figure 10: men vs women: 17.3% vs 11.6%). There was no data for individuals who identified their gender outside of male or female. The Census 2021 (3-6) data on long-term mental health condition as reported by the Aboriginal and Torres Strait Islander people in Adelaide by SA4 regions are presented in Figure 41. Compared to all of South Australia, Aboriginal and Torres Strait Islander people living in every SA4 regions of Greater Adelaide more commonly reported living with mental health conditions (SA: 14.5%, North: 16.8%, South: 17.9%, West: 15.9%, Central and Hills: 17.3%),

and those living in South Australia more commonly reported long-term mental health conditions compared to the national rate (14.5% vs 13.3%) (3-6).

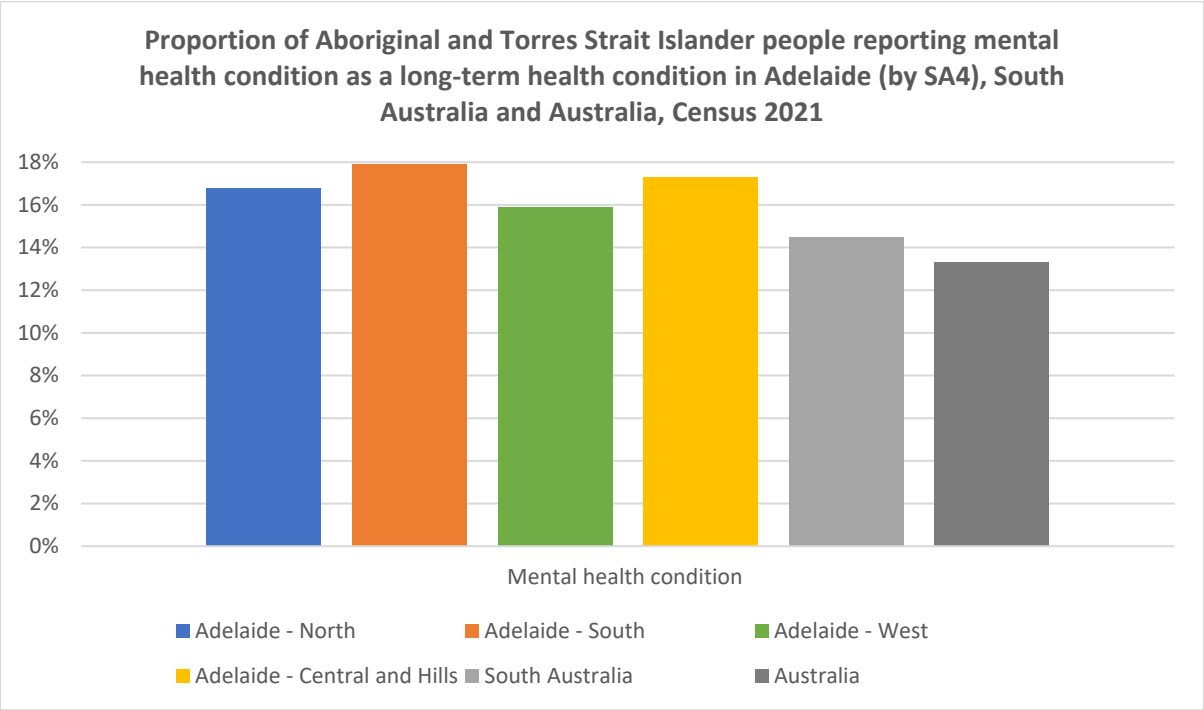


Figure 41 Prevalence of Aboriginal and Torres Strait Islander people reporting mental health condition as a long-term condition by Statistical Area Level 4 in Greater Adelaide, and in South Australia and Australia

Figure generated using ABS 2021 Census data (4-7). Mental health condition includes depression or anxiety. Data represents the number of people who reported that they have been told by a doctor or nurse that they have a mental health condition.

In the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS, 2018-19), around a third of Aboriginal and Torres Strait Islander peoples report having high to very high levels of psychological distress, this is followed by 67% or 3 in 5 Aboriginal and Torres Strait Islander people have reporting low to moderate levels of psychological distress (72). Aboriginal and Torres Strait Islander people living in non-remote areas across Australia reported experiencing more psychological distress compared to those living in remote Australia. In South Australia (Figure 42), 36% of Aboriginal and Torres Strait Islander people felt high levels of psychological distress regardless of remoteness. Psychological distress experienced by Aboriginal and Torres Strait Islander people living in non-remote South Australia was higher than the national average of all Aboriginal and Torres Strait Islander Australians (Figure 42: 36.4% vs 32.0). Psychological distress reported by South Australian Aboriginal and Torres Strait Islander people increased from 30.2% in 2004-05 to 37.1% in 2018-19 (72).

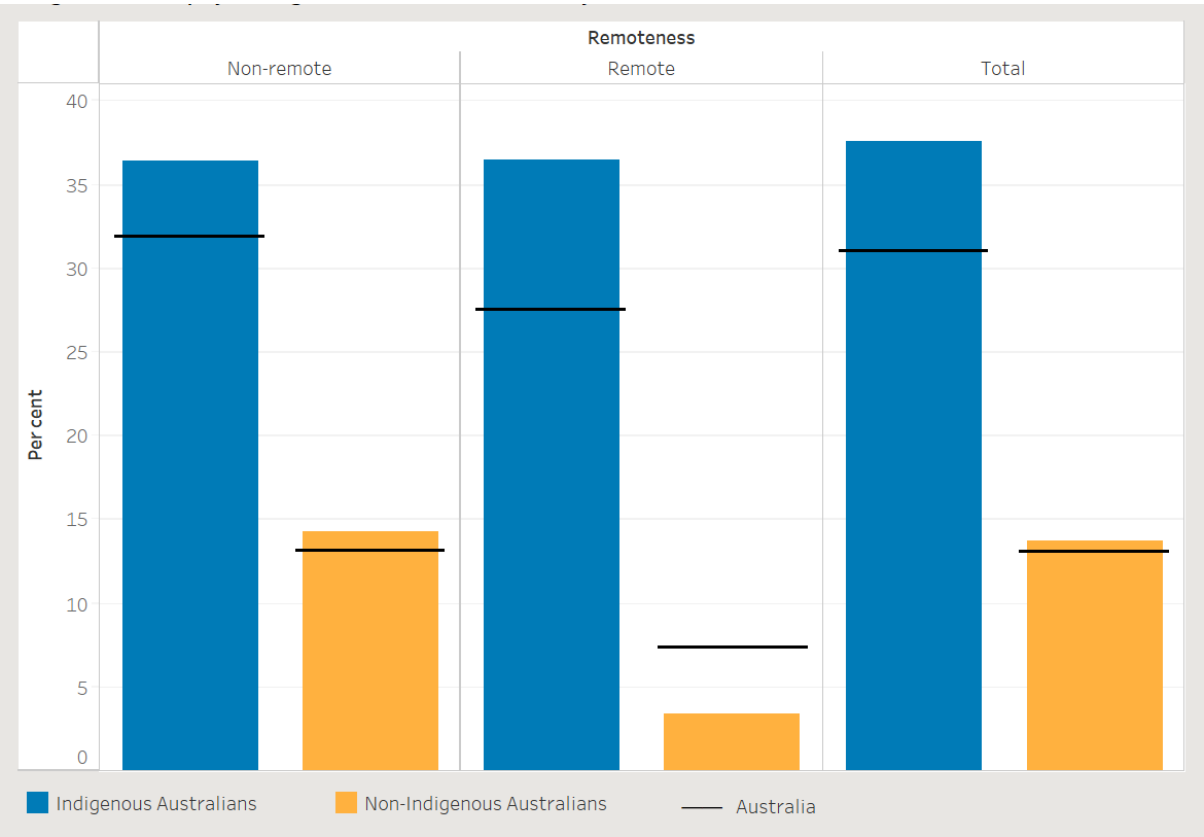


Figure 42 High levels of psychological distress of adults, by remoteness, South Australia, 2018–19

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (72)

2.5.4.1 Contact with mental health care service

Compared to non-Indigenous people in Australia, Aboriginal and Torres Strait Islander people were more likely to access community mental health care services as well as hospitals (Figure 43, Figure 44). Aboriginal and Torres Strait Islander people living in South Australia were less likely to access community mental health care services as compared to those nationally (Figure 43: 2017-18: 1041.2 per 1000 vs 1150.6 per 1000) but more likely to be hospitalised for mental health related conditions (2016-17: 46.1 per 1000 vs 32.2 per 1000) (79).

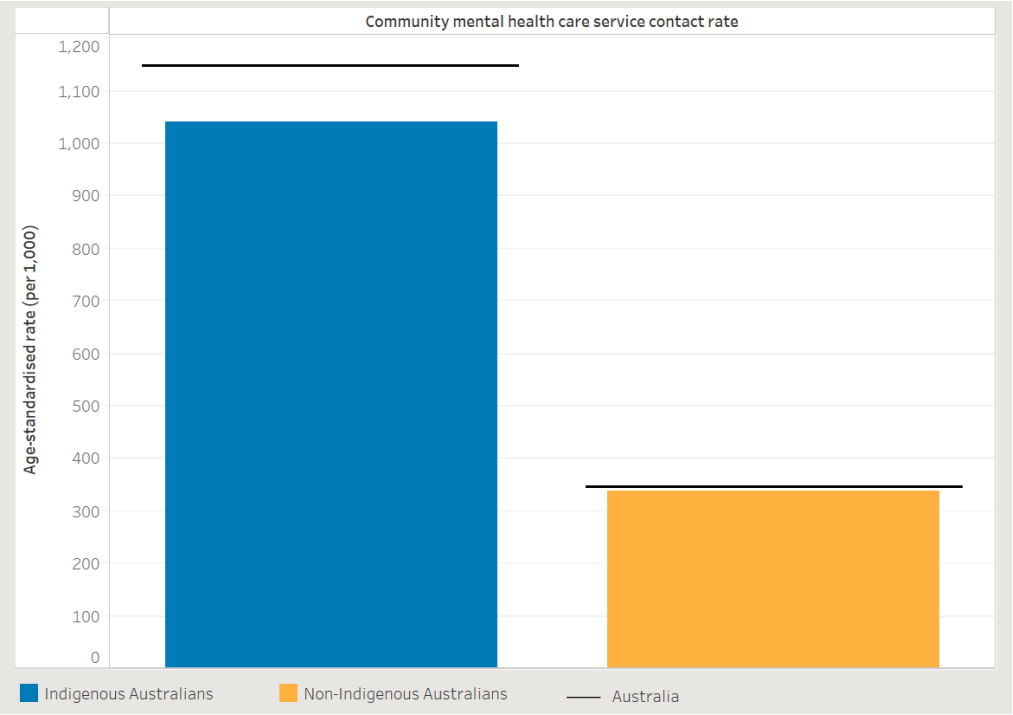


Figure 43 Community mental health care service contact rate, South Australia, 2017-18

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (79)

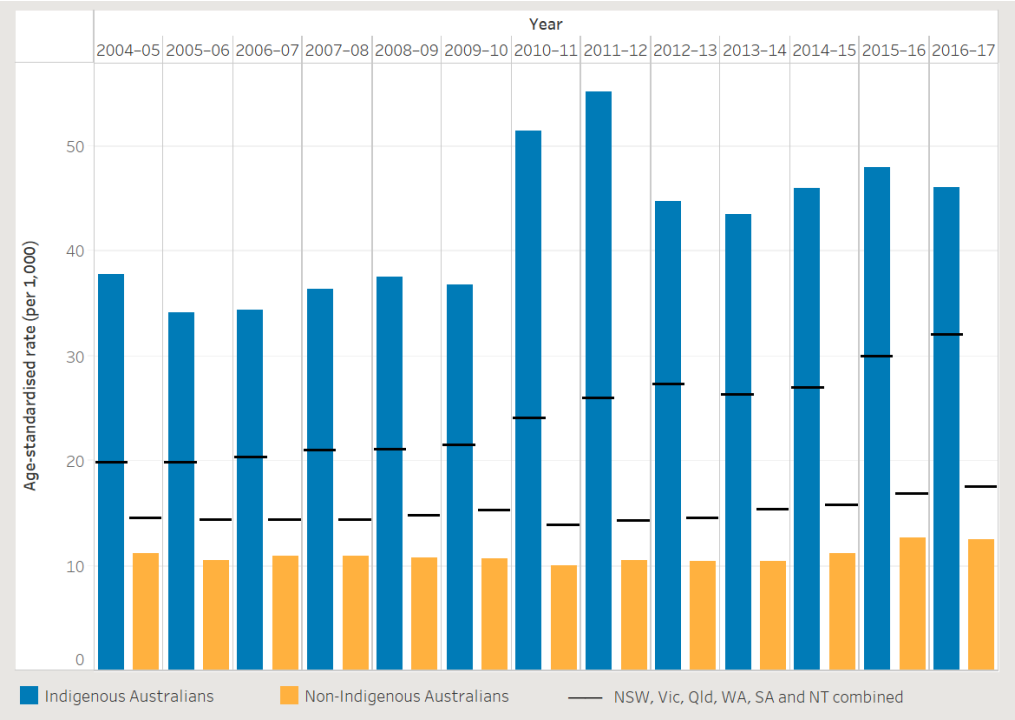


Figure 44 Hospitalisations for mental health related conditions, by year, South Australia

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (79)

2.5.5 Suicide, self harm

Aboriginal and Torres Strait Islander Australians had a higher risk of suicide. In 2015-19, 5.5% of all deaths in Aboriginal and Torres Strait Islander communities were reported as suicide while a further 3.7% were reportedly due to mental health related conditions Figure 45 (72).

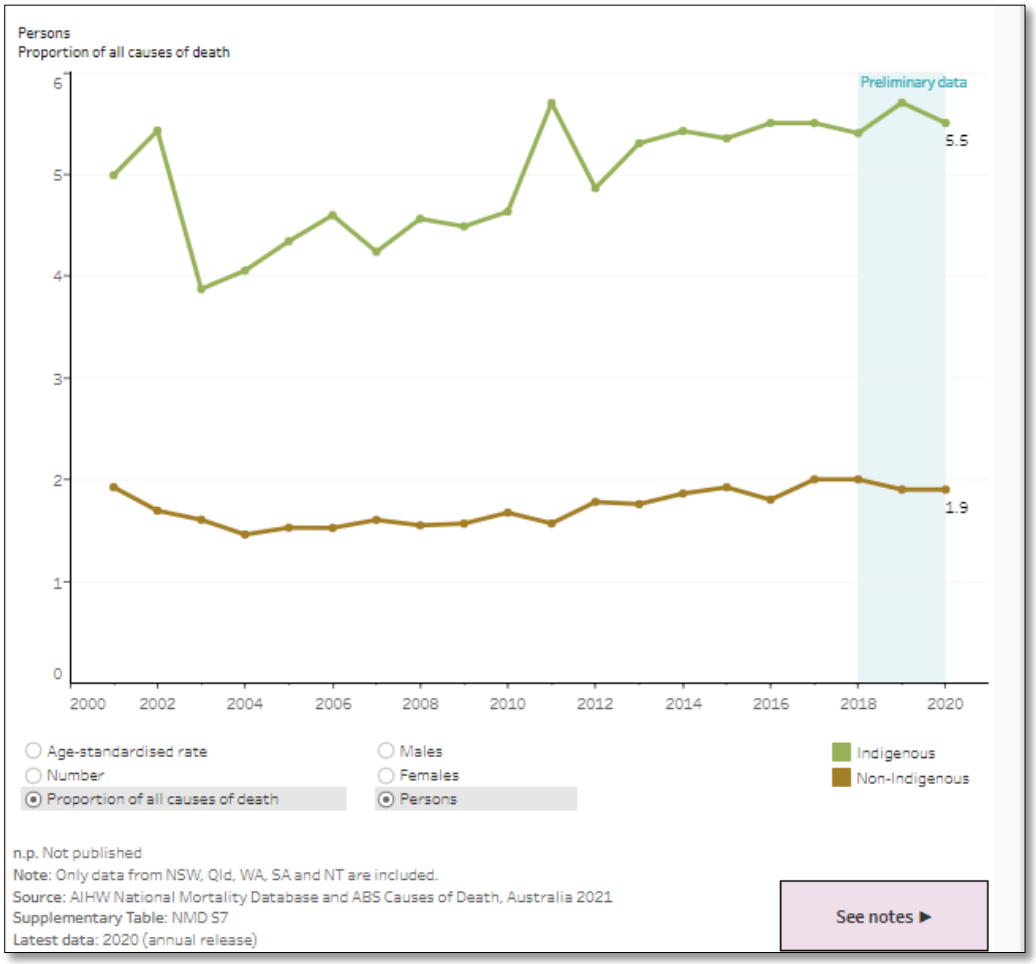


Figure 45 Proportion of deaths by suicide as a proportion of all causes of death by Aboriginal and Torres Strait Islander status, selected states and territories, 2001 - 2020

Source: AIHW (80)

The age-specific rates of suicide deaths (numerator: age specific suicide deaths, denominator: all deaths) have a different pattern for Aboriginal and Torres Strait Islander individuals as compared to non-Indigenous individuals, with more than half of suicide related deaths in South Australian Aboriginal and Torres Strait Islander communities occurring in the age group of 35 to 44 years (Figure 46) (80).

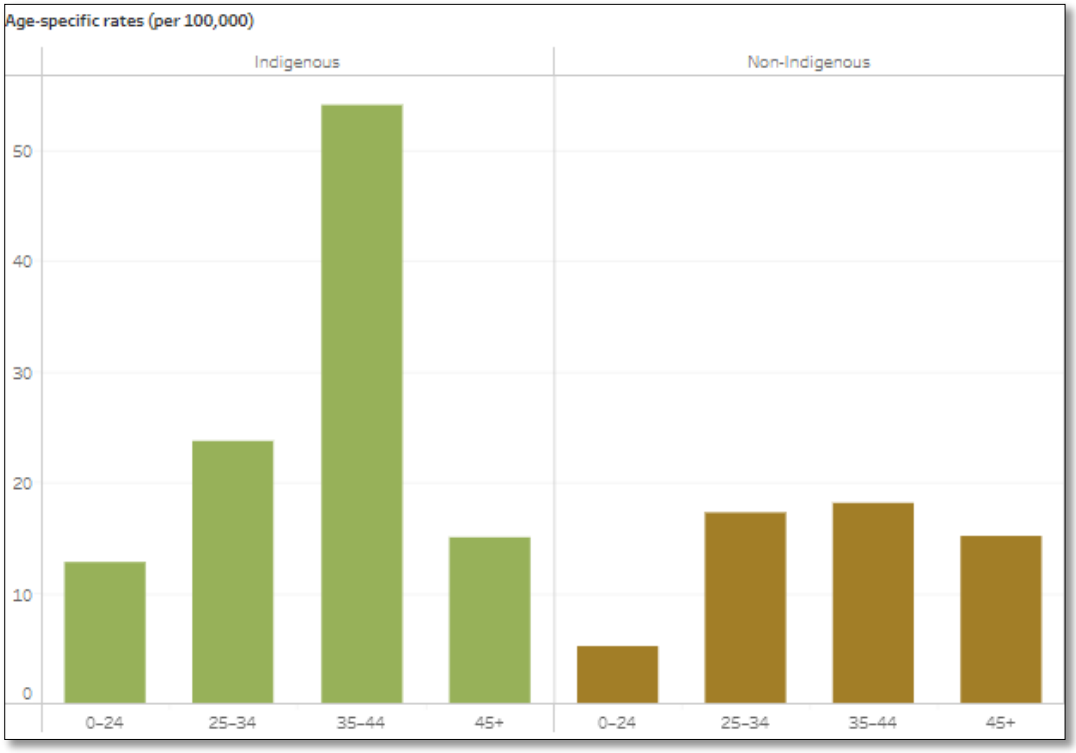


Figure 46 Age-specific suicide deaths in South Australia, 2016-2020

Source: AIHW (80)

In South Australia, there were 12 suicide related deaths in 2019, and 10 suicide related deaths in 2020 (Table 10) *(81)*.

Table 10 Number of deaths by suicide of Aboriginal and Torres Strait Islander people, by state of usual residence, 2011-2020

	Count of suicide deaths by year									
State of residence	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
New South Wales	18	21	25	23	41	40	44	48	50	54
Victoria	8	6	7	7	7	7	6	10	13	21
Queensland	45	31	52	40	53	51	53	63	73	70
South Australia	10	7	10	10	7	1	14	3	12	10
Western Australia	36	34	35	46	40	47	27	39	30	36
Tasmania	0	1	3	0	1	3	1	0	1	4
Northern Territory	27	27	18	29	13	18	27	21	30	27
Australian Capital Territory	0	4	3	4	3	1	1	3	2	1
Australia	**144**	**128**	**151**	**157**	**164**	**169**	**174**	**185**	**215**	**223**

Source: ABS Causes of Death Data (81)

2.5.6 Mental Health care feedback from the Council

Feedback from the Council around mental health outcomes in the Adelaide PHN region provided insights for ways forward in the future:

- co-design of community mental health programs targeting holistic health and healing, increases in Aboriginal Liaison Officers or Health Workers with targeted training, access to 24-hour care and walk in services
- peer support programs and structures

  "Shame is the biggest thing holding people back."

- a need for services specifically Aboriginal men
- programs and works for LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual) in the Aboriginal and Torres Strait Islander community
- patient centred approaches to care across networks
- training and awareness for families

  "There are increases in suicides affecting the community. Need education for family around how to identify early signs or what to look out for, along with education around coping mechanisms."

2.6 Life-style and family health

2.6.1 Pregnancy and antenatal care

Highlights

The Aboriginal Family Birthing Programs in South Australia have been shown to increase antenatal attendance for expecting mothers.

As shown in Figure 47, Aboriginal and Torres Strait Islander women in South Australia had a lower rate of accessing perinatal care in their first trimester (63%) when compared to both Aboriginal and Torres Strait Islander women nationally (68%) and non-Indigenous women in SA (rate in non-Indigenous women not shown in Figure 47: 83.5%) (44). Moreover, 2.6% of SA Aboriginal and Torres Strait Islander women did not receive any antenatal care compared to 0.8% Aboriginal and Torres Strait Islander women nationally and 0.2% non-Indigenous women in SA (44). These outcomes are consistent with other reports where Aboriginal women have a lower rate of accessing antenatal care and reported feeling disenfranchised, abandoned, and judged while pregnant and accessing care (82, 83).

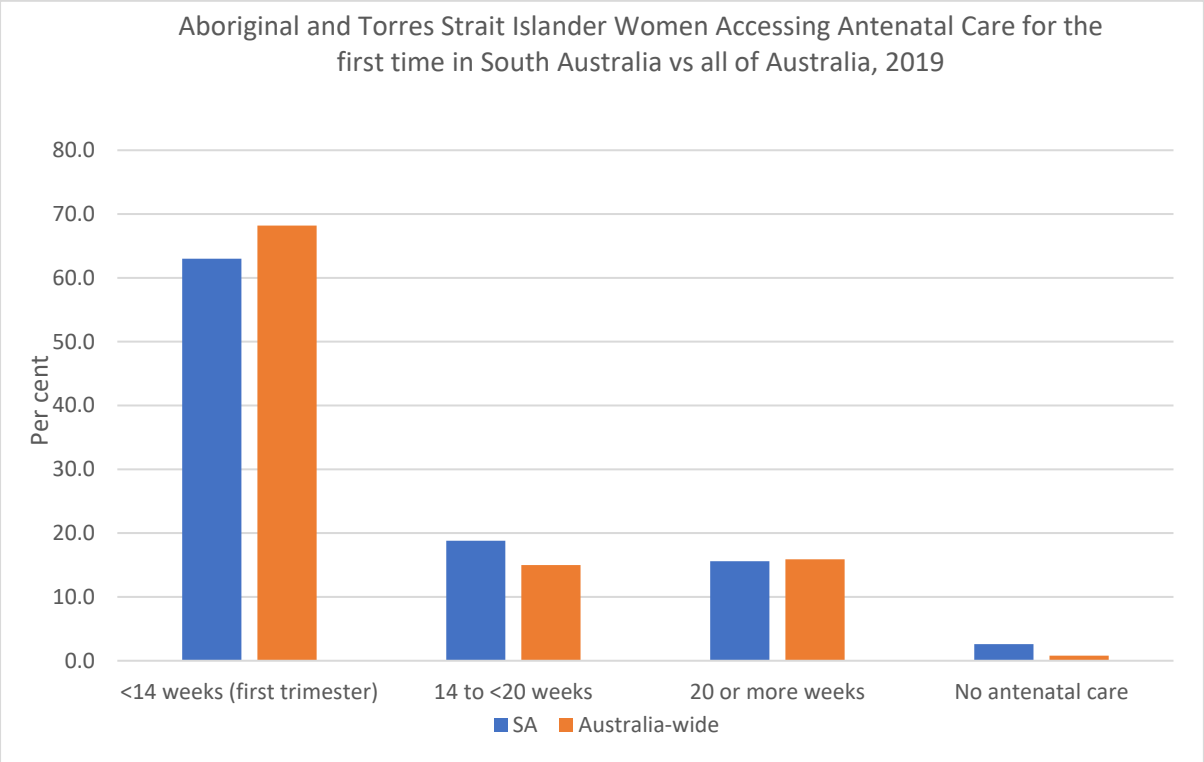


Figure 47 Aboriginal and Torres Strait Islander Women Accessing Antenatal Care for the first time in South Australia vs all of Australia, 2019

Figure generated using data from AIHW report (44)

These impacts have not been recognised by peek national bodies, with the Australian National Maternity Services Plan describing Australia as being one of the safest countries internationally to give birth in (84), however this can only be assumed for the dominant population. Factors impacting on access to care for Aboriginal and Torres Strait Islander women in SA in the first trimester have

included the age of the mother, for instance young mum's often have not accessed care due to fear and shame, educational level with decreases in access with no secondary education, later recognition of pregnancy or smoking (85). These outcomes have been further supported through the Council, with transgenerational trauma and grief still impacting significantly on pregnant Aboriginal and Torres Strait Islander women in the Adelaide PHN, and fear of the 'System' (Child Protection Service).

> *"Distrust due to high rates of children being removed, especially if mother in is a domestic violence relationship."*

Given the over representation of Aboriginal and Torres Strait Islander children being removed in the Adelaide PHN (see Section 2.6.1), these fears are well warranted. Certainly, questions have been raised in SA Aboriginal and Torres Strait Islander communities given the lack of engagement in kinship care arrangements, or support for the parents who have had their child removed. Guilt, loss, shame and despair are all experiences reported by women who have had a child removed, but for Aboriginal and Torres Strait Islander women this is further compounded by transgenerational trauma and grief from ongoing colonisation (86).

Approaches to improving antenatal care attendance in South Australia have included culturally specific care through Aboriginal Family Birthing Programs (85). Additionally increased employment of Aboriginal Maternal Infant Care (AMIC) workers in health services. Community co-designed programs which centralise the role of AMIC workers to target areas of importance for antenatal care (i.e. smoking during, nutrition access to antenatal care) are needed to improve birth outcomes for Aboriginal and Torres Strait Islander communities (87).

2.6.2 Preterm birth

Lower birthweight and higher rates of preterm birth rates continues to be reported for Aboriginal and Torres Strait Islander infants (87), both of which have been suggested to increase the risk of health outcomes later in life. In SA Aboriginal and Torres Strait Islander women were more likely to have a preterm baby (10.8% vs 10.4%) are but were more likely to have and early term birth (38.8% vs 33.7%) as compared to national rates (88), see Figure 48.

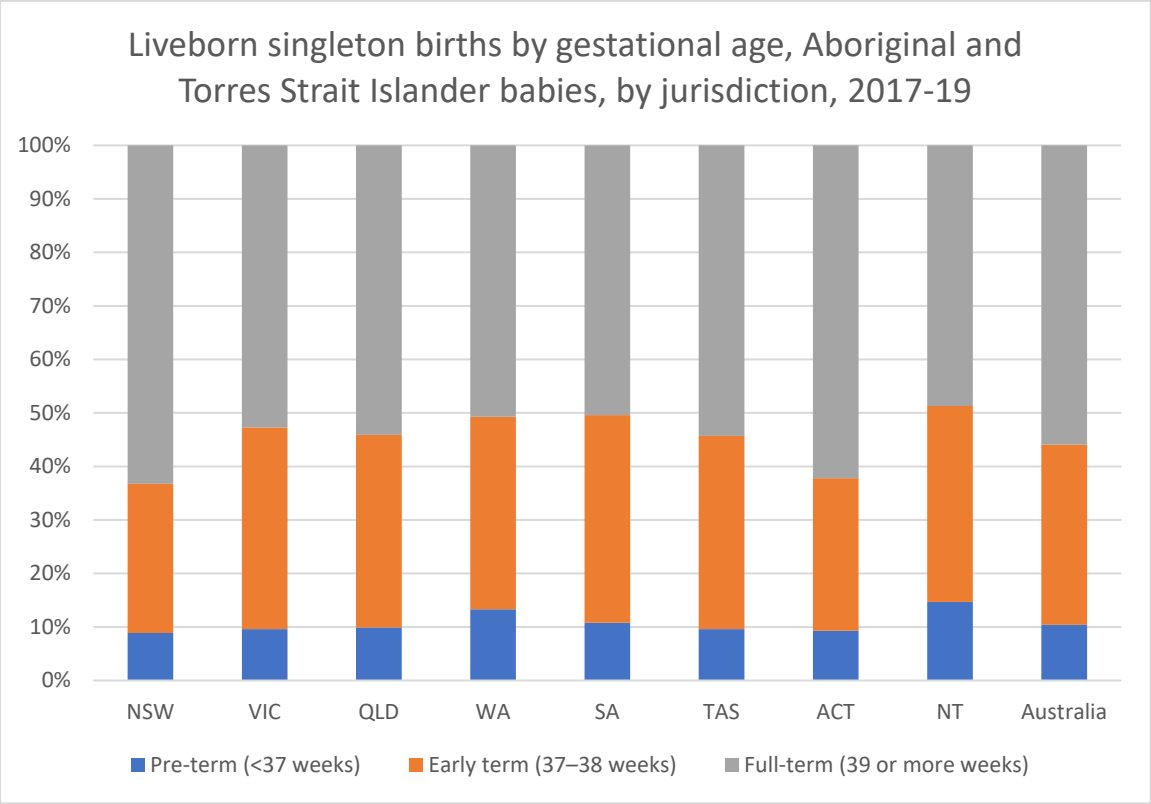


Figure 48 Gestation age of Aboriginal and Torres Strait Islander babies by jurisdiction, 2017-19

Figure generated from AIHW dataset (88)

2.6.3 Maternal age

Aboriginal and Torres Strait Islander community have younger mothers, with more than 1 in 10 mothers being under 20 years of age and 1 in 3 mothers being aged 20 to 24 years in 2019 (88), see Figure 49. In contrast, the most common age for non-Indigenous mothers to have a child was 30 to 34 (88). While the age distribution of Aboriginal and Torres Strait Islander mothers has changed in the last decade (Figure 49), the biggest change has been a reduction in women under age 20. Given the age distribution of Aboriginal and Torres Strait Islander mothers is much younger than non-Indigenous mothers, antenatal and postnatal care delivery needs to be tailored according to the life-stage and cultural needs of the mothers.

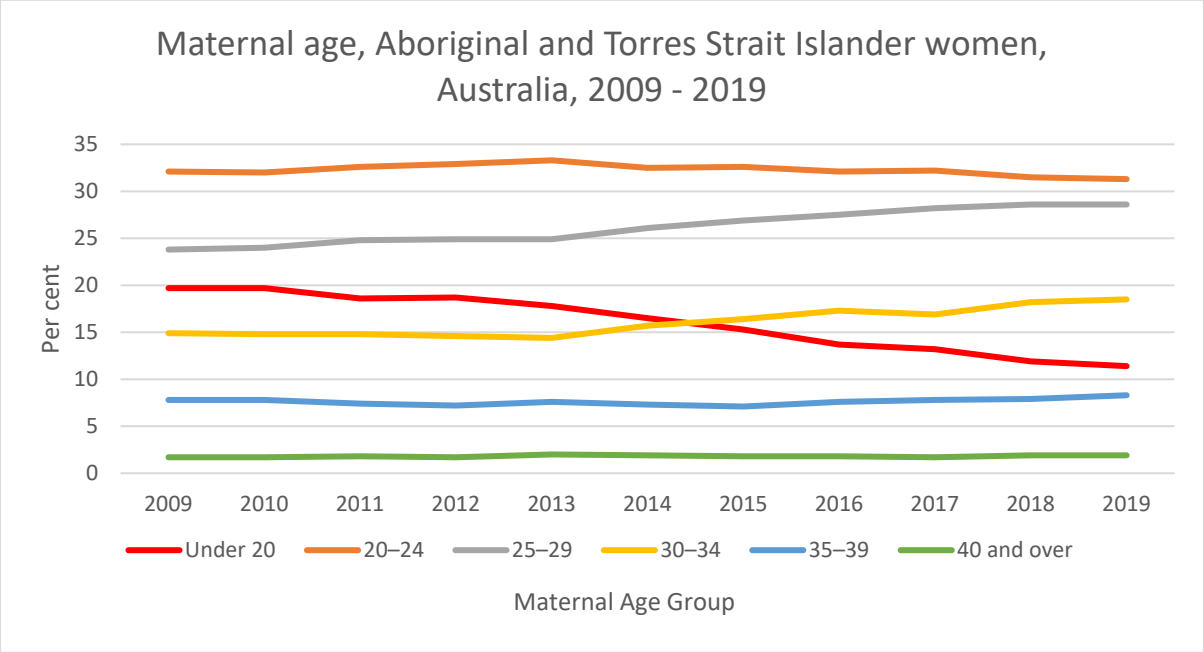


Figure 49 Maternal age of Aboriginal and Torres Strait Islander women in Australia, 2009 – 2019

Figure generated from AIHW dataset (88)

2.6.4 BMI during pregnancy

Aboriginal and Torres Strait Islander women giving birth in SA were less likely to be underweight as compared to the national average (Figure 50: 4% vs 7%), but more likely to be regarded in the obese range (Figure 50: 37% vs 31%). This in itself has an impact on what birthing options would be provided to Aboriginal and Torres Strait Islander, being regarded in an obese category requires birthing in a tertiary health service, which decreases options or consideration of culturally specific birthing options.

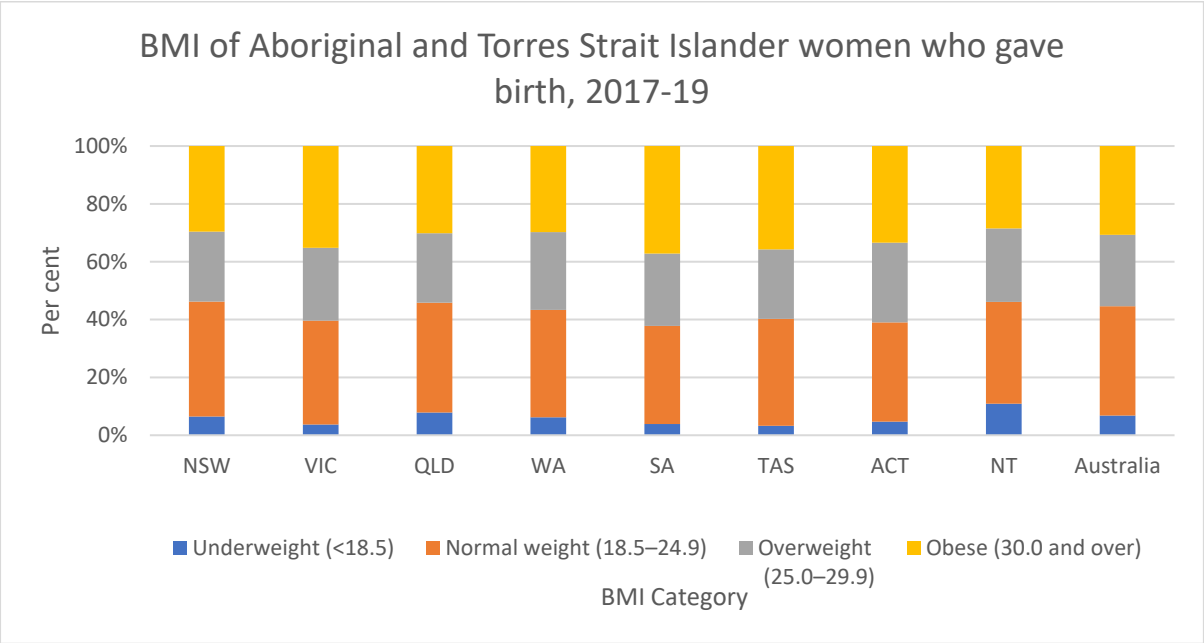


Figure 50 BMI of Aboriginal and Torres Strait Islander women who gave birth by jurisdiction, 2017-19

Figure generated from AIHW dataset (88)

2.6.5 Smoking during pregnancy

More than half (51.2%) of all Aboriginal and Torres Strait Islander women in South Australia smoked in the first 20 weeks of their pregnancy, and 41.5% of these women continued smoking after 20 weeks of pregnancy (89). In SA Aboriginal and Torres Strait Islander women had a higher rate of smoking during pregnancy when compared to those nationally (Figure 51: 51.8% vs 44.3%) (89). A range of state specific community co-designed programs have been developed such as SISTAQUIT, which could be tailored to a SA context. This would require community leadership, co-design and support.

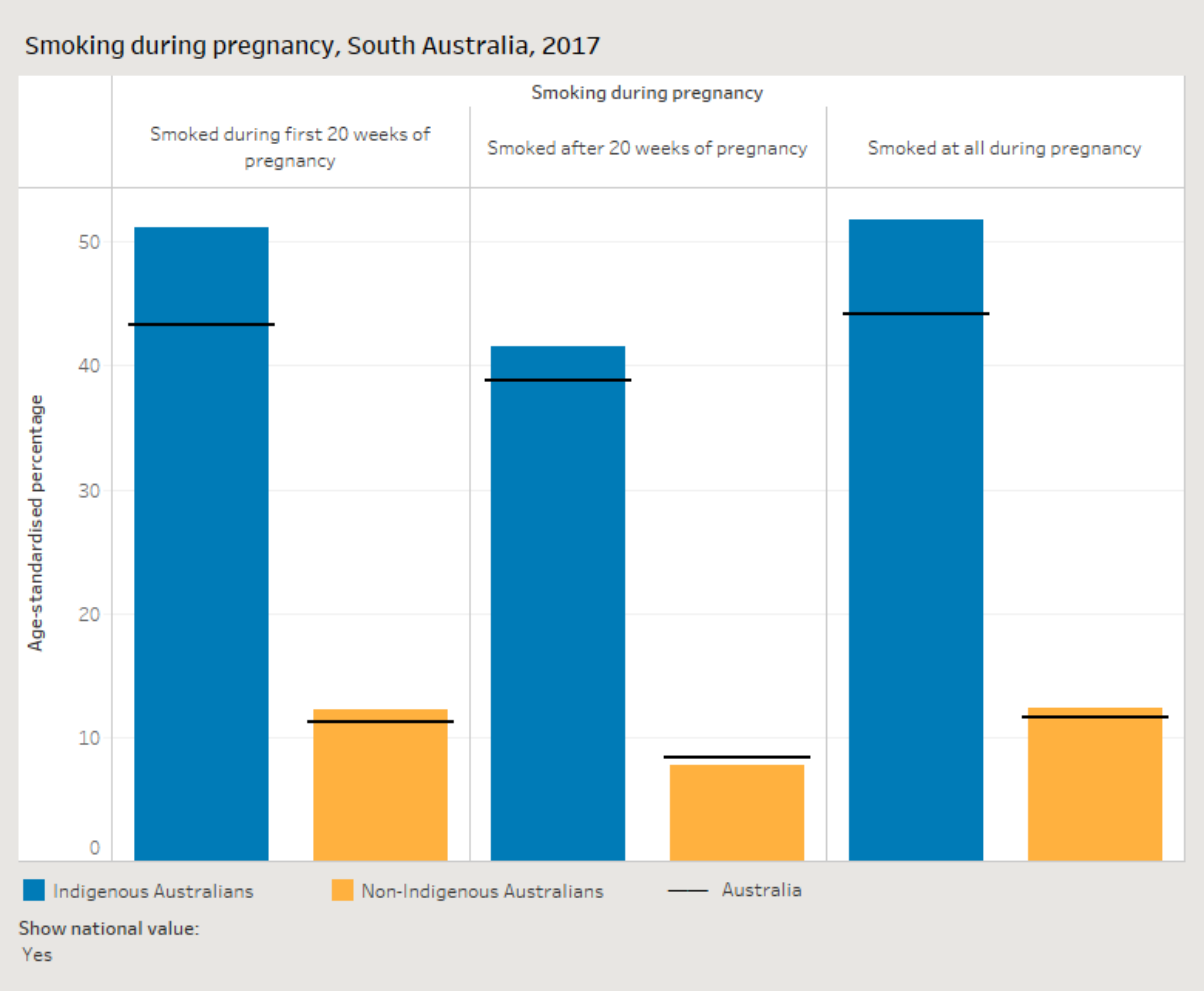


Figure 51 Aboriginal and Torres Strait Islander women who smoked during pregnancy, by gestational age, compared to Indigenous and non-Indigenous women across Australia, 2017

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (89)

2.6.6 Perinatal care (0-12 months)

A quarter of babies born to Aboriginal and Torres Strait Islander mothers in South Australia were never breastfed compared to 14.8% of Aboriginal and Torres Strait Islander infants nationally, Table 11 (90).

Table 11 Breastfeeding status, by jurisdiction, Aboriginal and Torres Strait Islander infants aged 0–3, 2018–19

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	AUS
	%								
Child has been breastfed									
Currently breastfed	16.6	12.7	30.5	34.0	10.0	25.0	28.6	51.9	24.0
Was breastfed but now ceased	74.1	52.4	65.3	46.8	62.5	54.2	71.4	32.7	60.9
Breastfeeding duration									
Less than 1 month	6.5	7.9	3.8	8.5	15.0	8.3	14.3	3.8	6.6
1 to less than 6 months	32.4	17.5	35.2	19.1	32.5	29.2	28.6	9.6†	28.1
6 to less than 12 months	23.1	9.5	11.0	7.4	2.5	16.7	0.0	11.5	15.1
12 months or more	10.1	11.1	9.7	13.8	15.0	4.2	14.3	13.5	10.7
Total ever breastfed (current or ceased)	*89.5*	*69.8*	*94.5*	*79.8*	*77.5*	*83.3*	*85.7*	*84.6*	*84.9*
Never breastfed	13.0	28.6	8.5	24.5	25.0	25.0	14.3	13.5	14.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total number of infants aged 0–3	**24,664**	**6,271**	**23,566**	**9,430**	**4,017**	**2,430**	**744**	**5,162**	**77,461**

Data table modified from AIHW dataset (90). Data has high relative standard error and should be used with caution.

Evidence surrounding care in the first 100 days for Aboriginal mothers and their infants have found a continuity of care is lacking (91). If services are available, they are in hospitals rather than in health centres and are very much focussed antenatally rather than postnatally (89). Child and Family Health Services does provide all parents with access to Aboriginal Cultural Child and Family Support Consultants (ACCFSCs), however these services may not be being accessed for reasons outlined in 2.6.1. Further work is warranted to provide continuity of care in the perinatal period through co-design and collaboration with community.

2.6.7 Early childhood

Due to a younger age structure of Aboriginal and Torres Strait Islander people in Adelaide, more than 1 in 10 are in their early childhood period, that is, between the ages of 0 to 4. Early childhood period presents a unique opportunity to have the best start in life and continue a better trajectory.

The Indigenous Health Check for ages 0 to 4 was designed for Aboriginal and Torres Strait Islander children to provide an appropriate and needs-suited preventive healthcare check in various social and cultural determinants health improvement. Data from Indigenous Health Check rate shows that (Figure 18) less than 1 in 4 Aboriginal and Torres Strait Islander children in Adelaide PHN underwent a health check either in-person or by telephone in 2020-21.

Culturally appropriate and quality early childhood education is an important closing the gap target for Aboriginal and Torres Strait Islander people. The baseline year of 2016 saw only 76.7% of Aboriginal and Torres Strait Islander children enrolled in a preschool program, now 96.7% of Aboriginal and Torres Strait Islander children are enrolled in a preschool program nationally, and almost 100% in South Australia (Figure 52) (92).

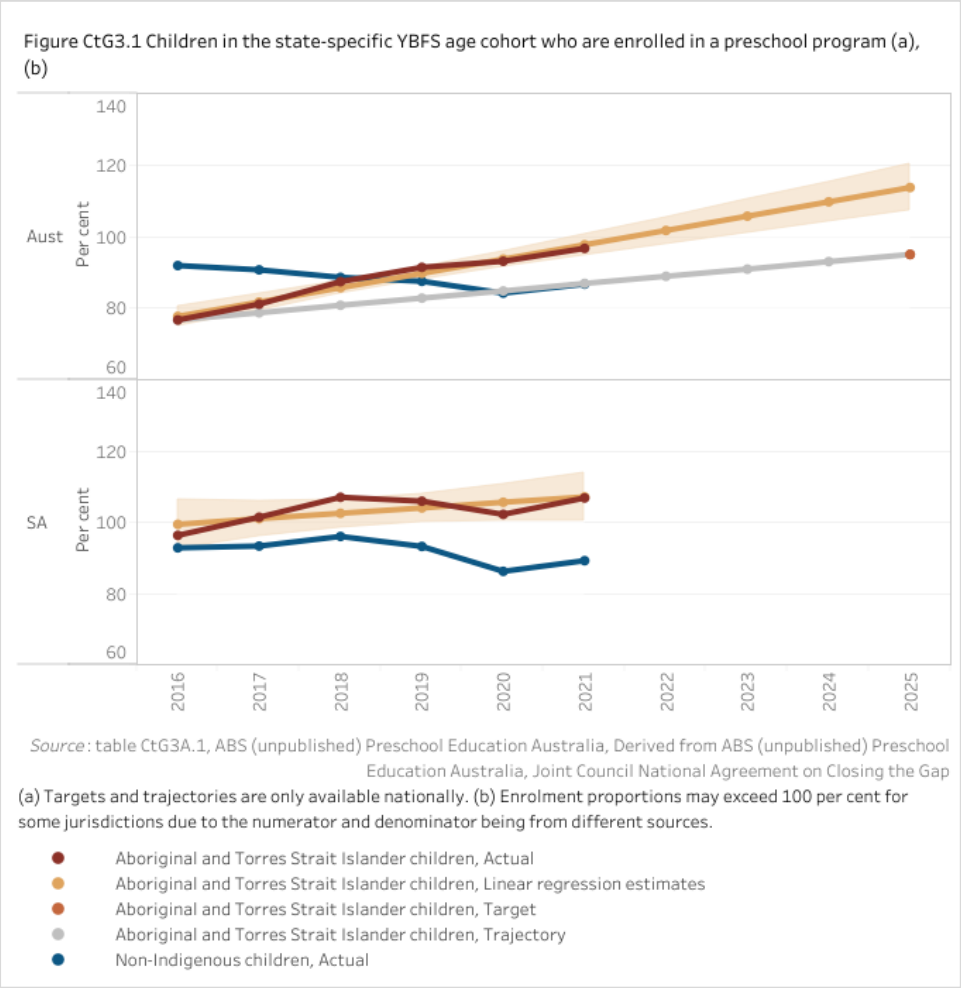


Figure 52 Aboriginal and Torres Strait Islander children in Australia and South Australia enrolled in a preschool program

Source: Closing The Gap (92).

2.6.8 Education in young people

As an initiative to improve the social determinants of health, there was a national target to improve the reading, writing and numeracy skills of the Aboriginal and Torres Strait Islander children (93). The aspired level by 2018 has not been reached. Approximately one in four Aboriginal and Torres Strait Islander children in years 5, 7, 9, and one in five year 3 remained below the national minimum standards in reading. Nearly one in five remain below minimum standards in numeracy. However, there has been improvements in the last decade (Figure 53).

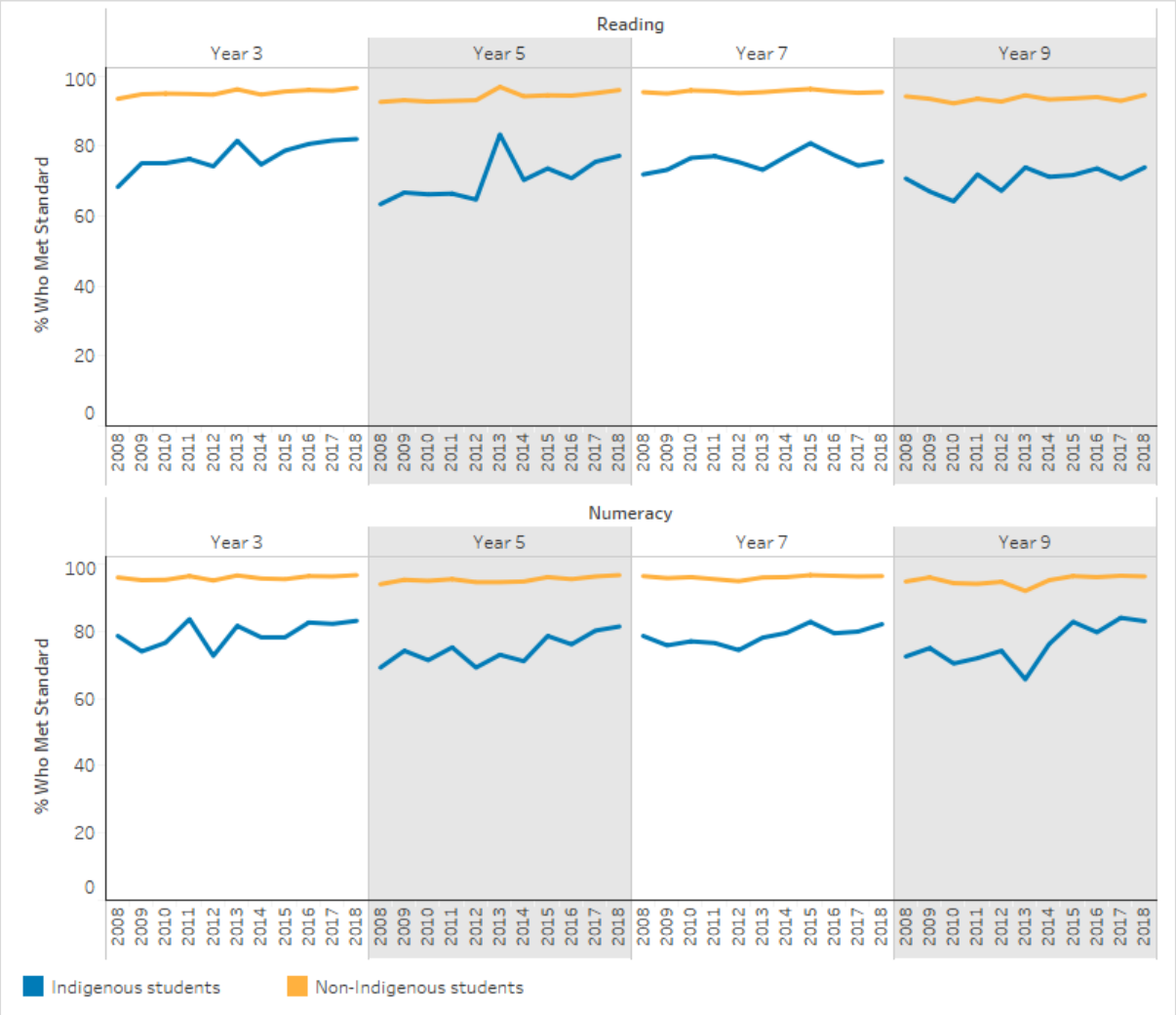


Figure 53 Proportion of Aboriginal and Torres Strait Islander children meeting national minimum standards in reading and numeracy in the last decade

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020

The National Close the Gap campaign has a key target to increase the proportion of children being assessed as developmentally on track across all areas of the Australian Early Development Census by 55% (75). In South Australia action is required to increase this level to meet this target by 2031 (Figure 54).

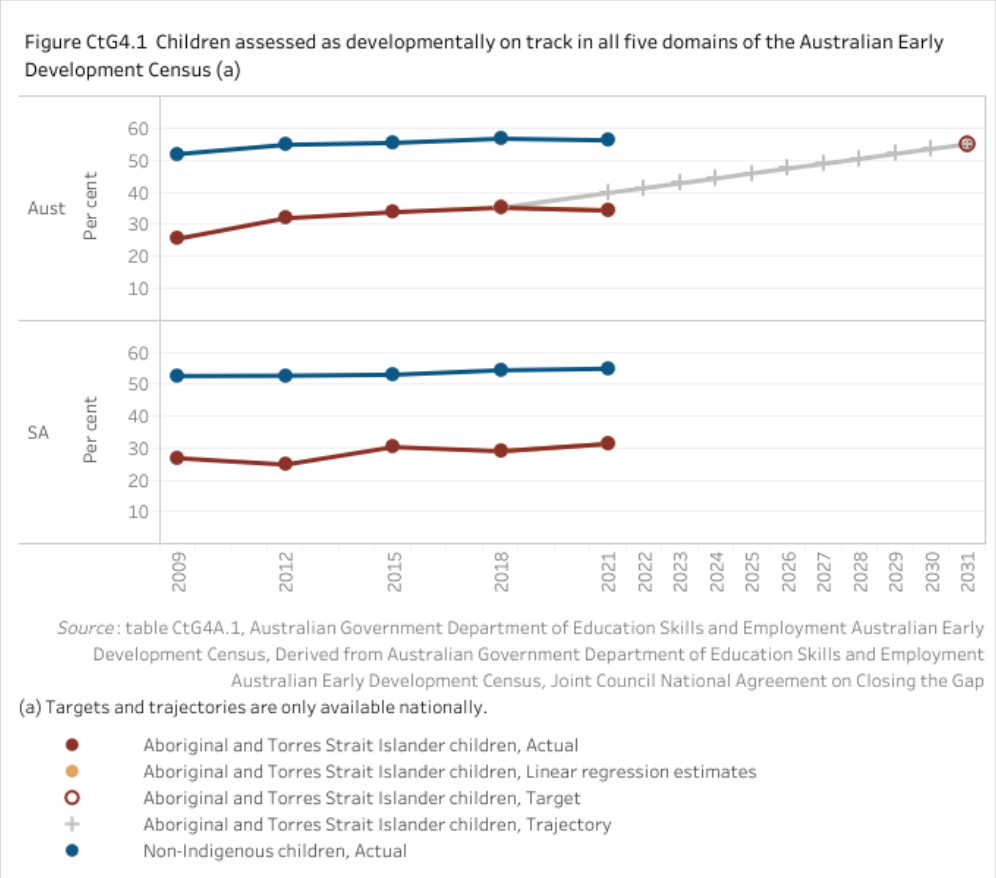


Figure 54 Children assessed as developmentally on track in all five domains of the Australian Early Development Census, Aboriginal and Torres Strait Islander children and non-Indigenous children in Australia and South Australia, 2009 - 2021

Source: Closing The Gap (75)

2.6.9 Dental/Oral health

Aboriginal and Torres Strait Islander children in SA aged 4 and under are at twice the risk of being hospitalised for dental issues compared to those nationally (13.8% vs 6.2%), and these children continue to be at a higher risk of hospitalisation due to dental problems until 15 years of age (9.2% vs 6.1%) (See Figure 55) (35).

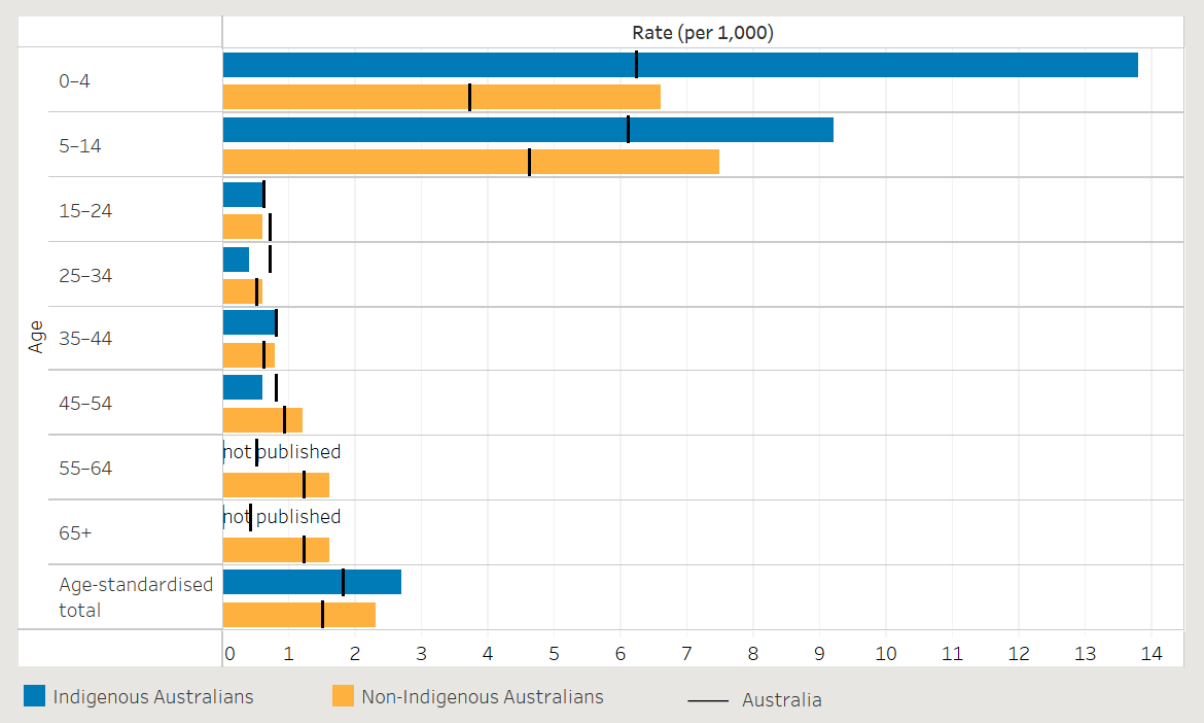


Figure 55 Hospitalisations with a principal diagnosis of dental problems in South Australia, 2015 – 2017

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (35)

Community consultations with the Council identified that dental care was a huge concern in the Adelaide PHN. Specifically out-of-pocket expenditure for dental access was noted as a barrier as there was no financial assistance for gap payments and wait lists to access dental care are exorbitant. The Council also commented on the importance of access to good oral care and hygiene, especially for early intervention and prevention as it can impact on so many areas of life i.e., surgical interventions.

2.6.10 Immunisation

Highlights

Prior to 6 years of age 95.5% of Aboriginal and Torres Strait Islander children in SA are fully immunised.

The childhood immunisation program for Aboriginal and Torres Strait Islander children is significantly effective with 95.5% of those living in South Australia being fully immunised by age 5 (Figure 56). This rate is higher than the rate of immunisation (94.7%) in non-Indigenous children living in South Australia (94). Early childhood checks, community immunisation clinics and AMIC workers are likely to play a significant role in these high levels.

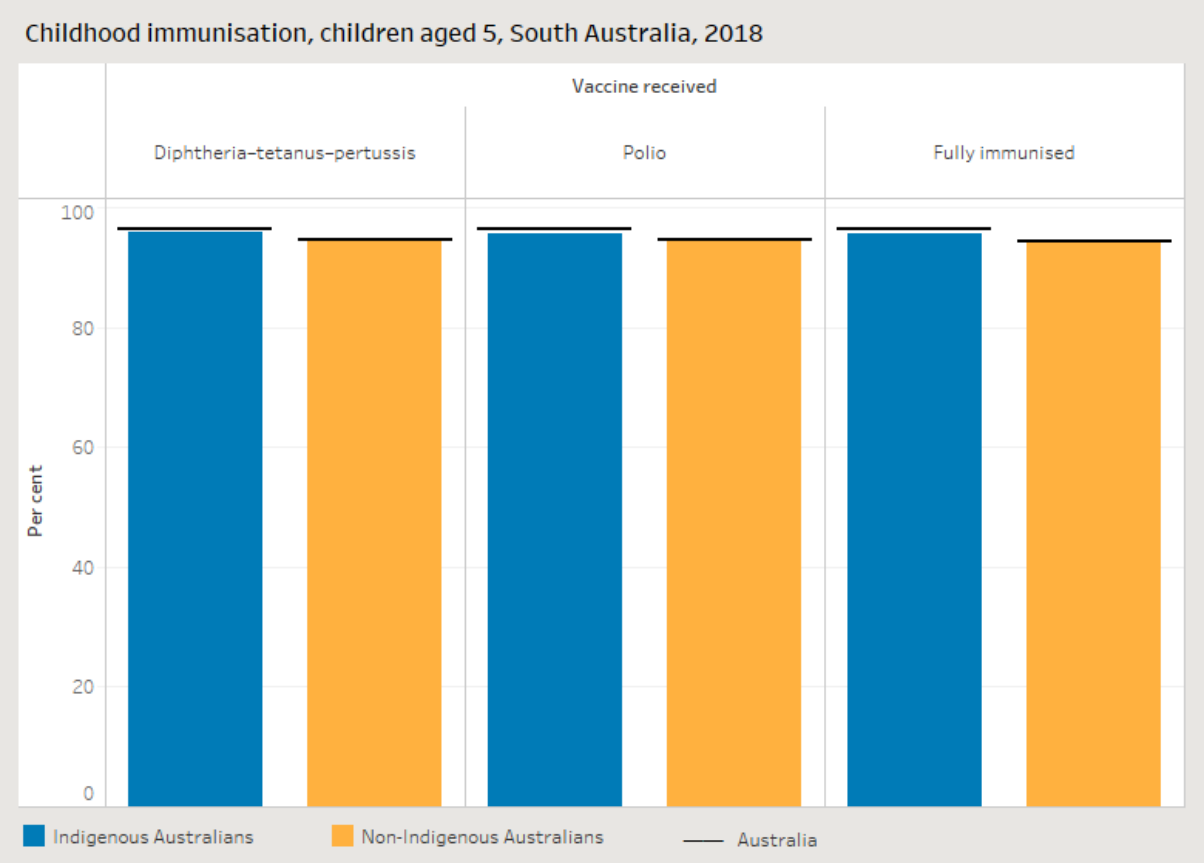


Figure 56 Childhood immunisation in children aged 5 in Aboriginal and Torres Strait Islander children living in South Australia, compared to non-Indigenous children, 2018

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (92)

2.6.11 Chronic conditions in young people

Aboriginal and Torres Strait Islander young children are at higher risk of developing various chronic and complex conditions such as ear, eye, dental issues, rheumatic heart disease. The age-specific prevalence rates are presented above in chronic condition specific section.

2.6.12 Injury in young people

Highlights

The rate of age specific hospitalisations from injury for Aboriginal and Torres Strait Islander children in SA from ages 15-24 years is much lower than the national average.

Nationally injury is a leading cause of hospitalisation for children (aged 0-16 years), costing the Australians healthcare system $212 million annually (95). Aboriginal and Torres Strait Islander children are disproportionally impacted by injuries and significant health inequities are present. From 2015-19 injury accounted for almost half (47%) of Aboriginal and Torres Strait Islander children's deaths for ages 1-4 years, whereas from 0-4 years accidental drowning accounted for 25% of deaths (Figure 57) (95). These trends differ across age categories, with suicide a common cause of mortality for 5-14 years of age (95). Within each injury type health inequities are present, for instance in burns 10.4% of child cohort in the Burns Registry of Australia and New Zealand being Aboriginal of Torres Strait Islander children (96). These children have greater burns severity, treatment and complications (streptococcus infections 4.3 times longer) and a hospital length of stay four days longer as compared to non-Indigenous children (97).

Of the small amount of work being conducted in this area in urban NSW, protective injury prevention factors have included family and community wellbeing, such as parental social and emotional wellbeing (98). However, Australia still awaits release and launch of the National Injury Prevention Strategy to support action in this area. Significant unknowns remain surrounding Aboriginal and Torres Strait Islander children injury, along with community co-designed prevention and support initiatives.

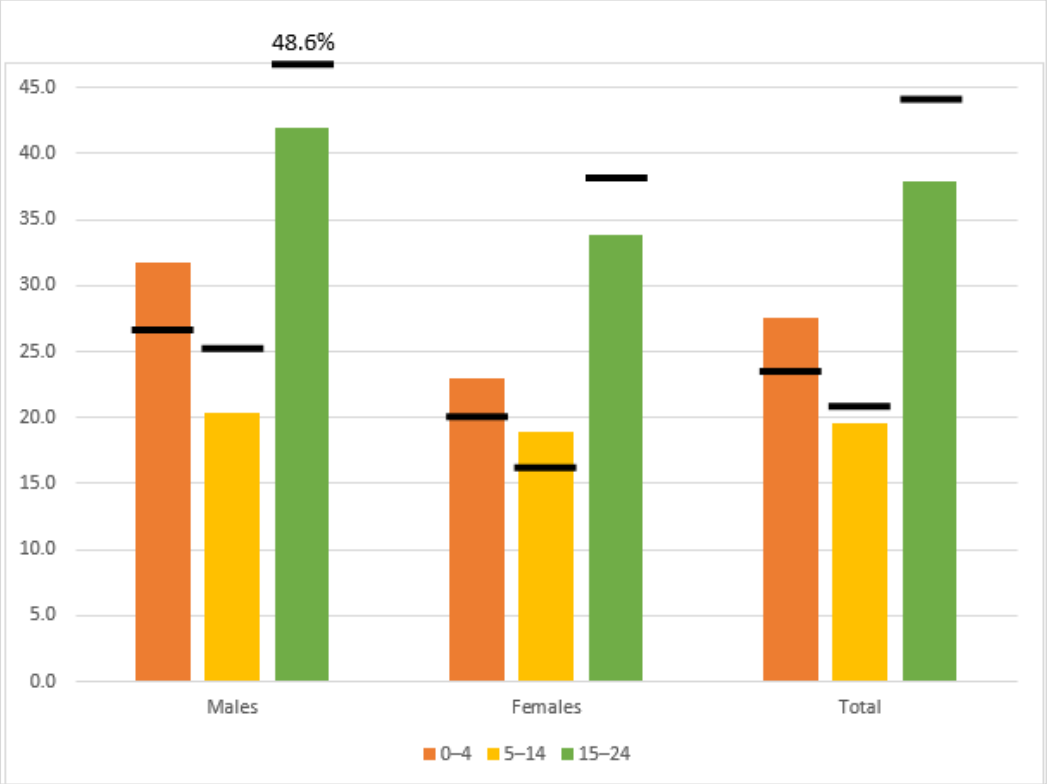


Figure 57 Age-specific hospitalisation rates for a principal diagnosis of injury and poisoning, by Aboriginal and Torres Strait Islander status and sex, South Australia and national average, July 2015 to June 2017

Source: Australian Trauma Quality Improvement Collaboration (95)

2.6.13 Death rate in children

Aboriginal and Torres Strait Islander children are an important gift for community, part of extended family and connection to community in many different and dynamic ways (99). In this kinship relationships establish caring and nurturing roles across the life cycle, which are imperative for identity development, strength and resilience, which are protective factors for a child's health and well-being (100). In South Australia this child mortality rate in Aboriginal and Torres Strait Islander children is correlated with area level socioeconomic disadvantage, with the highest rate of death is in the most disadvantaged area (101). Socioeconomic disadvantage is directly related to marginalisation from ongoing colonisation and is the reason for significant health inequities impacts. This devastation for communities needs to stop, tailored support to move the social gradient of health in this area is needed, to ensure the health and wellbeing for the whole community.

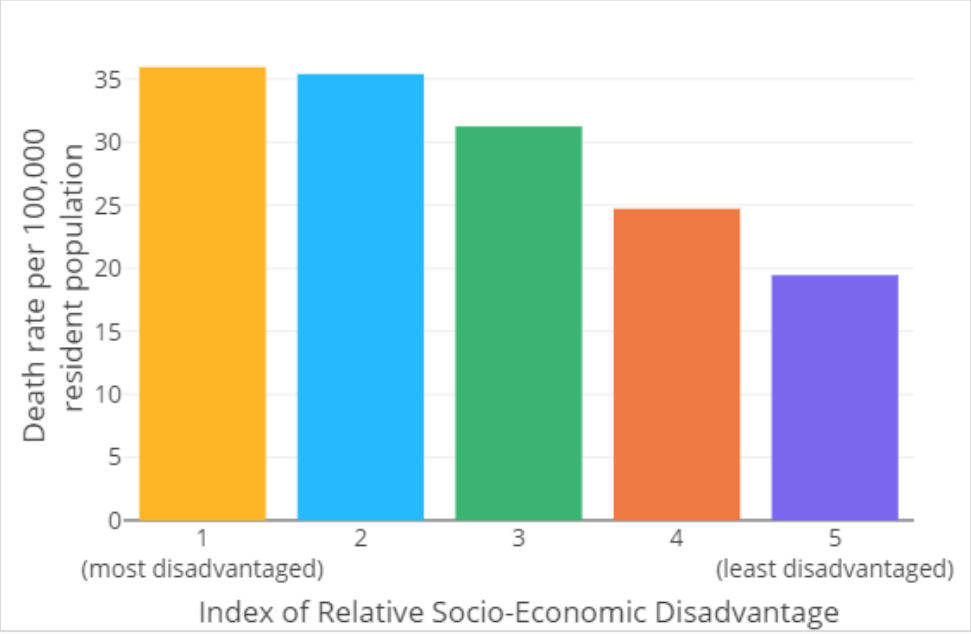


Figure 58 Death rate by Index of Relative Socio-Economic Disadvantage for all children and young people who died in South Australia, 2005–2020 (101)

Source: Child death and serious injury review committee GoSA (101)

2.7 Elder health and wellbeing

2.7.1 Life expectancy

Aboriginal and Torres Strait Islander people have a reduced life expectancy compared to non-Indigenous Australians, see Figure 59 (102). This reduced life expectancy is seen across both males and females, and also in major cities, remote and very remote areas. For example, in major cities, Aboriginal and Torres Strait Islander males have a life expectancy of 72.1 years, which is 8.6 years less than the life expectancy of non-Indigenous Australians in major cities. Additionally, females in Aboriginal and Torres Strait Islander communities have a longer life expectancy compared to their male counterparts, which is a trend seen in non-Indigenous Australians (Figure 59). Presently there is no data for Aboriginal and Torres Strait Islander individuals who define their gender different to that of male or female. These devastating outcomes are a stern reminder of the ongoing colonisation which continues to impact on Aboriginal and Torres Strait Islander communities. A multi factorial approach is needed in this area with community to improve life expectancy.

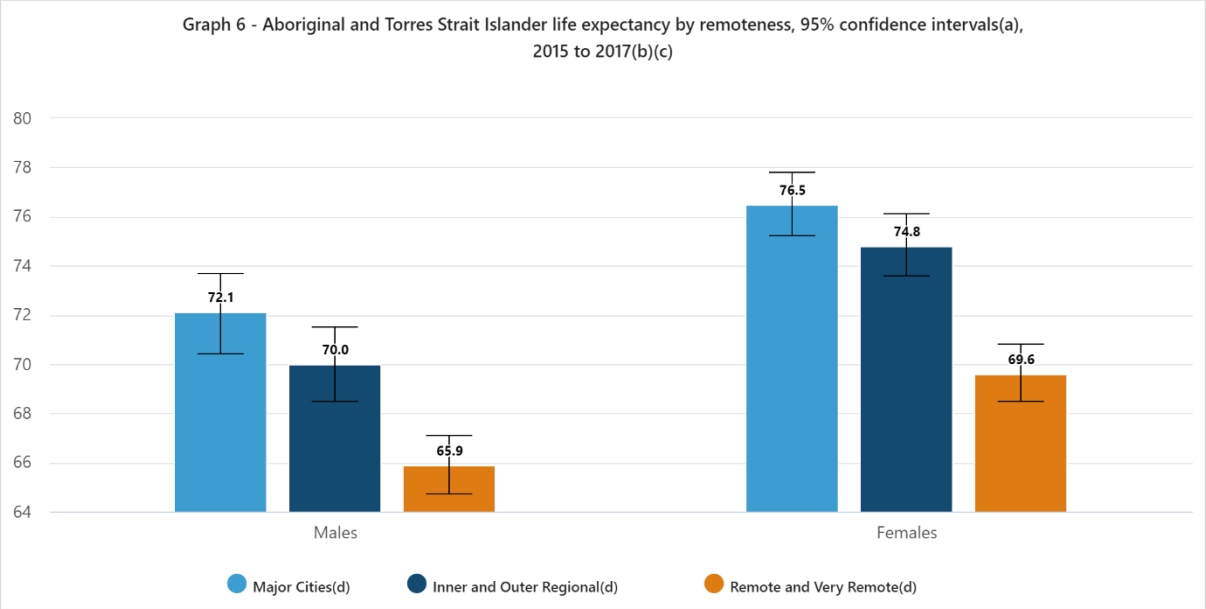


Figure 59 Aboriginal and Torres Strait Islander life expectancy by remoteness 2015-2017

Source: ABS Life Tables for Aboriginal and Torres Strait Islander Australians 2015-2017 (102)

2.7.2 Causes of death

Highlights

Death from kidney and circulatory disease decreased in Aboriginal and Torres Strait Islander people in Australia from 2010-19.

Aboriginal and Torres Strait Islander people have a different set of causes of mortality compared to non-Indigenous Australians (103). Circulatory diseases accounted for the largest gap in mortality between Aboriginal and Torres Strait Islander people in 2015 to 2019 (103). Between 2010 to 2019, across Australia, death due to kidney and circulatory disease in Aboriginal and Torres Strait Islander people decreased, while death due to cancers, injury and poisoning increased (103). In South Australia, circulatory disease related deaths in Aboriginal and Torres Strait Islander people was higher than circulatory disease related deaths in Indigenous people in NSW, QLD, WA, SA and NT combined, see Figure 60. There is much work to be done in this area to change these outcomes, this needs to focus on community co-designed programs, with trauma informed, decolonising approaches.

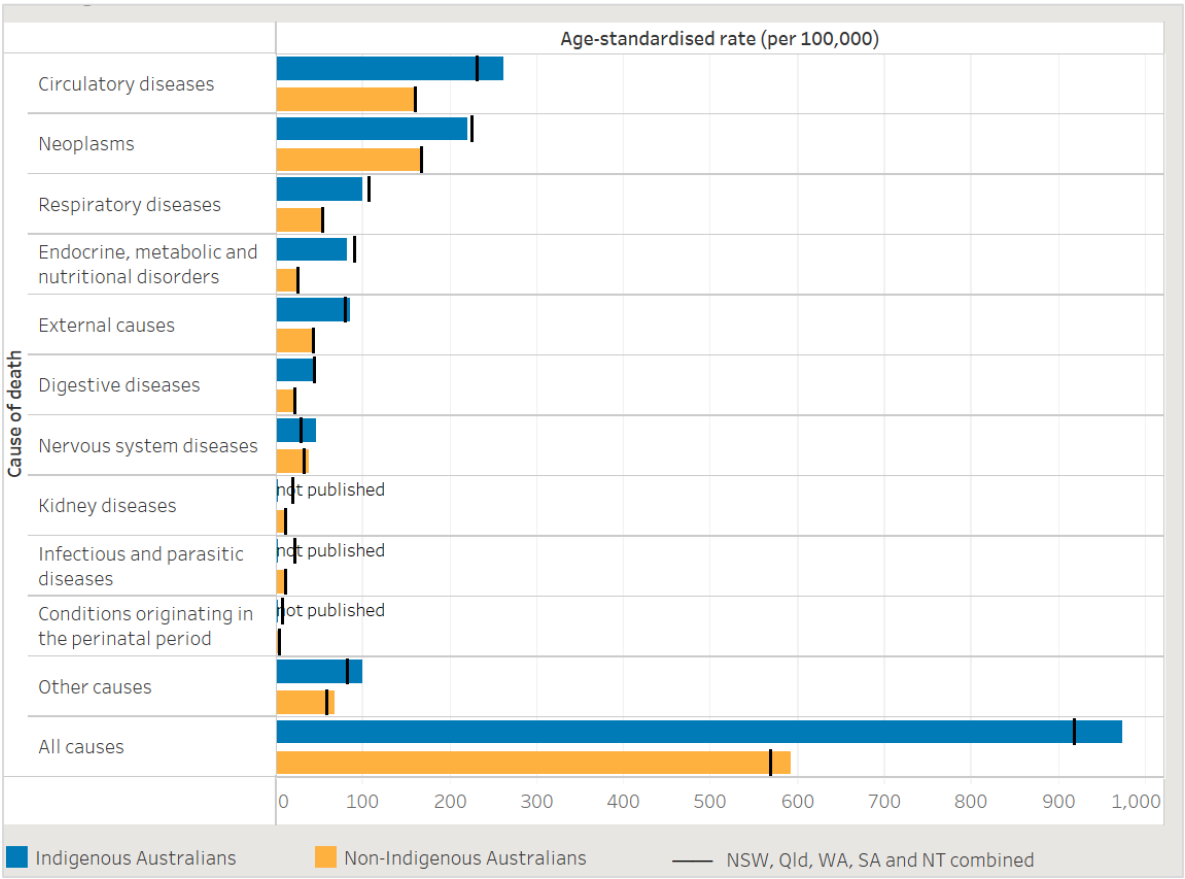


Figure 60 Leading causes of death in Aboriginal and Torres Strait Islander people in South Australia

Source: AIHW 2020, Aboriginal and Torres Strait Islander Health Performance Framework Report 2020 (103)

2.7.3 Dementia prevalence

Dementia in Aboriginal and Torres Strait Islander Australians is an under-reported area, with no area specific or national data. It is likely that data does exist in this area, but it is not identifiable in that Aboriginal and Torres Strait Islander status is not recorded or reported in this area. Smaller studies have however reported high levels of dementia in older Aboriginal and Torres Strait Islander community, especially in those living in the rural and remote areas. One study reported the prevalence of dementia among Aboriginal and Torres Strait Islander people aged 60 and over, and living in urban areas to be 3 times as high as the rate of non-Indigenous Australians (21% vs 6.8%) (104).

2.7.4 Palliative care

Aboriginal and Torres Strait Islander people experience reduced life expectancy; therefore, the death of family and community members are more frequently experienced in Aboriginal and Torres Strait Islander community. The younger age structure also means that dying people often leave behind

young grieving family, which is different from non-Indigenous populations. Death is a time when cultural, spiritual and religious values are held high. Absence of the system recognising these values can become a barrier to appropriate palliative care arrangements. The family based and kinship determined decision process is invaluable in palliative care decision making which is often not well understood in the health services (105). There is a lack of identifiable data surrounding palliative care for Aboriginal and Torres Strait Islander people in South Australia. Palliative Care SA, have however noted on their website that they have ongoing work to do in this area (106).

2.8 COVID-19 Pandemic and its effect

Internationally virus pandemics have had devastating impacts on First Nation communities. In 1918-19 the H1N1 pandemic (Spanish flu), had a mortality ratio in Māori 7.3 times that of Pākehā, Table 12 outlines the mortality ratios for First Nations communities internationally to H1N1 (107). The 1957 H2N2 (Asian flu) had a similar mortality ratio of 6.2 for Māori as compared to Pākehā (107). In Australia it is challenging to provide precise mortality ratios on First Nations peoples, as prior to the 1967 referendum, various jurisdictions did not collect data on Aboriginal and Torres Strait Islander peoples (108). Even today, under identification of Aboriginal and Torres Strait Islander patients in hospital records and health data repositories remains problematic (109).

Table 12 H1N1 Spanish Flu pandemic impact on First Nation communities across the globe expressed as a mortality ratio, 2018-19 (107)

1918-19 H1N1 – Spanish Flu Pandemic					
		Mortality Ratio**			**Mortality Ratio ****
Native American			Sami		
	USA	3.2		Norway	4.8
	Alaska	6.8		Sweden	8.2
First Nation, Inuit, Metis				Finland	16.9
	Canada	4.8	Māori		
	Labrador	8.3		New Zealand	7.3
	Greenland	4.9	Pacific Islander		
Aboriginal & Torres Strait Islander				Tonga	2.6
	Australia	172.4*		Somoa	16.5
				Hawaii	4.1
*** Recording of specific mortality of the Spanish flu on Aboriginal and Torres Strait Islander peoples in Australia was poor during this time.** **** Mortality to ratio is to the dominant non-First Nations population**					

Table adapted from Wilson et al 2012 (107)

Inadequate pandemic planning for Aboriginal and Torres Strait Islander communities became very evident in research outcomes from the 2009 H1N1 pandemic with Aboriginal and Torres Strait

Islander communities, where it was identified to be grossly inadequate, as such the 2019 Australian Health Management Plan for Pandemic Influenza, is a different document to its predecessors (110, 111). Instead this strategy's scope included addressing equity concerns, additional support, two-way communication, and culturally appropriate communication strategies (112). Along with critical engagement with NACCHO, ACCHOs and the establishment of a national Aboriginal and Torres Strait Islander Advisory Group on COVID-19 for the Australian Department of Health (112, 113).

The COVID-19 pandemic had the potential to be lethal to Aboriginal and Torres Strait Islander communities, particularly Elders who are knowledge keepers and educators in community. Pandemic management for COVID-19 in Aboriginal and Torres Strait Islander communities has been well managed and exemplary, as compared to other regions nationally and internationally (113, 114). Cases in Aboriginal and Torres Strait Islander communities have been lower than expected with effective strategies in keeping communities safe and increasing vaccination rates (115).

A lot of effort has been exerted in increasing COVID-19 vaccination rates in Aboriginal and Torres Strait Islander communities since the beginning of 2022, as can be seen the steep increase in vaccination rates in Aboriginal and Torres Strait Islander people in all states across Australia, Table 13 (116) . Australia's response to COVID-19 among Aboriginal and Torres Strait Islander communities can be attributed to the critical leadership provided by NACCHO, involvement of ACCHOS, as well as the strong Aboriginal and Torres Strait Islander leadership and unified voice fighting against this pandemic. Actions included; community closures or limiting access of travel to communities by the wider public (ie non-essential workers, tourists), tailored and specific COVID-19 health processes (ie evacuation teams, quarantine facilities, mobile clinics, food security), targeted media campaigns (videos, artwork, social media platforms), ability to get culturally appropriate information out quickly across a range of languages and targeted community grants for the COVID-19 response (117). Additionally, Aboriginal and Torres Strait Islander families have been connecting back together on country with border restrictions in place, and in some cases at times throughout the pandemic in 2019-2021 communities have fought back against boarder reopening to specific cultural tourism sites, demonstrating self-determination, strength and voice in relation to the pandemic.

Table 13 Percentage of COVID-19 vaccinations, Aboriginal and Torres Strait Islander people aged 15 years and over who have received 2 doses, by Section of State

		10 November 2021				13 July 2022		
		Total	Range at LGA level (%)	Difference (% points)		Total	Range at LGA level (%)	Difference (% points)
New South Wales		**76.9**				**85.4**		
	Sydney	81.3	74 - 89	15		87.2	80 - 93	13
	Rest of NSW	74.8	48 - 89	41		84.5	79 - 95	16
Victoria		**73.6**				**88.5**		
	Melbourne	76.4	69 - 88	19		88.8	84 - 93	9
	Rest of Vic	70.5	56 - 88	32		88.1	83 - 93	10
Queensland		**42.1**				**78.1**		
	Brisbane	49.9	43 - 56	13		81.0	78 - 83	5
	Rest of Qld	38.6	26 - 81	55		76.9	65 - 95	30
South Australia		**43.6**				**75.2**		
	Adelaide	44.0	35 - 72	37		74.8	71 - 90	19
	Rest of SA	43.2	32 - 87	55		75.7	63 - 90	27
Western Australia		**31.0**				**81.0**		
	Perth	33.9	28 - 66	38		82.5	76 - 93	17
	Rest of WA	28.8	10 - 56	46		79.8	66 - 96	30
Tasmania		**62.8**				**86.3**		
	Hobart	66.6	64 - 76	12		87.0	85 - 91	6
	Rest of Tas	60.3	53- 83	30		85.9	78 - 94	16
Northern Territory		**48.9**				**85.5**		
	Darwin	53.0	48 - 60	12		87.5	87 - 90	3
	Rest of NT	47.1	24 - 75	51		84.6	75 - 96	21
ACT		**82.7**	..	..		**89.6**	..	..

A closer look by LGA in Adelaide area reveals some LGAs have a much lower vaccination uptake than others as presented in Table 14 (118).

Table 14 LGA specific vaccination rates by doses in Adelaide, October 2022 (118)

Medicare Address LGA 2021 Code	Medicare Address LGA 2021 Name	Indigenous individuals received Dose 1 % (16+)	Indigenous individuals received Dose 2 % (16+)	Indigenous individuals eligible received Dose 3 % (16+)	Indigenous individuals eligible received Dose 4 % (30+)
44340	Mitcham	90.4%	85.7%	70.4%	41.7%
47980	Unley	88.7%	83.7%	67.5%	47.5%
40700	Burnside	86.0%	84.0%	71.4%	51.1%
40070	Adelaide	85.3%	79.1%	73.1%	49.5%
45290	Norwood Payneham St Peters	84.6%	79.6%	71.3%	49.2%
48410	West Torrens	82.8%	77.3%	64.7%	28.0%
42600	Holdfast Bay	82.1%	81.5%	66.7%	53.8%
47700	Tea Tree Gully	82.1%	78.8%	63.1%	33.2%
46510	Prospect	81.8%	77.3%	65.3%	**
47140	Salisbury	81.7%	76.3%	60.2%	33.6%
41060	Charles Sturt	80.1%	75.7%	60.9%	36.0%
40910	Campbelltown (SA)	80.0%	77.0%	63.2%	33.3%
45340	Onkaparinga	79.9%	74.8%	61.0%	36.3%
45890	Port Adelaide Enfield	79.2%	73.6%	59.4%	35.0%
44060	Marion	78.7%	72.8%	60.1%	41.7%
45680	Playford	76.8%	71.8%	54.7%	34.6%

3 Services in Adelaide

When Aboriginal and Torres Strait Islander health services were asked to report on their service needs, 43% of Aboriginal and Torres Strait Islander Health services in South Australia rated 'access to services' (119) as a top 5 health service gap (Figure 61).

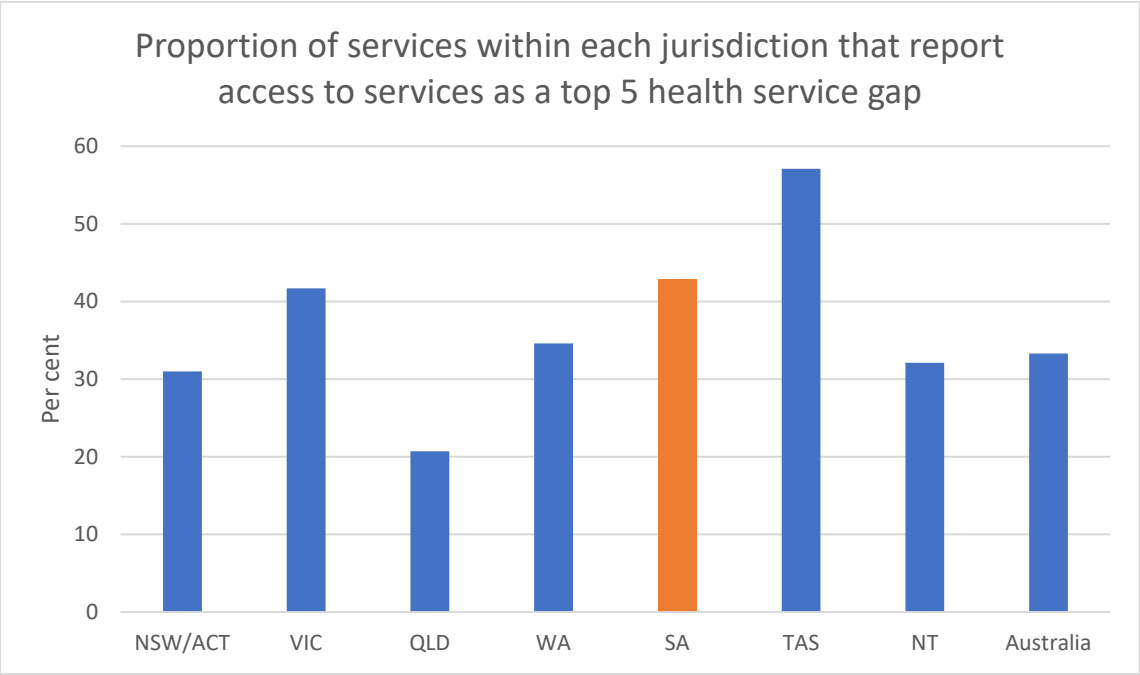


Figure 61 Proportion of Aboriginal and Torres Strait Islander health services reporting 'access to services' as a health service gap

Source: Aboriginal and Torres Strait Islander Health Performance Framework 2021 (119)

3.1 Workforce

Increasing the number of Aboriginal and Torres Strait Islander people working in health is key to providing culturally safe and responsive health services. There is developing work in this area. For example, Central Adelaide Local Health Network (CALHN) has a strategic plan toward employment and retention of Aboriginal workforce to improve the Aboriginal health, across the tertiary education sector there are dedicated pathways and support programs for Aboriginal and Torres Strait Islander students. The plan is with the intention to build a culturally-strong and sustainable workforce, and to demonstrate the commitment to work together, in sharing Aboriginal culture, knowledge and values (120).

3.1.1 Cultural safety & Appropriateness

Highlights

Cultural Safety Training should be mandated, part of annual training for health services and staff. This training should be measures through quality indicators in service delivery.

The Australian Commission on Safety and Quality in Health Care in Australia (the Commission) is focussed on "*safe delivery of health care*", "*partnering with consumers*", "*partnering with healthcare professionals*" and "*quality value and outcomes*" to sustain the health system, create overall health gains and improve outcomes and experiences of patients (121). In this work the Commission in consultation with national, state and territory governments, public and private system providers, health professionals and patients has developed a range of National Safety and Quality Health Service (NSQHS) Standards. These include a user guide for Aboriginal and Torres Strait Islander

health (121, 122). The NSQHS Standards for Aboriginal and Torres Strait Islander health focus on six actions (122, p.3):

> ***Partnering with Consumers***: (1) Partnerships between health service organisations and Aboriginal and Torres Strait Islander communities must occur to meet healthcare needs.
>
> ***Clinical Governance***: (2) A health service organization has safety and quality priorities for the specific healthcare requirements of Aboriginal and Torres Strait Islander patients and (3) a means to implement and monitor these priorities. (4) Strategies to improve workforce practice and understanding surrounding cultural awareness and competence. (5) Health service organisations provide a welcoming environment and are connected to Aboriginal and Torres Strait Islander identity.
>
> ***Comprehensive care***: (6) Standards to improve the identification and recording of Aboriginal and Torres Strait Islander patients.

Ongoing colonisation continues to impact on Aboriginal and Torres Strait Islander communities through dispossession, racism, systemic discrimination and reinforces barriers in accessing appropriate healthcare. While increasing Aboriginal workforce is essential, non-Indigenous workers and services need to provide culturally safe and responsive services. After this training which is essential in this process, key policies and procedures and measurable tangible outcomes for reporting are needed which are in line with the Commission requirements.

Community consultations with the Council identified the cultural safety of both health providers and health professionals as a key area for improvement.

> *"Cultural awareness training – mandatory for all General Practitioners on a yearly basis, including measures".*

Presently the Royal Australian College of General Practitioners provides cultural awareness and cultural safety training, but as a 6-hour online training module. This training provides GPs with points for their Continuing Professional Development (CPD). In this way this training is not mandatory or contextualised for the local Aboriginal and Torres Strait Islander setting in which a health professional may be working. This format is also described as the 'sheep dip' approach to Cultural Safety and there is little evidence in demonstrating that this training shifts the way in which health professionals practice their care to improve health and wellbeing outcomes for Aboriginal and Torres Strait Islander communities (123)). A recent review by the Commission from health services across Australia identified (124).

- Training was variable not covering all accreditation points from the Commission
- Significant variation in the length and mode of training
- Survey respondents reported only half of their training was undertaken in partnership with or by Aboriginal and Torres Strait Islander trainers
- Limited evaluation of training had occurred
- Only 4 services out of all who participated had quality markers surrounding Cultural Safety.

Key recommendations by the Commission from this report include that all training should cover general topics and themes in partnership with local community or educators in Aboriginal and Torres

Strait Islander health and that clinical quality indicators be created by organisations to track and demonstrate how they are meeting cultural safety requirements for accreditation (125).

3.1.2 Trauma informed

Trauma informed service and care is a priority for Aboriginal and Torres Strait Islander community in the Adelaide PHN and this needs to be provided using a decolonisation processes.

> *"Trauma is not being addressed and it is manifesting in poor health outcomes for our people."*

3.2 Existing programs in Adelaide

Highlights

There are 22 specific Aboriginal and Torres Strait Islander health programs in the Adelaide PHN.

Wellbeing SA has compiled an Aboriginal Service Directory to assist Aboriginal and Torres Strait Islander individuals, families and health professionals looking for culturally appropriate and specific care. The service directory can be accessed through the Aboriginal Services Directory Website (126).

Across the Adelaide PHN region there are 22 reported services for Aboriginal and Torres Strait Islander communities, these services cover a range of areas with Wellbeing SA (127):

- 31% of services are reported as Aboriginal corporations
- 27% focus on accommodation needs, from Aboriginal specific services, to mainstream services which engage Aboriginal and Torres Strait Islander clients
- 41% focus on health and medical services,
- 18% target drug and alcohol misuse
- 68% have a key focus on education training
- 18% focus on homelessness support.

Included in this snap shot for South Australia is the Aboriginal Health Council of South Australia, who are the peak representative body in South Australia for community-controlled health and substance misuse in South Australia (128). The have four key programs (128).

1. Primary health and primary healthcare – which provide comprehensive care in Aboriginal Community Controlled Health organisations across South Australia
2. Sexual Health and Blood Borne Virus – works with broader health services across South Australia for prevention and treatment of these conditions. There is a strong focus on individuals 16 and 35 years.
3. Tackling Indigenous smoking – focusses on decreasing and prevention of smoking in community.

4. National Disability Insurance Scheme – is increasing the number of Aboriginal Community Controlled Health organisations registered and delivering services to Aboriginal and Torres Strait Islander people under the NDIS.

Also included, Nunkuwarrin Yunti ('Working Together – Doing Right Together') in based in Adelaide and is an Aboriginal Community Controlled Health Service providing a diverse range of health services and programs across South Australia which are tailored made to meet the health and wellbeing requirements of Aboriginal and Torres Strait Islander people across the life course (129). Their care and approach has a multidisciplinary approach, with the patient at the centre of care. They offer care across a range of programs: dental, allied health, smoking cessation, general practice, maternal and family care and chronic conditions management.

The Aboriginal Sobriety Group Indigenous Corporation is in this snapshot and is a community centric organisation providing support for Aboriginal and Torres Strait Islander community in South Australia. Their overarching mission is to "support the journey towards sobriety, cultural connections, health, wellbeing, safety and security for our clients and community" (130). They offer a variety of different programs surrounding homelessness, mobile assistance patrol, rehabilitation centres for alcohol and substance misuse, and the Colin Betty Gym and Boxing club (131). Also, KWY Aboriginal Corporation provides programs for Aboriginal and Torres Strait Isalnder families impacted by domestic and family violence, child protection, youth work, kinship care, disability, mentoring, Aboriginal education outcomes and perpetrator intervention (132).

Included in this snapshot is also a range of mainstream services which offer programs specifically for Aboriginal and Torres Strait Islander communities in the Adelaide PHN. Sonder is a not-for-profit organisation with locations which span across the Adelaide PHN providing support and programs for mental health, alcohol and drug use, chronic conditions management and employment, to improve health and wellbeing outcomes of South Australians (133). Through Closing the Gap – Integrated Team Care, Sonder provides support from complex and chronic conditions management, they also employ a range of Aboriginal Health Practitioners who work with General Practitioners for support and advocation around annual Indigenous Health Checks (134). There is also Watto Purrunna Aboriginal Primary Health Care Service sites within SA Health and has four sites across the Adelaide PHN area, providing free comprehensive primary health care and support for Aboriginal and Torres Strait Islander people (135).

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