Brisbane South PHN

Health Needs Assessment 2022-23 to 2024-25 Report

Executive Summary

Brisbane South PHN enters its sixth year of operation at a time of significant change, challenge and opportunity. Our operating environment is becoming more complex and more fluid; and we continue to build our maturity as a commissioning organisation.

The Health Needs Assessment (Needs Assessment) provides the PHN with a deep understanding of the health and service needs of the whole region, applying a multiphase approach, supported by robust governance, to:

- Identify health and service needs and potential solutions.
- Prioritise needs with reference to the remit of the PHNs, as described by the Department of Health.
- Inform organisational resource investment and approaches, including priority populations and geographies for otherwise-mandated activities.
- Provide a platform for communities, health and other system partners to understand and respond to the needs of our region.

This is the second comprehensive health needs assessment process undertaken by Brisbane South PHN. In the intervening years since the last comprehensive health needs assessment (submitted November 2017) there have been several significant health system reform initiatives, including the rollout of the National Disability Insurance Scheme (NDIS) and the Practice Incentive Payment Quality Improvement (PIP QI) for general practice.

The Coronavirus (COVID-19) pandemic has strengthened the role of PHNs in the coordination of primary care response and support efforts, particularly with respect to the provision of personal protective equipment, enhancing telehealth access in the primary care setting, and COVID vaccine rollout in primary care and residential aged care facilities. The ongoing uncertainty linked to the COVID-19 pandemic also requires the PHN to be responsive to local needs; delivering agile and evidence-based activities while preparing for a recovery underpinned by meaningful partnerships that centre community health and wellbeing.

Brisbane South PHN maintains its commitment to addressing the health and service needs identified in the last comprehensive health needs assessment. Many of these needs have not shifted significantly within this four-year period, which is to be expected for complex, multifactorial, and systemic issues such as chronic disease, mental health, and suicide prevention needs.

Alongside these continuing commitments, the interface of the primary health system with adjacent sectors and systems (such as the disability sector), has emerged in our new Needs Assessment as an increasing need. This Needs Assessment highlights an increasing focus on health equity – the people and places in the region with the greatest needs. This finding is consistent with the priorities identified in our new Strategic Plan; we are proud to be an organisation that put people at the heart of healthcare, prioritising those with the greatest need.

With these priorities in mind, Brisbane South PHN sees its opportunities for further action in the following areas:

- Partner, collaborate and lead system reform, delivering measurable and meaningful health and wellbeing impact.
- Integrate and coordinate care systems within a holistic social determinants framework.
- Support community-led action that delivers sustainable change in health and wellbeing.
- Improve the health and wellbeing outcomes of our community, with a focus on addressing health inequities and inequalities.
- Enable strong and connected primary care to create a person-centred system that improves health access, experiences and outcomes.

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Background and context

Foreword

Our work to deliver the best possible health and wellbeing for every person in the Brisbane south region must be built on the best possible understanding of our region's diverse health and wellbeing needs, strengths and potential. Our new Health Needs Assessment is key to this, putting forward a comprehensive review of our region's health and wellbeing that sets the course for our work over the next three years.

Health Needs Assessments were mandated by the Commonwealth when PHNs were first established in 2015 as a systematic approach that ensures we use our resources and commonwealth funding to improve health in the most effective way. We use this to assist us with commissioning services that are appropriate and responsive, as well as shaping our work with the primary care sector. It is, without doubt, the most important foundational process that we undertake as a PHN.

The Health Needs Assessment also examines the wider influences on health such as environment, education, employment, behaviour, diet and exercise. These and other social determinants are a key predictor of health outcomes and, while they cannot be changed by the PHNs directly, they do provide an important framework for our response. Our place-based approach is based on local needs and looks behind the numbers to understand why and how these localised factors have occurred.

We have looked closely at disparities in health need and access, whether they result from poor access to health services, demographic differences, different and conflicting health priorities or different levels of chronic disease. I am proud of the strong equity lens that has been applied to this work, supporting our efforts to ensure those with the greatest need are supported to live well and experience care that is connected, high quality and easy to access. Equity lies at the very heart of our mandate and our Health Needs Assessment allows us to prioritise and target our efforts to deliver maximum impact.

The success of our health response is dependent upon the partnerships that we build and sustain with communities and health system actors. In a resource-constrained environment our scale and impact is amplified by these enabling partnerships; our Health Needs Assessment guides our priorities and shapes our approach to partnering.

Where we cannot, ourselves, work to provide a health response, we need to be able to influence policy or help steer research and development priorities so that it can be addressed. Our Health Needs Assessment enables us to be able to do this by providing compelling evidence at a population level.

A Health Needs Assessment is a significant body of work that draws on health data at local and at national levels, as well as critical interaction with our communities and specialised clinical partners. My sincere thanks to everyone who has contributed their time, expertise, lived experience and insights to this process, we couldn't do this without you.

Lastly, I would also like to thank the team who worked tirelessly over the last three years to deliver this important tool. This report is a testament to your rigour and dedication.

Mike Bosel
Chief Executive Officer

About our region

Located in South East Queensland, the Brisbane south region (Figure 1) is home to over 1.2 million residents, making the region the most densely-populated PHN region in Queensland. Extending from south of the Brisbane River through the Scenic Rim region to the New South Wales border, the Brisbane South PHN region is predominantly a metropolitan region with pockets of regional (Beaudesert SA3) and remote (Redland Islands SA2) areas. The region covers a total area of 3,770 square kilometres, and spans four local government areas – Logan and Redland (100% coverage each), Brisbane (approximately 54% coverage), and Scenic Rim (approximately 34% coverage). Brisbane south is a geographically diverse region – with areas of high density metropolitan residential populations, to regional and rural areas from Beaudesert to the northern New South Wales border at Mt. Barney, and remote areas of our Redland Islands which are accessible only by boat. There are numerous high-growth and green fields sites across the region, including Yarrabilba, Jimboomba, Greenbank and Flagstone; which highlight the dual strengths and challenges of the desirability of living in the region, and the infrastructure support required to enable these growing communities to thrive.

Figure 1. Brisbane South PHN region

The Brisbane South PHN population is very diverse, with over one-third of the population having been born in a country that is predominantly non-English speaking. The region is also home to the largest urban First Nations population in Australia, and large and growing Pasifika and Māori communities. With this great diversity comes great strength in community cohesion and resilience, making Brisbane south a remarkably unique Queensland region.

Role of Brisbane South PHN

In 2015, the Commonwealth Department of Health established Primary Health Networks (PHNs) with two key objectives:

- Improving the efficiency and effectiveness of medical services, particularly for those most at-risk of poor health outcomes.
- Better coordinating care so people receive the right care, in the right place, at the right time.

Brisbane South PHN (Primary Health Network) is a not-for-profit organisation. We work with health professionals and communities to understand the health and wellbeing needs of our region, and commission services that directly respond to these needs.

We are a key health system driver, connector, integrator and innovator. We specialise in person-centred, place-based health system reform that delivers real-world results. We strive to improve the health outcomes of everyone in our region by creating a more accessible and equitable health system.

Our strategic priorities

Our 2021 organisational strategy directly addresses health inequities and inequalities. It draws on the power of partnerships to support the best possible health and wellbeing outcomes for every person in our region, allowing us to be flexible and innovative as we identify and make the most of emerging opportunities.

Our strategy also reflects our maturing role and contribution to state and federal systems. We are proud to support positive, sustainable shifts in the health and wellbeing of our communities.

Above all, our strategy maintains an unwavering focus on the people we serve. Our analysis, planning and implementation is built on meaningful and measurable engagement, partnership and collaboration with the people of Brisbane south.

Our vision for Brisbane South is the best possible health and wellbeing for every person in the Brisbane south region.

Our purpose is partnering to build a health and wellbeing system in which every person in the Brisbane south region, especially those with the greatest need, is supported to live well and experiences care that is connected, high quality and easy to access.

We will do this by:

- Putting people at the heart of health care
- Prioritising those with the greatest need
- Valuing the strength of community
- Learning, adapting and innovating
- Partnering to deliver meaningful change and sustainable results.

Brisbane South PHN is focused on four key priority areas:

- Better knowledge: Evidence and equity-based planning
- Better coordination: Partnerships and networks for greater impact
- Better health: Accessible, appropriate, person-centred health care
- Better organisational performance: Excellence in organisational capability and culture

Commissioning

PHNs are commissioning organisations. Commissioning describes a continuous strategic cycle of population health planning, solution design and delivery, and monitoring, evaluating and learning from implementation to achieve the best value (Figure 2). Commissioning, at its heart, is driven by needs and outcomes (Field & Oliver 2013) to deliver services that meet consumer needs. The commissioning approach speaks to the foundational importance of a health needs assessment process, in gaining a deep understanding of the community's health and service needs to inform investment. Increasingly, this requires the PHN to act as a system convenor – bringing together and working with communities and system partners to address complex health and service challenges.

Commissioning involves using all available resources to achieve outcomes for people, building on their needs, assets and aspirations (New Economics Foundation, 2014).

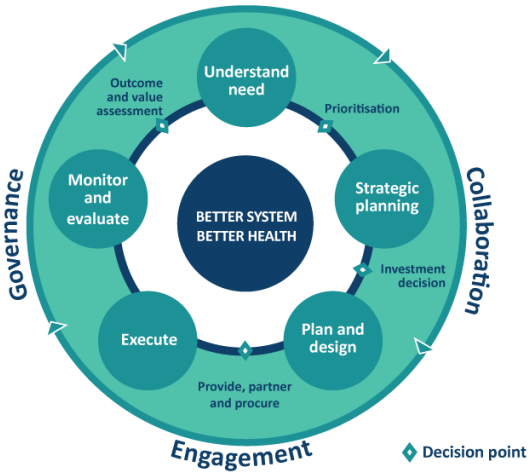

Figure 2. Brisbane South PHN Commissioning Cycle

Commissioning extends far beyond the functions of procurement– it encompasses eight commissioning levers, as described by Rebbeck (2018). These are:

- System leadership
- Clinical engagement
- Community engagement
- Optimising care settings
- Provider collaboration
- Procurement and performance management
- Market management
- Investment and disinvestment

Purpose of the Health Needs Assessment

Brisbane South PHN's Health Needs Assessment provides the PHN with a deep understanding of the health and service needs of the whole region, applying a multiphase approach, supported by robust governance, to:

- Identify health and service needs and potential solutions.
- Prioritise needs with reference to the remit of the PHNs, as described by the Department of Health.
- Inform organisational resource investment and approaches, including priority populations and geographies for otherwise-mandated activities.
- Provide a platform for communities, health and other system partners to understand and respond to the needs of our region.

Structure of our Health Needs Assessment

This Health Needs Assessment (Needs Assessment) presents a summary of local knowledge relating to a number of key areas. Where there are high degrees of overlap between related areas information is contained to a single chapter or referenced rather than being duplicated.

These areas are:

- Primary health needs
- Child, youth and family
- Older persons
- First Nations peoples
- Multicultural peoples
- Mental Health and suicide prevention
- Alcohol and other drugs

For each of these key areas;

1) The **health strategy** at a national, state, regional, and sector level is discussed, to identify strategic priorities that may drive future activity and investment.
2) The **health status** of the focus population is then examined, in terms of demographic and socioeconomic factors (providing insight into the social determinants of health), health behaviours and risk factors, and health outcomes.
3) The current **health system** is explored, gaining insight into the systemic and structural factors that can promote the observed health status. The health system describes relevant service utilisation and uptake within the focus area, consumer service experience of service, service mapping of available services, and the supporting health workforce.
4) A critical component of this Needs Assessment is its focus on **health equity**. Health equity describes the absence of avoidable differences in health status observed within and between population groups (WHO 2021a). Where permitting, the health and wellbeing of the following population subgroups is discussed:

- First Nations peoples
- Multicultural peoples
- People who identify as Lesbian, Gay, Bisexual, Trans/Transgender, Queer, Intersex and/or Asexual, or another form of diverse gender or sexuality (LGBQTIA+)
- People with disability
- People experiencing homelessness
- People living in regional, rural and remote communities

5) Finally, the **health response** is discussed. Health response presents the need statements that emerged from the health needs assessment process, the current activities that the PHN is engaged in to address these needs, and potential options for future activity.

In addition, this Needs Assessment includes two Supplements which explore emergent areas.

S1: Digital health. A detailed description of the strategy and policy environment.
S2: Oral health. A rapid needs analysis for this emergent need in the region.

Needs assessment approach

Guiding principles and methodology

Four core principles guided the development of this Health Needs Assessment:

1. Transparent: Brisbane South PHN would have an honest and open-minded approach to engagement processes. The rationale for engagement is clearly stated, including information on the decision to be made, who will make the decision, how the decision will be made, and how community feedback can be provided.
2. Respectful: Brisbane South PHN will respect the diversity of views expressed. While it may not be possible to satisfy all the views expressed, they will all be considered. We will listen to and value the ideas, feelings, and opinions expressed during community and stakeholder engagement processes; promoting the choice and rights of all stakeholders to engage.
3. Inclusive and collaborative: Brisbane South PHN will seek to involve a true representation of community and stakeholders in our region, where possible. Processes will be mindful of past consultation and engagement efforts, leveraging previously garnered insights to reduce consultation burden; with the intention to extend upon existing local knowledge and intelligence.
4. Timely: Key stakeholders will be informed and involved throughout the process. Validation of learnings with stakeholders will happen in a timely manner, and be leveraged to iteratively guide and reshape the process methodology as appropriate.

The Needs Assessment process was conducted across four phases, as noted in Figure 3.

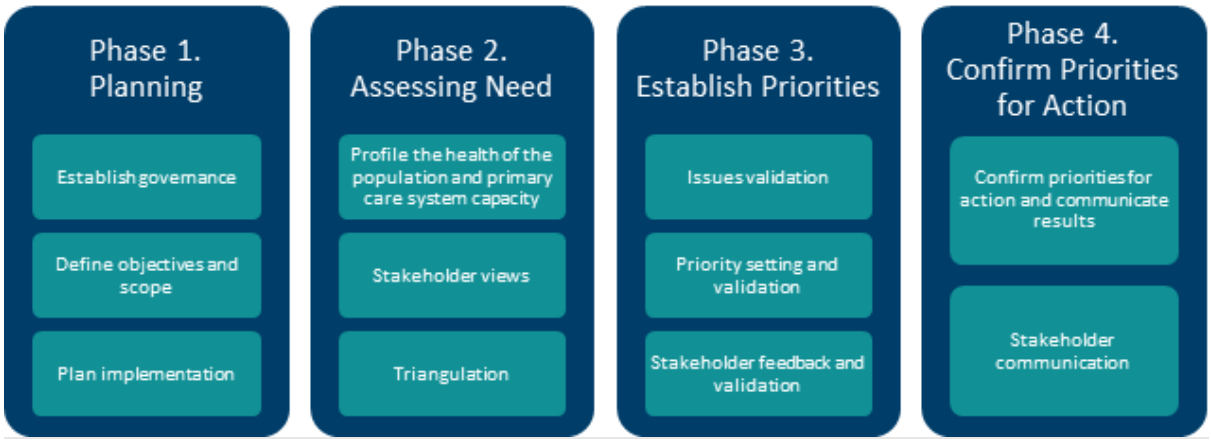

Figure 3. Health Needs Assessment process

Phase 1: Planning

The initial stage of the health needs assessment process centres around laying the foundation for robust project management, including the establishment of governance, agreement of scope and key bodies of work, and planning the implementation.

Governance

The project team were the central connector between the external Needs Assessment Advisory Committee, Needs Assessment Implementation Group and the Stakeholder Engagement and Communications team. The project team will drive the key activities and broad direction of the Needs Assessment, seeking input and guidance from members as required (Figure 4).

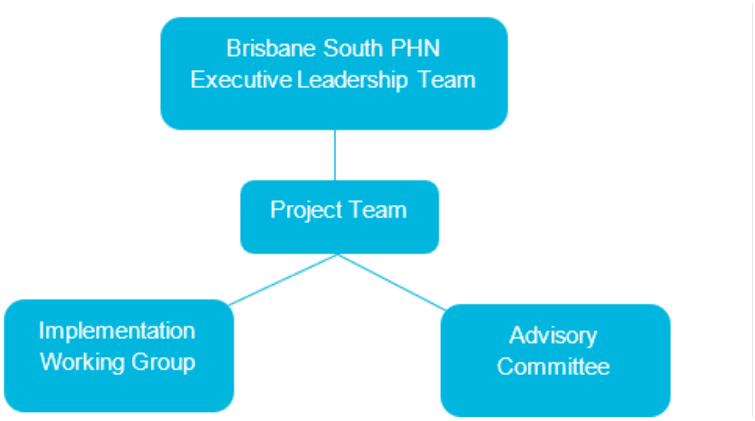

Figure 4. Brisbane South PHN Health Needs Assessment governance

The purpose of the External Advisory Committee was to provide strategic direction, leadership, guidance, and support for the implementation of the Needs Assessment. This Committee's membership represented key health and community service partners in the region. The purpose of this Implementation Working Group was to provide operational planning, leadership and advice, and to undertake stakeholder consultation directly related to their role.

Phase 2: Assessing Needs

Phase two encompasses the detailed gathering, analysis, synthesis, and triangulation of various sources of data. This includes a variety of publicly-available quantitative data sets, literature and other publications, and engagement of stakeholders to ascertain and understand health and service needs in the region.

Profile the health of the population and primary care system

Quantitative data analysis was undertaken on:

- Publicly-available data sets; such as Australian Bureau of Statistics (ABS) (population demography), Australian Institute of Health and Welfare (AIHW) (e.g. burden of disease, health system usage), and the Queensland Government Statistician's Office (QGSO) (regional sociodemographic factors).
- Service distribution and usage (i.e. service mapping) for publicly-available information (e.g. general practice and other primary care services, PHN-commissioned service data.

Qualitative data analysis was undertaken on:

- Consultation data and other documentation of existing stakeholder and community engagement
- National, State and local policy and strategy
- Results from targeted stakeholder engagement activities led by the PHN.

Stakeholder Views

Broad initial engagement was carried out through an online survey designed to seek high-level information from community and system stakeholders, assisting in a targeted approach to subsequent stakeholder engagement. This survey focussed on local organisations working in the region across health and social support services. Feedback on the survey questions was sought from the governance groups, and the survey was developed and distributed through an online platform (Survey Manager). Thematic analysis was undertaken on the results.

Targeted engagement activities were then undertaken, via a series of face-to-face focus group consultations. These were held with a focus on a specific topic area, and noted as follows:

- Aboriginal and Torres Strait Islander Health Needs Assessment Workshop (04 May 2021)
- ADA (Aged and Disability Advocates) Australia: Ageing and Disability (26 May 2021)
- Understanding Disability in the Brisbane South Region (01 June 2021) – participants included representatives from Multilink, Multicap, Metro South Health Equity and Access Unit, and Consumers and People with a Lived Experience
- Understanding Hepatitis in the Brisbane South Region (18 May 2021)
- Sisters Inside: Health Priorities and Concerns for Incarcerated Women (12 May 2021)
- Understanding Homelessness in the Brisbane South Region (28 May 2021)
- Understanding LGBTQIA+ peoples in the Brisbane South Region (18 May 2021).

Triangulation

Triangulation describes the analysis of multiple sources of information to draw together an improved understanding of a particular issue or challenge.

The triangulation process was completed through the use of triangulation matrices that collated the evidence for each potential issue against each of the four need types defined by Bradshaw's Taxonomy of Needs (refer to Figure 5). This process was repeated for each of seven topic areas.

The triangulation and prioritisation approaches were discussed with the governance groups.

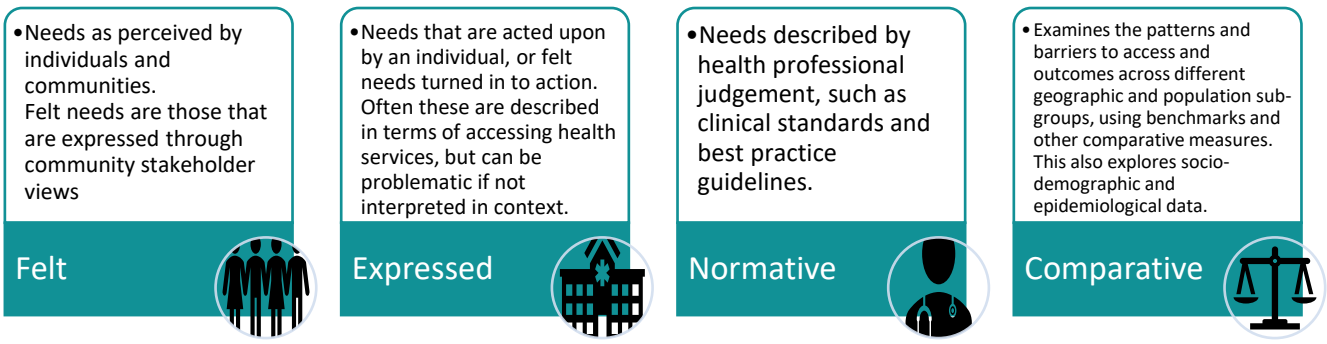

Figure 5. Bradshaw's Taxonomy of Needs
Source: Bradshaw 1972

Phase 3: Establish Priorities

This phase is critical in transforming a potentially extensive list of health and service needs into a distilled and actionable shortlist of priorities. The prioritisation process is central to this phase.

Our Prioritisation Process

Prioritisation aims to focus available resources on the most important issues to achieve measurable and meaningful impact on health outcomes. This will determine priorities for further development in activity work planning.

The Department of Health requires PHNs to have fit-for-purpose techniques for prioritisation, ensuring that:

- the methodology is evidence-based
- the process is balanced and takes account of the views of different groups and parties
- decision-making processes are transparent, fair and reasonable

The Governance Groups provided insight and feedback in to the prioritisation criteria, noted adjacent. These criteria aimed to be as mutually exclusive as feasible, to reduce duplication of prioritised needs. Participants in the prioritisation process included members of the Needs Assessment Governance Groups and members of the Brisbane South PHN Clinical and Community Advisory Council who nominated to participate. Participants engaged in briefing sessions prior to undertaking the prioritisation process, which was facilitated through an online survey medium. This enabled flexibility in respondents' schedules to participate in the process, ensured that all voices were equally heard and represented, and provided robust data for qualitative and quantitative analysis.

Criterion 1. Scale/magnitude of the issue

This criterion aims to understand the scale and magnitude of the issue. This can be observed through the incidence or prevalence of an issue across the population of interest.

How many people does this issue affect?
How widespread is the issue?

Criterion 2. Impact of the issue

This criterion aims to understand the size and nature of the impact that the issue has on people affected by it. This can be thought of as the potential implications, costs or risks of inaction.

For a health need, this impact might relate to the burden on health and wellbeing. For a service need, this might relate to the impact on the ability of the service system to effectively respond to the health needs of the population.

In addition to the size of the impact of the issue, it is also important to consider equity. That is, how equitably (or not) the impact is felt or experienced across the population, particularly when considering portions of the community experiencing greater levels of vulnerability.

How much of an impact does this issue have?

Does the issue have an inequitable impact on more vulnerable groups in the community?

What is the impact of not taking action?

Criterion 3. Level of endorsement

This criterion aims to validate that the issue is genuinely an issue through the subjective endorsement (or dis-endorsement) of it, based on the professional expertise and wisdom of participants in the prioritisation process.

It should be noted that this criterion is intentionally subjective. There will be limitations in the data and information that is available on any issue. For this reason, validating each issue using the subjective opinion of informed and knowledgeable stakeholders against the triangulated findings is reasonable.

How much do you agree that this is a valid issue from your perspective?

How well do the findings that support the issue align with your own expertise and experience?

Criterion 4. Alignment

This criterion aims to prioritise issues that relate to, or are likely to have, a response that falls within the primary health and community care sectors, as aligned to the PHN's strategic intent.

How does the issue align with the strategic intent of Brisbane South PHN?

This acknowledges that Hospital and Health Services (HHSs) in Queensland are also required to undertake a health needs assessment covering their system responsibility for acute/tertiary care and hospital-based services.

Is the issue experienced in the primary health or community settings?

This criterion also considers 'feasibility' to some extent in the context of how the issue can be addressed through a regional approach.

How well can the issue be addressed at a regional level?

Criterion 5. Effectiveness of system response

This criterion aims to prioritise issues that are not likely to be adequately or effectively addressed through the current system response.

How appropriate or effective is the current system response to this issue?

This helps to identify issues that are lower relative priorities if there are adequate existing resources and responses.

Likewise, it helps to identify issues as higher relative priorities when there is no, or a highly ineffective, system response to the issue at present.

Limitations

There are a number of limitations observed throughout the health needs assessment process.

1. Variable geographic granularity of available data – various data sources may collect and report on data at various geographic levels. For example, some data sets may present results at the Statistical Level Area Three (SA3) level, whereas others may report only at a Local Government Area (LGA) level.
2. Limitations in the collection of data elements that relate to priority population subgroups Data elements that capture whether a person identifies as First Nations are common in many data sets; however, this is not so for many other priority population subgroups. For example, there are limited standards on the collection of data elements that allow identification of people from multicultural backgrounds health and service needs, where most data sets collect a country of birth and/or whether an interpreter is required. Other limitations include the lack of data related to sexual orientation and gender diversity, and people with disability.
3. Data availability and currency – various data sources may have their most recent publication or updates completed a number of years ago. This includes the pending release of ABS 2021 Census data from 2022 onwards.

Geography

A variety of geographical breakdowns are used throughout this report, including:

- Australia and Queensland-level data.
- Brisbane South PHN region — based on the geographic boundaries defined by the Commonwealth Government, this mirrors the geographical footprint of the Metro South Hospital and Health Service (HHS) region.
- Local Government Area — gazetted Local Government boundaries as defined by the state government.
- Australian Statistical Geography Standard — includes SA4s, SA3s, and SA2s.

The Australian Statistical Geography Standard (ASGS) is a classification of Australia into a hierarchy of statistical areas used by the ABS (ABS 2021a). The ASGS is a social geography, developed to reflect the location of people and communities, and used for the release and analysis of statistics and other data. The ASGS is updated every five years to account for growth and change in Australia's population, economy and infrastructure. The ASGS areas used within the reports include:

- Statistical Areas Level 2 (SA2s) are medium-sized general-purpose areas built to represent communities that interact together socially and economically. Most SA2s have a population range of 3,000 to 25,000 people.
- Statistical Areas Level 3 (SA3s) are designed for the output of regional data; most have populations between 30,000 and 130,000 people.
- Statistical Areas Level 4 (SA4s) are designed for the output of a variety of regional data, and represent labour markets and the functional area of Australian capital cities. Most SA4s have a population of over 100,000 people.

Summary of priorities

Brisbane South PHN approached examining the Needs Assessment through multiple lenses.

- Through the **lifespan** (Child, Youth and Family and Older Persons), recognising that health and service needs naturally change dependent upon age and stage of life.
- From the **health equity perspective**, reviewing both demographic and geographic population subgroups. First and foremost, First Nations peoples and Multicultural Peoples. Other priority population groups are examined as appropriate, as guided by literature, consultation and engagement, and available quantitative data.
- From **specific health and service needs**, given the funding focus on Mental Health, Suicide Prevention and Alcohol and Other Drugs within the PHN context, these three areas have detailed needs analysis and assessment. Each section also includes consideration of the effects of COVID-19 and the PHN's role in responding to the pandemic.
- **Health system enablers,** including Workforce and Technologies were examined throughout all aspects of the needs assessment.

Figure 6 demonstrates the relationships between these complex and interconnected aspects of the Needs Assessment.

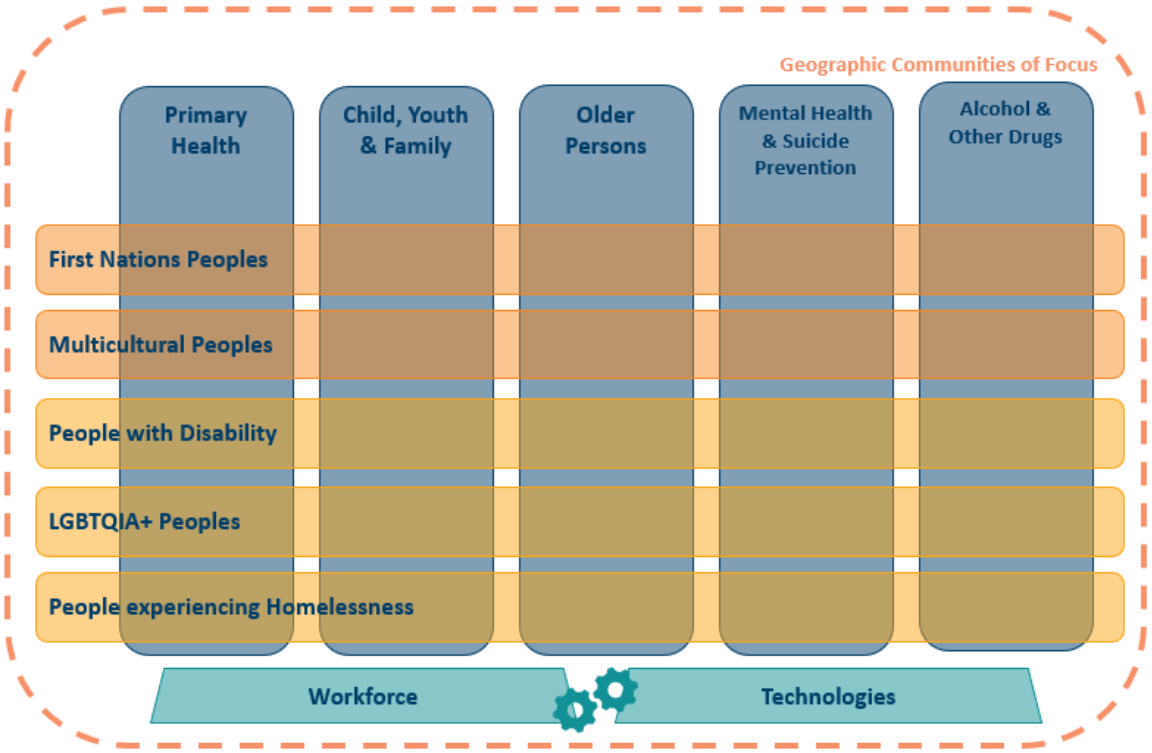

Figure 6. Health needs assessment approach conceptual framework

Primary Health Priorities

1. A need to focus on the social determinants of health – these are associated with health behaviours and health outcomes.
2. Several geographic areas within the Brisbane south region experience higher levels of health needs – Beaudesert SA3, Southern Moreton Bay Islands, North Stradbroke Island and Logan LGA (particularly Jimboomba SA3).
3. Chronic disease continues to have considerable impact and burden on communities in Brisbane South. These include cardiovascular diseases, respiratory diseases (asthma and COPD), musculoskeletal conditions, and cancers.
4. Several priority populations within the community experience disproportionate health and wellbeing outcomes – First Nations peoples, peoples from multicultural backgrounds, people who identify as LGBTQIA+, people experiencing homelessness, people transitioning into community from correctional facilities.
5. A need to focus on health behaviours, as these mediate health outcomes as protective or risk factors. These include nutrition, physical activity and alcohol consumption.

Child, Youth & Family Priorities

1. Priority populations experience higher levels of child, youth and family health needs, including children and families in regional areas, First Nations communities, multicultural families and LGBTQIA+ young people.
2. Maintaining the health and wellbeing of children, youth and families to enhance positive health outcomes and improve quality of life.
3. Working to address the broad range of factors that contribute to mental health challenges experienced by young people in the Brisbane south community.

Older Persons Priorities

1. Developing and supporting a skilled and capable workforce as an important enabler of the aged and health care service systems.
2. Continued need for empathetic and high-quality end-of-life planning and palliative care to support the ageing population in Brisbane South to age with dignity.
3. Maintaining the health and wellbeing of older people in protecting against negative health outcomes and improving quality of life.

First Nations Peoples Priorities

1. Working to address the social and emotional wellbeing challenges that First Nations peoples disproportionately experience.
2. First Nations people disproportionately experience chronic health conditions, including cardiovascular diseases and type 2 diabetes.

Multicultural Communities Priorities

1. Systems and services are often difficult for people multicultural background to navigate and access.
2. Working in partnership with the growing Pasifika and Māori communities and services to build on their strengths and support optimal health and wellbeing.
3. Multicultural communities experience disproportionate health and social outcomes compared to the wider population in Brisbane South.

Mental Health and Suicide Prevention Priorities

1. Need for mental health support across the stepped care continuum, from prevention and low intensity supports through to psychosocial supports and clinical care coordination for people living with severe and complex mental health concerns.
2. Priority populations experience higher levels of need relating to mental health and suicide prevention. These include people who identify as children and young people and people who identify as LGBTQIA+.
3. The local mental health service system is not able to meet people's mental health needs.
4. There are numerous barriers for people experiencing mental health concerns to find and access the right support.

Alcohol and Other Drugs Priorities

1. Priority populations experience higher levels of need relating to alcohol and other drugs support. These include adult men and First Nations peoples.
2. Focusing on the prevention of alcohol and other drugs issues alongside treatment.

1. Primary health

Primary care in Australia refers to those services in the community that people go to first for health care: general practices, Aboriginal Community Controlled Health Services (ACCHS), community pharmacies, many allied health services, mental health services, community health and community nursing services and dental services. It is differentiated from secondary care delivered by specialists, where a referral is usually required, and tertiary care delivered in hospitals.

Primary care is a vital component of the health system, involving services across private, public and non-government sectors, delivered in a community-based setting. These services vary across the continuum of health care from prevention and screening, diagnosis, through to treatment and management of conditions. Several factors can contribute to the utilisation of services such as whether the service is bulk-billed, urgent or after-hours attendances, availability, quality and cultural appropriateness of the service. Continuity of care and positive relationships with primary health providers are key to improving health outcomes for patients.

Different populations and geographic locations across the region experience unique barriers to primary health care, and therefore it is important to address this inequity to improve health outcomes. Improved and effective primary health care helps to reduce hospital admissions and health system costs by focusing on health and wellbeing and better management of non-hospital environmental health needs. Brisbane South Primary Health Network's commitment to primary health care in the region is reflected through our vision: *The best possible health and wellbeing for every person in the Brisbane south region.*

1.1 Strategic environment

1.1.1 National

Australia's Long Term National Health Plan sets out the Commonwealth Government's agenda for improving Australia's health system over the next decade. The plan makes commitments to strengthening primary care, supporting public and private hospitals, mental health and preventive health, medical research and ageing well. In terms of primary health care, the 2019 plan targeted equity and accessibility, patient-focussed care and preventative health and increased support for management of chronic conditions (Department of Health 2019a).

The Australian Government are currently drafting *Australia's Primary Health Care 10 Year Plan 2022-2032* (the *Draft* Plan) which sits under the *Long Term National Health Plan*. The *Draft Plan* acknowledges the significance of the Addendum to the 2020-2025 National Health Reform Agreement and the National Agreement on Closing the Gap, accompanied by the Commonwealth Closing the Gap Implementation Plan.

The *Draft Plan* also focuses on the integration of primary health care with hospitals and other parts of the health system, aged care, disability care and social care systems. The Quadruple Aim framework for optimising health system performance has been adopted by the Australian Government as the overarching aims of this plan, to:

- Improve people's experience of care.
- Improve the health of populations.
- Improve the cost-efficiency of the health system.
- Improve the work life of health care providers.

The objectives of the *Draft Plan* are:

- **Access:** Support equitable access to the best available primary health care services.
- **Close the Gap:** Reach parity in health outcomes for Aboriginal and Torres Strait Islander people.
- **Keep people well:** Manage health and wellbeing in the community.
- **Continuity of care:** Support continuity of care across the health care system.
- **Integration:** Support care system integration and sustainability.
- **Future focus:** Embrace new technologies and methods.
- **Safety and quality:** Support safety and quality improvement.

These aims and objectives are supported by enablers: People - at the centre of care; funding reform; innovation and technology; research and data; workforce; leadership and culture. Over the life of the plan, the ambition is for significant shifts in the way primary health care is delivered and how individuals and communities are engaged.

More recently, the Australian Government has published a range of strategies, policies and action plans aiming to focus coordinated action on specific health topics and populations such as preventive health, chronic conditions, men's and women's health, rural and remote health, rare diseases, and people with a disability. Consistently, these all set out a strategic environment that emphasises the role of primary health care in maintaining and improving the health and wellbeing of people and communities in Australia. They identify a common set of principles and themes such as:

- Improving integration and coordination between health services.
- Prioritising prevention and early intervention.
- Involving consumers and their supporters.
- Developing a capable workforce.
- Improving access to person-centred and evidence-based models of care.
- Increasing uptake and interoperability of digital health.
- Ensuring clinical leadership and governance to drive safe and high-quality care.

1.1.2 State

Queensland's *Advancing Health 2026* (2016) strategy was developed in response to the health challenges that are faced in Queensland, in order to develop solutions by working together across the wider health system. From a primary health perspective, this strategy aims to reduce inaccessibility and barriers experienced by varying population groups, and improve continuity of care to improve overall health and wellbeing for the community as well as the individual consumer. Moving from episodic care to a continual care approach can be achieved through collaboration between sectors of the health service, such as Primary Health Networks (PHNs) and Hospital and Health Services (HHSs), which will contribute to the improvements in health and wellbeing.

The *Specialist Outpatient Strategy* (2016) aimed to improve the patient journey through the health system, by increasing the capacity to provide more specialist appointments and health services and addressing the barriers that are experienced by those trying to access these appointments. Strategies to achieve this included increased funding for HHSs to facilitate more specialist outpatient appointments, supporting GPs to track specialist referrals and provide real-time access to hospital information about patients' health needs, improving GP understanding of available services for patients, providing patients with improved control over healthcare with online booking systems and establishing alternative models of care (such as telehealth and allied health) to provide better access for those in rural and remote parts of the state (Queensland Health 2016).

The *Advancing health service delivery through workforce: A strategy for Queensland 2017-2026* (2017) recognises that the delivery of safe, quality and person-centred care requires a "capable, organised and engaged" workforce, and that the empowerment of the workforce can lead to improved outcomes for consumers. The Advancing Health 2026 (2016) strategy provides the overarching framework, with a focus on four key areas for workforce development in Queensland; Designing, Enabling, Strengthening and Keeping Connected. This strategy aims to empower the Queensland health workforce, by facilitating an environment of capability, autonomy and engagement and recognising the growth of the workforce is vital to ensuring access to quality and responsive health care for Queenslanders (Queensland Health 2017).

Queensland Health is implementing digital health initiatives, with several being rolled out state-wide. Integrated electronic medical record (ieMR) is replacing paper charts in hospitals and other health services, allowing for ease of access and communication for health professionals. The Viewer collects data from several Queensland Health systems, improving access for health professionals and general practitioners to patient information. Telehealth is shaping the future of healthcare for rural and remote areas, by providing opportunities for improved access to a number of health services (Queensland Health 2019).

1.1.3 Regional

Brisbane South PHN undertakes activities which aim to strengthen and improve the primary health system within the region. Brisbane South PHN is committed to implementation of a primary health care digital health strategy, which can be adopted to enable a more integrated, safe and quality primary health care system. Digital health can help improve communication and accessibility, and Brisbane South PHN aims to guide its use in primary health care and therefore contribute to improving the health and wellbeing of the region. The digital health strategic framework aims to improve knowledge and digital health literacy, promote improved connections across sectors of the health system, improve collaboration of care within the primary health system, and facilitate the use of digital technologies to support better access for consumers and providers.

The *Brisbane South PHN Primary Health Transformation Plan 2020 - 2025* aims to partner with communities and care providers to create a person-centred primary care system that improves health experience and outcomes. Focus areas for action are identified in **Error! Reference source n ot found.**.

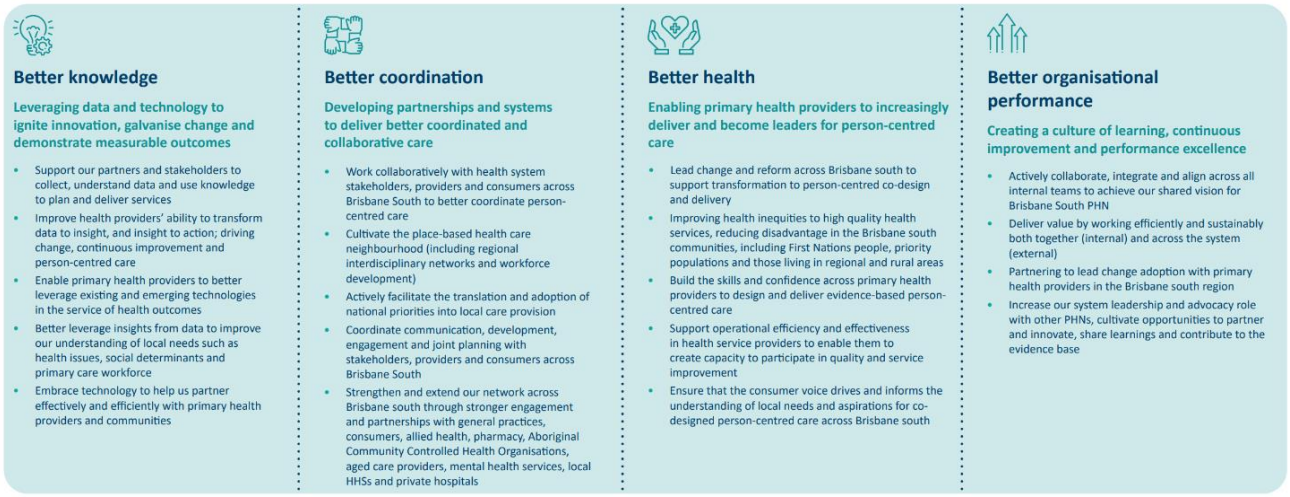

Figure 7. Focus areas of the Brisbane South PHN Primary Health Transformation Plan 2020 – 2025

The Metro South Health Service Plan 2017-2022 (Metro South Health 2017) identifies four key directions for the delivery of State-funded hospital and health services within the region including:

- Promoting wellbeing and health equity
- Delivering healthcare to support population growth
- Connecting healthcare and putting our patients first
- Pursuing innovation for smarter healthcare.

Several strategies refer to supporting and strengthening integration between primary care, hospitals and other community-based healthcare providers, such as:

- Addressing social determinants, behavioural and biomedical risk factors for health and wellbeing.
- Expanding provision of community-based, integrated models through collaboration with general practice and community health services.
- Establishing GP and allied-health led models of care.
- Maintaining a strong partnership with Brisbane South PHN to move towards a more integrated and coordinated health care system.

Together, Brisbane South PHN and Metro South Health have developed a Partnership Protocol that sets out a vision for a shared and coordinated approach in addressing the health needs of the local population (Metro South Health and Brisbane South PHN 2020). Expected outcomes from this partnered approach include:

- Improved coordination, efficiency and effectiveness of and between health and relevant community services.
- Improved access to the most appropriate health services at the right time and in the right place
- A more sustainable local health care system characterised by innovative care pathways and payment models.
- A stronger focus on the needs of vulnerable, at-risk and high-needs populations.
- Improved health literacy to enable better use of the healthcare system and support people to invest in a healthy lifestyle.
- Reduction in avoidable acute hospital admission/readmissions and emergency department presentations.

1.1.4 Sector

A recent focus of the Commonwealth Productivity Commission has been in unlocking Australia's productivity through better health outcomes for communities. In its inaugural five-yearly review of productivity in Australia, the Commission's *Shifting the Dial* report identified integrated care, patient-centred care, more contemporary funding models, health care quality and using information effectively as the areas where solutions exist to improve the health, wellbeing and prosperity of Australians (Productivity Commission 2021).

The Royal Australian College of General Practitioners (RACGP) *Vision for general practice and a sustainable healthcare system* emphasises the contribution of primary healthcare and particularly general practice in delivering sustainable, equitable and high-value healthcare (RACGP, 2019). The RACGP describes high-performing primary healthcare around six features — patient-centred, continuous, comprehensive, coordinated, high-quality and accessible. Supporting and implementing this vision can be supported through improving existing general practice services (e.g. funding, comprehensive care, quality improvement activities) and introducing innovative models of care (e.g. care coordination, research, data, regional collaboration).

1.2 Health status

1.2.1 Demography

1.2.1.1 Population

The estimated total population of the Brisbane South PHN region was 1,286,896 persons as of June 2020, based on Census data (QGSO 2021). This makes the Brisbane South PHN region the largest PHN region by population size in Queensland, and the 7th most populous PHN region of the 31 PHN regions across Australia.

Over half (57%) of the Brisbane south population reside in the Brisbane Local Government Area (LGA), followed by the Logan (28%), Redland (13%) and Scenic Rim (1%) LGAs.

The Brisbane South PHN region is comprised of a total of 23 Statistical Area Level 3 (SA3) regions. Of these, 18 SA3s are entirely within the Brisbane South PHN boundary and five are partially within the boundary. Three of the five partial SA3s each account for less than 1% of the geographic area within the Brisbane south region, and have been excluded from most of the analysis in this document. The remaining SA3s, Brisbane Inner and Sherwood-Indooroopilly have 46% and 35% of their geographic area within Brisbane South PHNs region. The estimated resident population of Brisbane South PHN over the past decade overall and broken down by SA3 region is shown in Table 1.

This data shows the five largest SA3 regions by estimated population in 2021 were:

- Cleveland Stradbroke — 92,634 persons
- Browns Plains — 90,185 persons
- Brisbane Inner — 86,706 persons (note, some of the Brisbane Inner SA3 region falls outside the Brisbane South PHN region)
- Mt Gravatt — 81,017 persons
- Holland Park-Yeronga — 80,620 persons.

Between 2010 and 2021, Jimboomba and Brisbane Inner SA3s experienced considerable absolute and relative growth in population. Jimboomba SA3 encompasses the Priority Development Areas of Yarrabilba and Greater Flagstone (Queensland Government 2021).

By 2041, the total population of Brisbane south is projected to increase by almost an additional 500,000 people, representing about a 1.5 per cent annual growth from the 2020 Estimated Resident Population. SA3 regions projected to experience the highest average annual growth include Jimboomba (5.8%), Beaudesert (3.4%) and Brisbane Inner (2.9%) (Queensland Government 2021).

Table 1. Change in Estimated Resident Population by SA3, Brisbane South PHN region and Queensland

SA3	Estimated Resident Population as at June 30			Absolute change in population, 2010-2020	% change in population, 2010-2020
	2010	2015	2020		
Queensland	4,404,744	4,777,692	5,176,186	771,442	1.59%
Brisbane South PHN	1,079,763	1,175,146	1,286,896	207,133	1.74%
Brisbane LGA					
Brisbane Inner	59,880	69,776	86,706	26,826	4.07%
Brisbane Inner - East	38,893	42,269	46,540	7,647	1.79%
Carindale	48,428	51,626	56,009	7,581	1.42%
Centenary	33,448	34,220	34,035	587	0.16%
Forest Lake - Oxley	64,801	73,163	79,880	15,079	2.12%
Holland Park - Yeronga	67,435	73,413	80,620	13,185	1.78%
Mt Gravatt	67,534	72,951	81,017	13,483	1.81%
Nathan	37,594	40,149	42,854	5,260	1.27%
Rocklea - Acacia Ridge	54,876	60,807	67,511	12,635	2.09%
Sherwood - Indooroopilly	49,523	52,607	57,622	8,099	1.49%
Sunnybank	47,510	51,942	53,838	6,328	1.21%
Wynnum - Manly	65,906	71,045	74,888	8,982	1.24%
Logan LGA					
Beenleigh	38,150	41,777	46,192	8,042	1.92%
Browns Plains	73,812	81,401	90,185	16,373	2.02%
Jimboomba	37,251	45,039	60,021	22,770	5.56%
Loganlea - Carbrook	55,877	60,826	65,379	9,502	1.55%
Springwood - Kingston	77,099	80,299	80,208	3,109	0.37%
Redland LGA					
Capalaba	72,104	74,023	75,599	3,495	0.44%
Cleveland - Stradbroke	77,130	83,860	92,634	15,504	1.83%
Scenic Rim LGA					
Beaudesert	12,512	13,953	15,158	2,646	1.92%

Source: QGSO 2021.

1.2.1.2 Age and sex profile

The distribution by sex of the population was 49.3% male and 50.7% female, which is comparable to Queensland figures. Variation in this distribution within the region is slight, ranging from a ratio of 49.1:50.9 in the Redland LGA to 49.8:50.2 in Scenic Rim (PHIDU 2021).

As of June 2021, the median age in Brisbane south was 35.8 years (34 years for males and 36 years for females), slightly below the state median of 37.9 years (38 years for males and 37 years for females), indicating a slightly younger age population profile than Queensland (QGSO 2021).

The SA3 regions of Cleveland-Stradbroke (45.1 years), Beaudesert (43.5 years), Capalaba (39.7 years), Centenary (39.2 years) and Wynnum-Manly (39.0 years) had an older age profile than the wider Brisbane South population (QGSO 2021).

By 2041, the median age for the Brisbane south region is estimated to be 38.7 years, reflecting the ageing profile of the population. SA3 regions experiencing higher-than-average increases in their median age by 2041 include Cleveland-Stradbroke (+5.0 years), Beaudesert (+4.3 years) and Brisbane Inner (+4.0 years) (QGSO 2021).

The age distribution of the region was generally reflective of the age profiles of Queensland (Figure 8), with a higher proportion of younger children aged 0 to 10 years, lower proportion of adolescents aged 10 to 20 years, slightly higher proportion of adults aged 20 to 50 years, and a lower proportion of older adults aged 65 years and over (ABS 2021b).

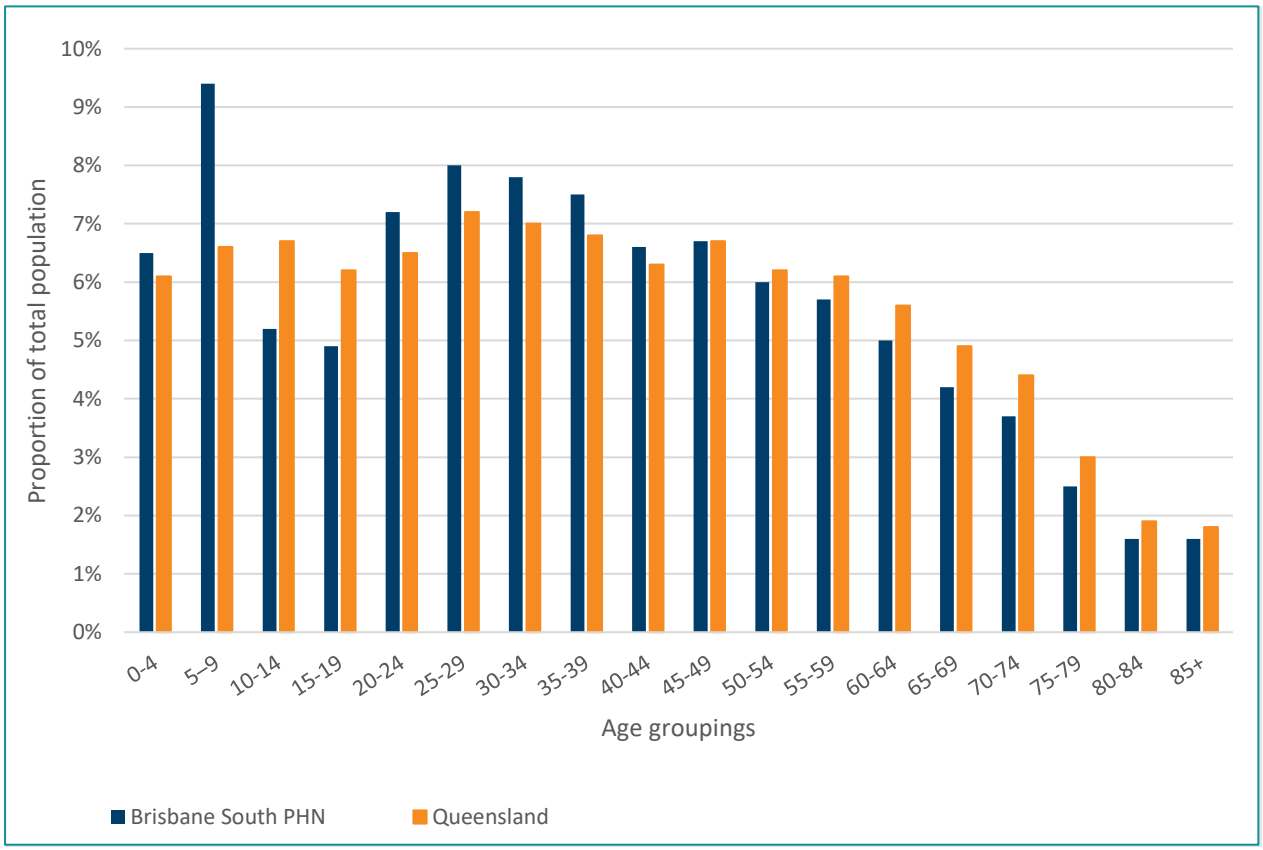

Figure 8. Proportion of Brisbane South and Queensland populations by 5-year age band, Estimated Resident Population at 30 June 2020.
Source: ABS 2021

Responses to the local Health Needs Assessment survey raised that the ageing demographics of the region pose additional challenges for healthcare regarding prevention, early intervention treatment and ongoing management of health issues.

1.2.1.3 Births and deaths

The birth rate in Brisbane South in 2019 was 12.6 births per 1,000 population, with a total of 15,916 births registered. This birth rate was slightly higher than the Queensland birth rate of 12.1 births per 1,000 population. Brisbane south's birth rate has declined by approximately 1.5 births per 1,000 population over the last decade, which broadly reflects state trends. Compared with the regional birth rate, birth rates were higher in Browns Plains (17.4), Forest Lake – Oxley (15.6), Jimboomba (15.5), Springwood – Kingston (15.4) and Beenleigh (14.8). In comparison, birth rates were lower in the SA3s of Brisbane Inner (8.3), Sherwood – Indooroopilly (8.3), Centenary (9.6) and Cleveland – Stradbroke (9.9) (QGSO 2021).

A total of 6,783 deaths were registered in the Brisbane south region in 2019, at a rate of 5.4 deaths per 1,000 population, lower than the Queensland rate (6.4 per 1,000). SA3s with a relatively higher rate of deaths were Beaudesert (9.5), Cleveland – Stradbroke (7.9) and Centenary (6.9), which broadly reflects the older age profile of these areas (QGSO 2021).

1.2.1.4 Cultural diversity

The demographic profile of Brisbane South demonstrates a rich cultural diversity of the people and communities across the region.

An estimated 24,129 people or 2.1% of the population identified as Aboriginal and/or Torres Strait Islander, based on the 2016 Estimated Resident Population. This proportion of First Nations people was lower than the wider Queensland proportion of 4.0%. At an SA3 level, the highest absolute numbers of First Nations people resided in Springwood – Kingston (2,719 peoples), Browns Plains (2,548 peoples) and Forest Lake – Oxley (2,528 peoples). Relative to total population, the highest proportions of First Nations people resided in Beaudesert (5.2%), Beenleigh (3.7%), Forest Lake – Oxley (3.5%) and Springwood – Kingston (3.5%).

More detailed analysis of the health and service needs of Aboriginal and Torres Strait Islander people in Brisbane South is provided in *Section 4: First Nations Peoples.*

Culturally and linguistically diverse (CALD) is a term often used to refer to people who were born overseas, have a parent born overseas or speak a variety of languages. People from CALD backgrounds can experience disproportionate health outcomes due to cultural and language barriers, stigma and discrimination. For the purposes of the Needs Assessment, the term multicultural will be used to describe people from culturally and linguistically diverse backgrounds, including people from refugee and asylum seeker backgrounds.

Based on 2016 Census data, 63.0% of people living in Brisbane South were born in Australia, with a further 19.4% born in non-English speaking background (NESB) countries, and 11.5% born in predominantly English-speaking countries (e.g. United Kingdom, Ireland, Canada, United States of America, South Africa, and New Zealand) (QGSO 2021).

With 30.9% of the population born overseas, the Brisbane South region is considerably more culturally diverse than the wider Queensland population (21.6% of people born overseas). Similarly, 21.7% of the population in Brisbane South reported speaking a language other than English at home, compared to 12.0% of Queensland's population. An estimated 43,302 people or 3.8% of the

population in Brisbane South reported speaking English 'not well' or 'not at all' — more than double the Queensland rate of 1.8% (QGSO 2021).

SA3s which recorded higher proportions of people born overseas included Sunnybank (53.8%), Rocklea – Acacia Ridge (45.6%), Brisbane Inner (40.1%) and Mt Gravatt (39.2%) (QGSO 2021).

More detailed analysis of the health and service needs of people from multicultural backgrounds in Brisbane South is provided in *Section 5: Multicultural health.*

1.2.1.5 Remoteness

Remoteness refers to categorisation of areas of Australia using a measure of relative access to services applied by the ABS (ABS 2021a). Based on 2016 Census data, almost all (96.5%) of the population of Brisbane South resided in a remoteness area of 'Major City', with only a small proportion (3.5%) residing in an area classified as 'regional' or 'remote'. These areas were in Jimboomba, Beaudesert, Cleveland – Stradbroke (including Southern Moreton Bay Islands) and Browns Plains SA3s (QGSO 2021).

1.2.1.6 Household composition

Household composition is measured through the Australian Census of Population and Housing and provides an indication of the type of household structure within each dwelling across the community. It also helps to describe the familial relationships and natural supports within the community.

At the 2016 Census, there were a total of 391,973 households recorded across Brisbane South. Most households were one family households (70%), followed by lone person households (22%), group households (6%), and multiple family households (2%) (QGSO 2021).

For those households involving families, approximately 46% of these families were composed of couple relationships with children, followed by couple families with no children (36%), and single-parent families (16.2%). The proportion of couple families with children was slightly higher in Brisbane South when compared to the total Queensland proportion of couple families with children (43%). There were several areas of variability observed within the region, including:

- higher rates of couple families with no children in Brisbane Inner (58.7%), Holland Park – Yeronga (42.5%), and Cleveland – Stradbroke (41.8%)
- higher rates of couple of families with children in Jimboomba (53%), Rocklea – Acacia Ridge (52%), Centenary (52%), Sunnybank (49%), and Carindale (48%)
- higher rates of single parent families in Beenleigh (25%), Springwood – Kingston (22%), Forest Lake – Oxley (21%), and Browns Plains (21%) (QGSO 2021).

1.2.2 Socioeconomic factors

The 'social determinants of health' refers to the influence of a range of socioeconomic factors in the context of health outcomes for people. Understanding the social and economic conditions experienced by communities across Brisbane South, such as family circumstances, housing, financial security and education outcomes, helps to identify potential risk factors, barriers to health service accessibility and inequities in health outcomes (Figure 9) (AIHW 2020a).

Figure 9. Social determinants of health
Source: Dahlgren and Whitehead 2007.

Respondents to the local Health Needs Assessment survey identified socioeconomic disadvantage as the key driver in unmet health needs. Consultation with Brisbane South PHN's Community Advisory Council and Clinical Council reported the need for strategies to help people cope with economic challenges, identifying the following issues:

- increasing household debt
- financial barriers causing inequitable access to health care (e.g. private services with out-of-pocket costs) and preventive health activities
- unemployment levels
- reductions in private health coverage.

The Index of Relative Social Disadvantage (IRSD) is a summary measure of the social and economic conditions of geographic areas across Australia. It enables ranking areas based on their relative levels of disadvantage, with lower index values representing areas of greater disadvantage relative to the broader community.

At a whole of region level, Brisbane south experienced slightly higher levels of socioeconomic advantage than the national population and ranks as the 10th most advantaged PHN in Australia (PHIDU 2021).

Table 2 represents the relative level of disadvantage experienced within each SA3 of the Brisbane South PHN region across quintiles, showing the proportion of the population who fall within each quintile. Quintiles are derived from distribution at the Queensland-level.

This data shows that across the region, 15.6% of people residing in Brisbane South fell within the most disadvantaged quintile. SA3 regions with particularly high proportions of the population within this most disadvantaged quintile included Beaudesert (55%), Springwood – Kingston (49.7%), Beenleigh (49.4%), Browns Plains (39.6%) and Forest Lake – Oxley (35.9%) (QGSO 2021).

Table 2. Population by Index of Relative Socioeconomic Disadvantage quintiles by SA3, Brisbane South PHN region and Queensland, 2016

SA3	Quintile *1 (most disadvantaged)*	Quintile 2	Quintile 3	Quintile 4	Quintile 5 *(least disadvantaged)*
Queensland	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Brisbane South PHN	**15.6**	**13.3**	**21.1**	**22.6**	**27.5**
Brisbane LGA					
Brisbane Inner	5.0	12.4	25.4	26.2	31.1
Brisbane Inner - East	0.0	1.2	8.0	24.4	66.4
Carindale	3.0	1.6	11.1	24.9	59.3
Centenary	1.4	0.0	8.2	20.6	69.9
Forest Lake - Oxley	35.9	19.9	20.4	17.2	6.7
Holland Park - Yeronga	3.9	5.7	22.2	28.0	40.2
Mt Gravatt	5.3	11.2	22.3	31.0	30.2
Nathan	2.7	17.3	24.8	21.2	34.0
Rocklea - Acacia Ridge	10.7	9.4	21.8	37.3	20.8
Sherwood - Indooroopilly	0.0	9.4	16.0	18.9	55.7
Sunnybank	6.0	30.2	37.9	15.6	10.2
Wynnum - Manly	3.5	13.0	26.9	28.9	27.7
Logan LGA					
Beenleigh	49.4	23.6	14.1	10.6	2.3
Browns Plains	39.6	32.5	15.0	8.8	4.1
Jimboomba	0.8	8.1	44.1	30.7	16.4
Loganlea - Carbrook	23.6	16.9	23.9	17.6	18.0
Springwood - Kingston	49.7	6.5	9.2	24.3	10.2
Redland LGA					
Capalaba	5.8	12.7	26.7	25.0	29.7
Cleveland - Stradbroke	13.8	11.3	19.4	20.1	35.5
Scenic Rim LGA					
Beaudesert	55.0	13.5	26.4	5.1	0.0

Source: QGSO 2021.

Table 3 provides a breakdown of several specific socioeconomic indicators at Local Government Area level, including financial stress related to housing costs, education outcomes, income support, digital accessibility, transport barriers and homelessness.

Table 3. Selection of socioeconomic indicators by LGA, Brisbane South and Queensland

Socioeconomic indicators	QLD	BSPHN	Local Government Area (LGA)			
			Brisbane (a)	Logan	Redlands	Scenic Rim (b)
Financial stress: Low income households under financial stress from mortgage or rent (%)	30.1	32.1	33.9	33.5	27.1	25.8
Education: Completed year 10 or below, or did not attend school (ASR per 100 people)	32.7	29.3	22.1	37.8	33.7	36.3
Welfare: Age pensioners (% of 65+ pop., Jun 2021)	62.0	60.7	50.7	70.4	66.4	61.9
Disability support pensioners (% of 16-64 yrs pop., Jun 2021)	4.9	4.1	3.0	5.8	4.5	6.3
Receiving unemployment benefit (%, Jun 2021)	7.7	6.9	5.1	9.9	6.2	8.4
Female sole parent pensioners (%, Jun 2021)	4.2	3.5	1.8	6.5	3.4	4.5
Digital accessibility: Internet not accessed from dwelling (%, 2016)	13.6	10.9	9.6	12.6	11.0	16.9
Transport: Adults reporting difficulty or cannot get to places needed with transport (ASR per 100, 2014)	3.8	3.8	3.6	4.1	3.2	3.6
Homelessness: Persons experiencing homelessness (rate per 10,000 persons, 2016)	45.6	52.7	51.6	40.2	17.1	20.9

Data notes: (a) and (b) figures shown for entire LGA — have not been adjusted to reflect only the LGA proportion within the PHN region.
Source: QGSO 2021.

This data shows the Brisbane South PHN region generally reflected wider Queensland rates. On several of the indicators, Brisbane South PHN reported more favourable rates than Queensland (education, welfare receipt, digital accessibility), and slightly less favourable in others (financial stress, homelessness) (QGSO 2021).

At the LGA level, data shows relatively higher levels of financial stress in Brisbane and Logan, lower levels of education outcomes in Logan and Scenic Rim, a greater number of aged pensioners in Logan and Redlands, and higher rates of people experiencing homelessness in Brisbane (QGSO 2021).

Across the Brisbane South region, the unemployment rate at March 2021 quarter was 7.6% of the labour force, a total of 52,465 unemployed persons. Unemployment was relatively stable over the three to four-year period from 2016 until the March 2020 quarter, where the rate increased by over 1% over subsequent quarters, coinciding with the onset of the COVID-19 global pandemic (QGSO 2021).

Of those people accessing homelessness services in Brisbane LGA, service data suggests that most identify as male (71%) followed by female (28%) and transgender, intersex, X or unspecified (1%). For young consumers, the proportion of males to females was considerably more even at 53% to 45% respectively, with 2% identifying as transgender, intersex, X or unspecified, while 13% of young consumers in Brisbane LGA identify as lesbian, gay, bisexual or unsure (Micah Projects 2017).

Additional contextual insights provided by local stakeholders through the Health Needs Assessment survey relating to the socioeconomic conditions of the community included:

- Inequality driving the most pressing unmet health needs, with lower socioeconomic communities reporting high levels of people experiencing multiple conditions
- Material wellbeing in Redlands due to changing economic conditions (notwithstanding COVID-19) is creating difficulties with high rents, severe housing shortages, vulnerable housing situations including homelessness, and difficulties accessing health services.

1.2.3 Community strengths

1.2.3.1 Protective factors

Consultation with Brisbane South PHN's Community Advisory Council and Clinical Council reported a range of community strengths that act as protective factors for good health and wellbeing, including:

- spiritual health
- social supports (e.g. family, community)
- well-established community organisations
- interpersonal connection
- community infrastructure
- access to services in the primary care setting
- community engagement
- adaptation and resilience.

1.2.3.2 Volunteering

Voluntary work is an indicator of a community's capacity to support others and contribute to social cohesion, while also being an important protective factor for a volunteer's own health and wellbeing (PHIDU 2021). At a national level, rates of volunteering in Australia have been declining over the past decade.

The 2016 Census figures on voluntary work demonstrated that 169,315 people or 18.3% of the Brisbane South population undertook voluntary work through an organisation or group in the previous 12 months, slightly lower than the Queensland rate of 18.8%. Rates of volunteering were highest in relatively advantaged areas of the region, particularly the SA3s of Sherwood – Indooroopilly (27.0%), Centenary (22.3%), Holland Park – Yeronga (22.2%), Nathan (21.4%), and Carindale (21.3%).

1.2.3.3 Social cohesion

In 2018, the Queensland Government undertook the *Queensland Social Survey 2018* which provided measures of Queenslanders' perceptions and attitudes relating to social cohesion (QGSO 2019). The survey results are displayed for the Greater Brisbane region, of which approximately half of the population fall within the Brisbane South PHN region (based on its composite SA4 regions). In lieu of more localised data, the findings of the survey may be generalised for the Brisbane South region. These findings included:

- 95% of people having a sense of belonging in Australia to a great or moderate extent
- 64% agreeing or strongly agreeing that accepting immigrants from many different countries makes Australia stronger
- 49% believing that in the next three or four years their life in Australia would be the same as now, while 31% believed their life would be improved.

The Public Health Information Development Unit (PHIDU) *Social Health Atlases* (2018) also include a series of indicators relating to community strengths which demonstrate the level of social cohesion in the region. The modelled estimates of these indicators showed that in Brisbane South:

- 92.8 ASR per 100 persons aged 18 years and over were able to get support in times of crisis from persons outside of their household
- 29.4 ASR per 100 persons aged 18 years and over (or their partner) provided support to other relatives living outside the household
- 50.5 ASR per 100 persons aged 18 years and over felt 'safe' or 'very safe' walking alone in their local area after dark
- 18.0 ASR per 100 persons aged 18 years and over felt they had experienced discrimination or had been treated unfairly by others in the past 12 months.

1.2.3.4 Safety

Feeling and being safe from harm in one's community is an important indicator of physical and mental wellbeing, and avoidance of adverse health outcomes such as injury, hospitalisation and mortality.

Using data collected by the Queensland Police Service, there were a total of 115,103 reported offences across the Brisbane South region in 2020-21, at a rate of 8,790 offences per 100,000 people which is lower than the Queensland rate of 9,154 offences per 100,000 people.

These reported offences are further categorised as 'offences against the person', 'offences against property' or 'other offences'. Those categorised as 'offences against the person' included assault, sexual offences, robbery and homicide and are most closely related with the physical safety of the community. A total of 9,858 offences against the person were reported in Brisbane South PHN region in 2020-21, at a rate of 753 per 100,000 people. This was 13% lower than the state-wide rate recorded. SA3s with noticeably higher rates of offences against the person (per 100,000 persons) compared to regional and state rates included Brisbane Inner (2,306), Springwood – Kingston (1,470), Beenleigh (1,293) and Loganlea – Carbrook (1,030) (QPS 2021).

1.2.4 Risk factors, primary prevention and secondary prevention

Health risk factors describe the "attributes, characteristics, or exposures that increase the likelihood of a person developing a disease or health disorder". Risk factors may be considered in two broad categories:

- **Behavioural:** these are risk factors that relate to a person's actions and are typically modifiable through lifestyle behaviour change and other mechanisms. These include factors such as diet and physical activity.
- **Biomedical:** these are risk factors that are related to a person's bodily states, and the associated risk that these have on the maintenance of good health. These include factors such as blood pressure and cholesterol (AIHWa 2019).

Primary prevention refers to the activities undertaken to prevent an individual from developing a health condition, such as vaccination; whereas secondary prevention refers to the screening and early detection of health conditions, such as cancer screening (WHO 2021a).

Available data relating to health behaviour and risk factors that determine health status can be broadly considered as lifestyle, health screening and health literacy factors. Brisbane South PHN's Clinical and Community Advisory Councils identified the recent impact of COVID-19 on a range of health behaviours, including preventive health (e.g. diet and physical activity rates), relationship between COVID-19 risk and health behaviours (e.g. increased vulnerability of smokers), and participation in preventive health screening and other help-seeking behaviours.

1.2.4.1 Behavioural risk factors

There are several known indicators of a healthy lifestyle that contribute to the prevention and improved management of excess body weight (overweight and obesity) and a range of chronic diseases such as cardiovascular disease, diabetes, cancer, and some respiratory disorders. In the adult population, lifestyle-related risk factors that are associated with higher likelihood of adverse physical and mental health outcomes include:

- poor nutrition
- insufficient physical inactivity
- smoking
- sun exposure
- stress.

Detailed analysis of the lifestyle risk factors of children and young people in Brisbane South is provided in Section 2: Children, youth and families.

Table 4 compares a snapshot of relevant healthy lifestyle indicators for Brisbane South PHN to the wider Queensland population. This data is based on the Chief Health Officer 2020 Report, the most recent version of a two-yearly report produced on the health of Queenslanders using data from a phone survey from a sample of the population and broken down at a PHN level.

Table 4. Lifestyle indicators in Brisbane south

Lifestyle indicators	Brisbane South PHN (c)	Queensland (c)
Adults aged 18+ years with insufficient fruit intake (a)	49.0%	47.9%
Adults aged 18+ years with insufficient vegetable intake (a)	92.3%	91.6%
Adults aged 18+ years performing insufficient physical activity (b)	43.7%	41.7%
Adults aged 18+ years who smoke daily	10.0%	10.9%
Adults aged 18+ years who reported having been sunburnt in the last 12 months	49.7%	52.5%

Data notes: (a) according to National Health and Medical Research Council's (NHMRC) Australian Dietary Guidelines 2013; (b) according to Department of Health Australia's Physical Activity and Sedentary Behaviour Guidelines 2020; (c) data for fruit and vegetable intake is for 2018-2019, all other data is for 2019-2020
Source: Queensland Health 2020.

A higher proportion of adults in Brisbane South did not meet national guidelines for fruit and vegetable intake and physical activity compared to wider Queensland, but rates of obesity, smoking and sun exposure are more positive.

When considering these indicators by age, sex and geography, there were several key differences observed within the region, including:

- Rates of insufficient fruit and vegetable intake, smoking and sunburn were higher in males than females, while levels of physical inactivity were higher amongst females
- Rates of insufficient fruit and vegetable intake, physical inactivity and smoking were considerably higher in the Logan LGA than rest of the region
- Physical inactivity was associated with age, with rates increasing with age from 40% in adults aged 18-29 years to over 52% in adults aged 65+
- Adults living in more socially disadvantaged locations within the region were approximately 2.3 times more likely to smoke daily compared to advantaged locations
- Sunburn was inversely associated with age, with younger adults aged 18-29 years having the highest rates (62%).

Table 5 demonstrates the estimated proportion of adults engaging in various healthy lifestyle behaviours. The results of these indicators suggest there is significant room for improvement in engagement with physical activity across the region, particularly for those adults living within Logan LGA. Adequate consumption of fruit was relatively consistent across the region, with typical rates sitting at approximately half of the population regularly consuming fruit, again indicating opportunities for improvement (PHIDU 2021).

Residents of Logan and Scenic Rim LGAs were estimated to have a greater proportion of people who were current smokers, compared to both regional and state estimates. Brisbane, Logan, and Scenic Rim LGA residents were also estimated to more commonly consume more than two standard drinks of alcohol per day on average compared to Queensland estimates (PHIDU 2021).

Notable differences in smoking and excess alcohol consumption were noted in each LGA and at the wider PHN level, whereby males exhibited higher rates of these detrimental health behaviours than females (PHIDU 2021).

Key themes raised by community and sector representatives during local consultation regarding health behaviours included:

- Accessibility and affordability of fresh, healthy food, with low price point of high-energy and low-nutrition foods and beverages contributing to levels of obesity
- Lack of access to healthy lifestyle advice and programs to support chronic disease prevention.

Table 5. Lifestyle indicators by Local Government Area, 2017-18 modelled estimates

Lifestyle indicators (2017-18 modelled estimates)	Local Government Area (LGA)				Brisbane South PHN	Queensland
	Brisbane (a)	Logan	Redland	Scenic Rim (a)		
Adults aged 18+ years with adequate fruit intake (ASR per 100 persons)	52.8	48.7	51.3	49.0	51.2	50.6
Adults aged 18+ years undertaking low, very low, or no exercise in the previous week (ASR per 100 persons)	64.7	75.6	65.9	70.6	69.3	67.9
Adults aged 18+ years who were current smokers (ASR per 100 population)						
Persons	11.7	18.5	13.5	16.8	14.2	16.0
Males	14.5	21.9	16.2	20.6	17.1	19.4
Females	9.0	15.1	10.8	13.1	11.3	12.8
Adults aged 18+ years who consumed more than two standard alcohol drinks per day on average (ASR per 100 population)						
Persons	15.7	14.8	20.0	19.7	15.3	18.2
Males	23.1	22.2	29.6	29.1	22.7	26.8
Females	8.7	7.5	10.9	10.5	8.2	9.9

Source: PHIDU 2021.

Table 6 details self-assessed rates of psychological distress, which shows that residents in Logan LGA experienced the highest levels of psychological distress by proportion of population (PHIDU 2021).

Table 6. Rates of high psychological distress by LGA, Brisbane South PHN and Queensland, 2017-2018

Region	Adults aged 18+ years with high or very high psychological distress (based on Kessler 10 Scale)	
	Estimated no. of people	ASR per 100 people
Queensland	-	13.0
Brisbane South PHN	116,568	13.3
Brisbane LGA (a)	59,230	11.5
Logan LGA	38,110	16.1
Redland LGA	15,384	13.0
Scenic Rim LGA (b)	1,442	13.1

Data notes: (a) and (b) figures shown for entire LGA — have not been adjusted to reflect only the LGA proportion within the PHN region.
Source: PHIDU 2021

1.2.4.2 Biomedical risk factors

Biomedical risk factors describe the bodily states that increase the risk for the development of disease. Three major biomedical risk factors for the development of chronic conditions include high fasting blood glucose levels, high cholesterol, and high blood pressure.

In 2015, it was estimated that 4.7% of disease burden across the country was attributable to high fasting blood glucose levels. In addition to contributing to the burden associated with diabetes, 7% of cardiovascular disease burden and 60% of chronic kidney disease burden was attributable to high fasting blood glucose levels (AIHW 2020b). Unfortunately, localised data to the PHN region is not available on fasting blood glucose levels.

High cholesterol is associated with the development of atherosclerotic plaques in the arteries, which can in turn lead to cardiovascular and cerebrovascular disease. High cholesterol accounted for 37% of cardiovascular disease burden and 15% of stroke burden nationally (AIHW 2020c).

Persistent high blood pressure, or hypertension, is a risk factor for the development of cardiovascular diseases (such as coronary heart disease), stroke, and chronic kidney disease. Hypertension contributed 65% of hypertensive heart disease, 43% of coronary heart disease, 41% of stroke, 38% of chronic kidney disease, and 32% of atrial fibrillation & flutter burden (AIHW 2020b). Estimated rates of high blood pressure across Brisbane South PHN are noted in Table 7, which shows relatively comparable rates with the Queensland benchmark for the proportion of the population effected.

Table 7. Rates of high blood pressure by LGA, Brisbane South PHN and Queensland, 2017-2018

Region	Adults aged 18+ years with high blood pressure	
	Estimated no. of people	Proportion (%)
Queensland	-	23.1
Brisbane South PHN region	182,147	22.3
Brisbane (a)	102,334	22.1
Logan	50,835	23.0
Redlands	27,974	21.9
Scenic Rim (b)	2,855	22.3

Data notes: (a) and (b) figures shown for entire LGA — have not been adjusted to reflect only the LGA proportion within the PHN region.
Source: PHIDU 2021

1.2.4.3 Health literacy

Health literacy refers to the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about their health (ACSQHC 2014). While Australia's *National Statement on Health Literacy* (2014) highlights the importance of health literacy in safe and high-quality health care, there is no consistent national data available relating to the health literacy and/or the involvement of health consumers in the health system.

Limited local survey data was captured that identified lack of health literacy as a persistent major health issue within Brisbane South, with education required for people in the community to better understand areas relating to health and healthcare. Brisbane South PHN's Community Advisory

Council reported that while health literacy has been a longstanding priority for the region, levels have not improved.

Other issues relating to health literacy identified through local consultation included:

- limited understanding amongst community members about what health services are available and how to access them
- limited community engagement focusing on linking communities to health services
- need for healthy lifestyle advice and programs to educate patients and improve health literacy
- stigma as a barrier to help-seeking amongst some segments of the community (e.g. men).

1.2.4.4 Immunisation

Limited data is available for adult immunisation status.
Please refer to Section 2.2.3.2 - Immunisation for a discussion of immunisation rates for children and young people.

1.2.4.5 Cancer screening

Population-level screening and assessment for detection of certain conditions can enable earlier intervention and treatment. Australia has 3 national cancer screening programs: BreastScreen Australia, the National Cervical Screening Program (NCSP) and the National Bowel Cancer Screening Program (NBCSP). These programs target specific segments of the population to test for signs of cancer or pre-cancerous conditions.

Figure 10 presents participation in the three national cancer screening programs in Brisbane South, Queensland and Australia.

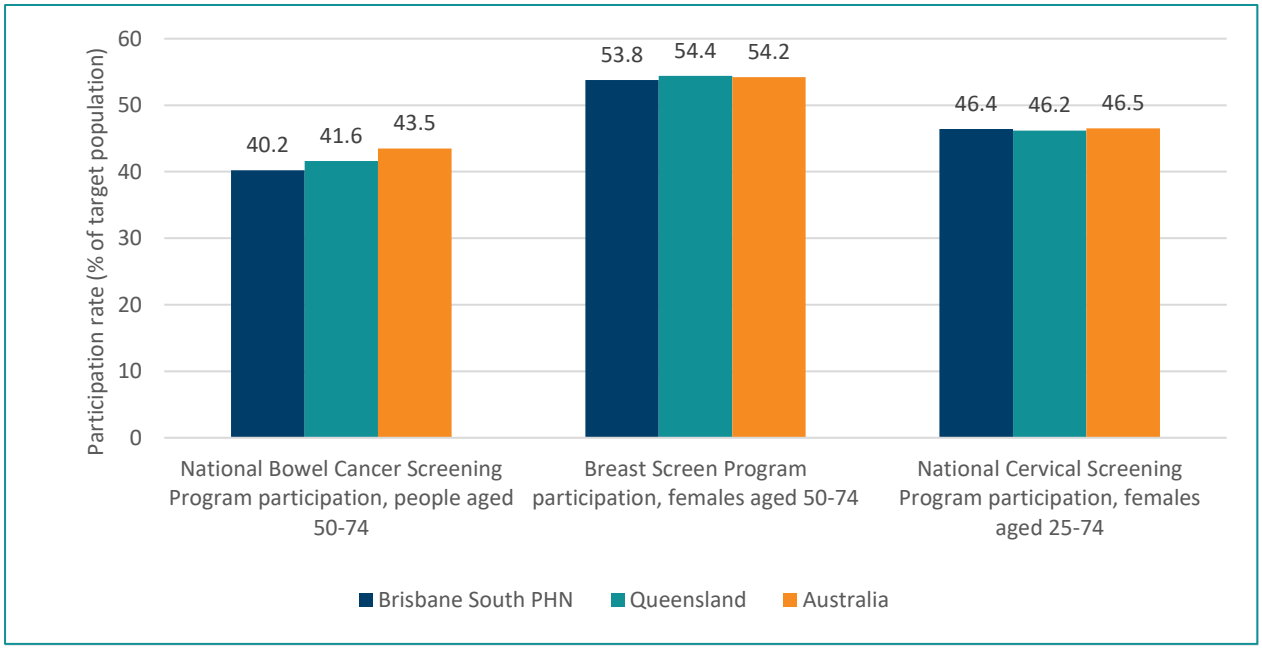

Figure 10. Participation rates in national cancer screening programs, 2018-19
Source: AIHW 2021

This data shows participation rates for bowel cancer in Brisbane South were lower than national rates, while rates for breast cancer and cervical cancer screening were comparable (AIHW 2021).

Between 2015-16 and 2018-19, participation rates in bowel cancer screening programs increased by almost 4% in Brisbane South, while breast cancer screening participation declined by 2% over that time. Due to changes in the NCSP screening regime, trend data is not available (AIHW 2021).

There was considerable variation observed within the region by SA3 for each cancer screening program, including:

- rates of participation in NBCSP ranged from 35% in Browns Plains and 36% in Springwood – Kingston to 45% in Centenary
- rates of participation in BreastScreen ranged from 43% in Sherwood – Indooroopilly and Brisbane Inner to 59% in Capalaba, and 58% in Cleveland – Stradbroke and Mt Gravatt
- rates of participation in NCSP ranged from 39% in Jimboomba and 40% Browns Plains to 51% in Carindale and Holland Park – Yeronga.

In 2014-15 in Brisbane South, age standardised rates of hospitalisation for cervical loop excision or laser ablation per 100,000 women aged 15 years and over were highest in Beaudesert (252), Brisbane Inner (212) and Brisbane Inner – East (212) while the lowest rates were observed in Mt Gravatt (123), Rocklea – Acacia Ridge (127) and Sherwood – Indooroopilly (130) (ACSQHC 2017).

1.2.5 Health Status

1.2.5.1 Self-reported health status

Self-reported levels of health are a component of the *Australian Health Performance Framework* (2021), and are an important indicator of subjective wellbeing and quality-of-life. Most recent data on self-reported health status came from the 2017-18 *National Health Survey* conducted by the Australia Bureau of Statistics.

Figure 11 shows the rate of people aged 15 years and over who reported a fair or poor level of self-assessed health (by SA3). The data shows several regions where levels of self-reported health and wellbeing were poorer, including Springwood - Kingston, Beaudesert, Beenleigh and Forest Lake - Oxley. Levels of self-reported health status were reasonably comparable between Brisbane South and wider Queensland.

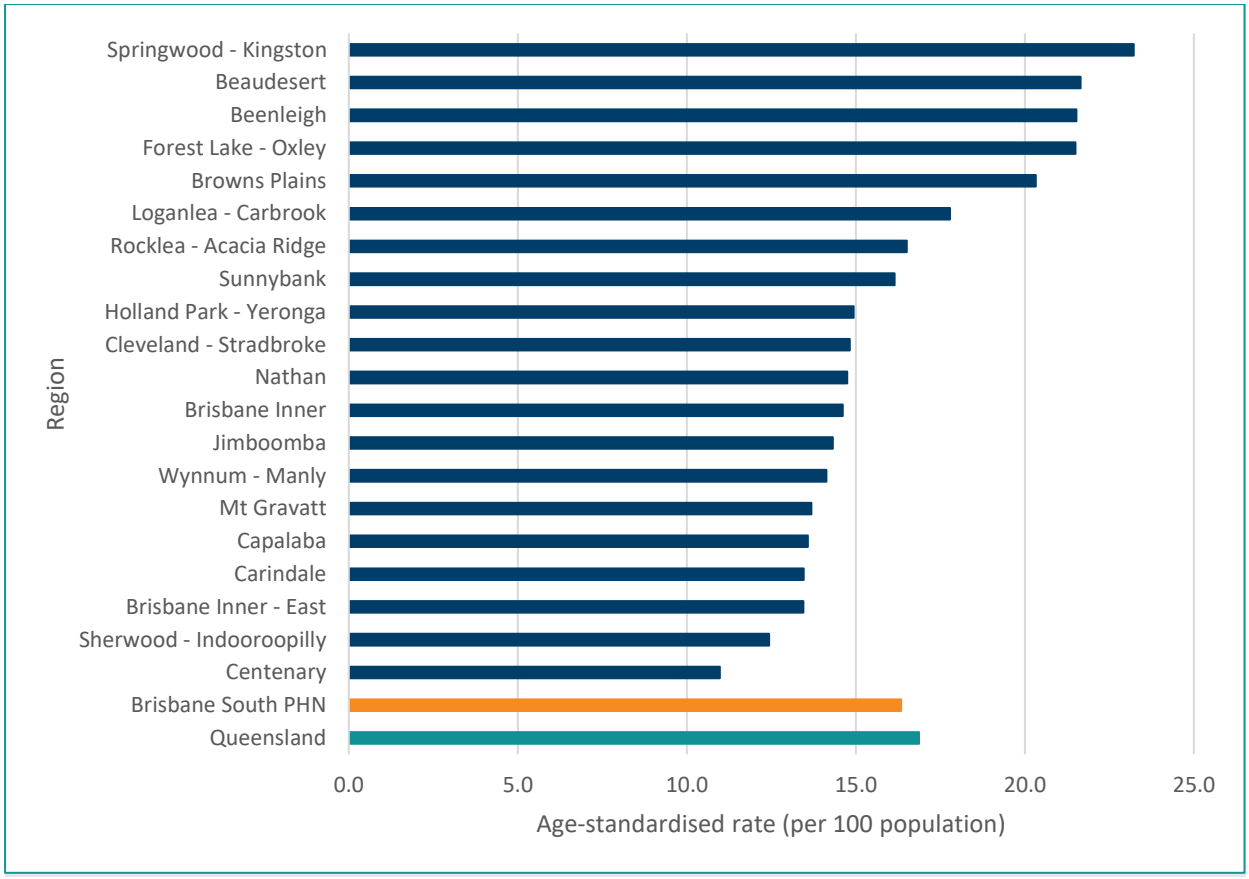

Figure 11. Age-standardised rate of people aged 15 years and over with fair or poor self-assessed health, 2017-18
Source: PHIDU 2021

1.2.5.2 Obesity

Obesity refers to an individual's weight status that is determined to be above a healthy range. Obesity is associated with the development of many chronic health conditions, such as cardiovascular disease and type 2 diabetes, and is one of the leading risk factors for poor health in Australia (AIHW 2020d). The aetiology of obesity is complex and multifactorial, including genetic predisposition, medical conditions (such as hypothyroidism), and lifestyle behaviours such as nutrition and physical activity. The complexity of obesity also exists in the contributions of the multitude of factors that impact lifestyle behaviours, such as built environment and available green space, access to nutritious foods and energy-dense low-nutrient foods, and increasingly sedentary workplaces (AIHW 2020d).

The AIHW (2020c) estimated that overweight and obesity contributed to:

- 45% of the disease burden from endocrine disorders (such as type 2 diabetes),
- over one-third of the burden from kidney and urinary diseases
- nearly 20% of cardiovascular disease burden in Australia in 2015.

Australia has the sixth highest rate of overweight and obesity among OECD countries. Approximately 65% of adults (aged 18+ years) in the Brisbane South PHN region were estimated to be overweight or obese, slightly below the national proportion (66.5%) (AIHW 2020d). Table 8 demonstrates that at a whole of PHN region level, the proportions of overweight and obese adults is comparable to the wider Queensland population. However, it is estimated that adults aged 18+ years residing in the Logan LGA demonstrated the lowest rates of overweight but the highest rates of obesity within the region, with a similar trend noted in the Scenic Rim. Further, a higher rate of males tended to be overweight, whereas a higher rate of females tended to be obese (PHIDU 2021).

Table 8. Overweight and obesity (adults aged 18+ years) across Brisbane South PHN (modelled estimates), 2017-18

		Overweight but not obese (ASR per 100 population)			Obese (ASR per 100 population)		
		Persons	Females	Males	Persons	Females	Males
Queensland		34.6	28.8	33.8	32.4	31.6	19.4
Brisbane South PHN		34.5	28.7	32.1	31.1	30.0	17.1
LGA	**Brisbane** [a]	35.3	29.6	28.2	27.2	26.2	14.5
	Logan	32.7	26.8	40.2	39.1	38.1	21.9
	Redland	35.6	29.7	31.3	30.3	29.3	16.2
	Scenic Rim [a]	34.2	28.0	36.9	35.4	34.0	20.6

[a] Brisbane South PHN component of LGA only

Source: PHIDU 2021

Obstructive sleep apnoea

Obesity is the strongest risk factor for the development of obstructive sleep apnoea (Hamilton & Joosten 2017), a condition that involves repeated periods of obstructed breathing during sleep. These disturbances in breathing are caused by partial or total obstruction of the upper airways and result in decreased blood oxygen levels. As such, people experiencing obstructive sleep apnoea experience interrupted sleep and often awake feel unrefreshed (Sleep Health Foundation 2011).

From late 2018, Medicare Benefits Schedule (MBS) items for sleep disorders were expanded, allowing general practitioners to refer clients to home-based and laboratory-based sleep studies without initial referral to a sleep specialist (Department of Health 2019b). Table 9 demonstrates the total number of home-based sleep study services in the Brisbane South PHN region in 2019, with the SA3s of Beenleigh, Beaudesert, and Cleveland – Stradbroke reporting the greatest uptake of these services (AIHW 2019a).

Table 9. Distribution of home-based sleep study services by SA3, people aged 18+ years, 2019

SA3 name	Total service	Rate per 1,000 population (crude)
Brisbane LGA		
Brisbane Inner [(a)]	285	3.4
Brisbane Inner - East	174	3.8
Carindale	237	4.3
Centenary	140	4.1
Forest Lake - Oxley	253	3.2
Holland Park - Yeronga	340	4.3
Mt Gravatt	407	5.1
Nathan	191	4.5
Rocklea - Acacia Ridge	309	4.7
Sherwood – Indooroopilly [(a)]	140	2.5
Sunnybank	241	4.5
Wynnum - Manly	396	5.4
Logan LGA		
Beenleigh	381	8.5
Browns Plains	488	5.6
Jimboomba	362	6.4
Loganlea - Carbrook	450	6.9
Springwood - Kingston	476	5.9
Redland LGA		
Capalaba	477	6.3
Cleveland - Stradbroke	497	5.5
Scenic Rim LGA		
Beaudesert	90	6.0

(a) represents SA3 with overlap in to other PHN boundaries.

Source: AIHW 2019a

1.2.5.3 Chronic disease

Within Australia, 87% of deaths were attributed to chronic conditions, as well as 61% of the total burden of disease and injury (AIHW 2018a). Cancer accounted for the greatest amount of disease burden (19%), followed by cardiovascular diseases (15%), mental and substance use disorders (12%), musculoskeletal conditions (12%) and injuries (9%). Together these disease groups accounted for around two-thirds of the total burden of disease (AIHW 2017a).

In 2019-20, almost half (49.8%) of adults living in the Brisbane South PHN region reported having at least one long-term health condition. Using an age-standardised rate to compare this with other PHN regions, Brisbane South PHN ranked 21st on rates of self-reported chronic conditions and was comparable with the national rate (ABS 2020).

Figure 12 shows the trend over time of people in Brisbane south reporting at least one chronic health condition. It shows that rates were more positive in Brisbane south than nationally in the seven years preceding 2019-20, with a relatively stable trend mirroring national fluctuations.

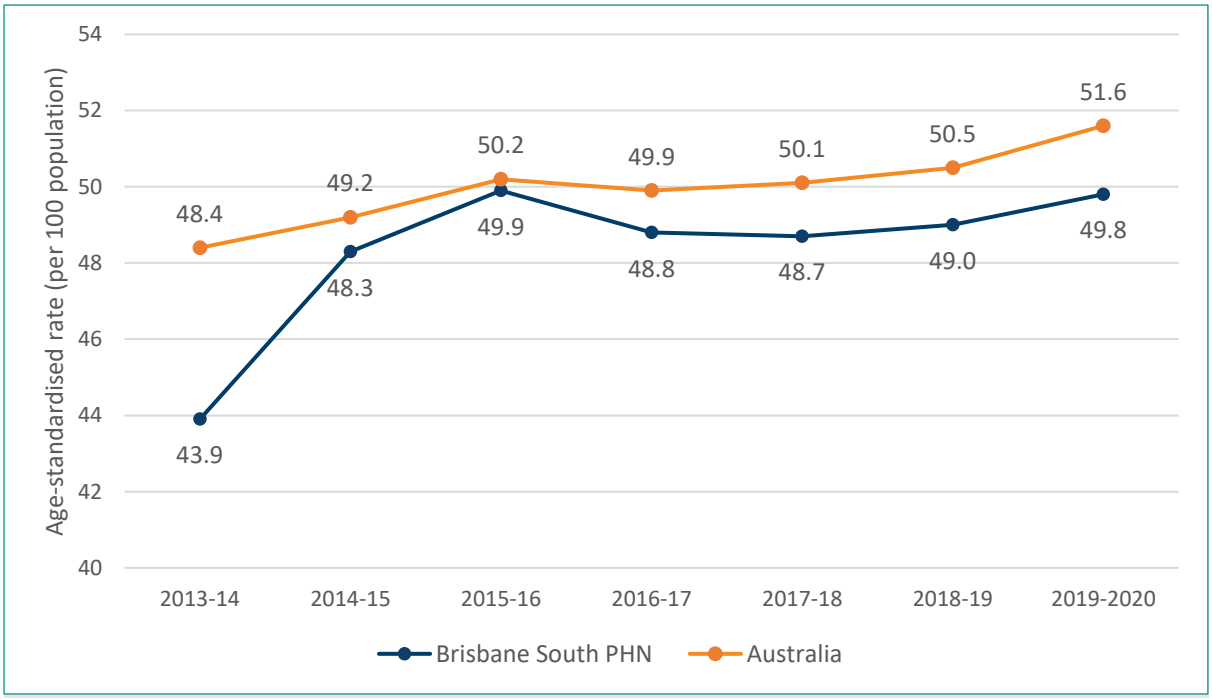

Figure 12. Proportion of adults reporting having a long-term health condition, 2013-14 to 2019-20
Source: AIHW 2021

Data collected through the *National Health Survey* undertaken in 2017-2018 provided a snapshot of the prevalence of a selection of chronic conditions, shown at SA3 level in Table 10. Despite Brisbane South generally having comparable or lower rates of chronic conditions than Queensland, the data identified several geographic 'hot spots' of relatively higher prevalence of most or all conditions when compared to rates in Queensland. These included Beaudesert, Beenleigh, Browns Plains, Forest Lake – Oxley, Jimboomba and Springwood – Kingston.

Table 10. Self-reported prevalence of select chronic conditions by SA3, 2017-2018

Region	Diabetes	Heart, stroke and vascular diseases	Asthma	COPD	Arthritis
Queensland	4.7	4.7	11.8	3.5	13.9
Brisbane South PHN	4.7	4.7	11.0	3.4	13.4
Brisbane LGA					
Brisbane Inner	3.9	3.7	8.9	3.3	9.2
Brisbane Inner - East	3.5	4.0	10.0	3.5	10.3
Carindale	3.8	4.3	9.9	2.9	12.3
Centenary	3.7	4.1	9.4	2.3	11.7
Forest Lake - Oxley	6.5	5.0	11.9	3.5	15.0
Holland Park - Yeronga	4.0	4.0	10.7	3.6	11.4
Mt Gravatt	4.2	4.3	9.1	3.1	12.7
Nathan	4.1	4.4	9.8	3.1	12.8
Rocklea - Acacia Ridge	5.3	4.8	9.4	2.9	13.4
Sherwood - Indooroopilly	3.2	3.6	9.0	2.6	9.9
Sunnybank	4.9	4.5	8.3	2.7	12.2
Wynnum - Manly	4.2	4.7	10.6	3.6	13.1
Logan LGA					
Beenleigh	5.8	5.2	13.6	4.0	15.4
Browns Plains	6.4	5.5	12.8	3.6	16.2
Jimboomba	4.2	5.5	12.9	3.6	15.4
Loganlea - Carbrook	5.0	5.1	12.5	3.6	14.5
Springwood - Kingston	6.1	5.2	11.7	3.8	14.1
Redland LGA					
Capalaba	4.0	4.9	11.8	3.5	14.1
Cleveland - Stradbroke	3.8	4.6	11.4	3.2	13.0
Scenic Rim LGA					
Beaudesert	5.5	4.8	14.0	4.6	16.4

Source: Public Health Information and Development Unit 2021

Type 2 diabetes

Type 2 diabetes is a chronic endocrine condition, where the body becomes resistant to the effects of insulin. Consequently, the pancreas overproduces insulin, and while in a state of insulin resistance, body tissues cannot effectively use this insulin to remove excess glucose from the bloodstream. Poorly managed type 2 diabetes is itself a risk factor for the development of other chronic health conditions (such as chronic kidney disease and vision impairment) and limb amputation, due in part to the microvascular complications it can cause to the eyes, kidneys, and peripheral nerves (Diabetes Australia 2021).

Estimates of the prevalence of type 2 diabetes within Brisbane South reveal a rate slightly above the Queensland prevalence. Overall, males were estimated to have a slightly higher prevalence compared to females, with prevalence increasing with age (Table 11) (AIHW 2021).

Table 11. Geographical variation in type 2 diabetes among adults registered in the National Diabetes Services Scheme (NDSS), 2018

Population	Brisbane South PHN		Queensland	
	Number	Proportion (%)	Number	Proportion (%)
Persons				
18-54 years	10,524	1.7	43,547	1.7
55-74 years	25,774	12.4	116,331	11.3
75+ years	11,085	18.5	55,060	17.4
Females				
18-54 years	4,980	1.6	21,062	1.7
55-74 years	11,1830	10.5	49,732	9.5
75+ years	5,409	15.9	26,450	15.1
Males				
18-54 years	5,544	1.8	22,485	1.8
55-74 years	14,591	14.5	66,599	13.1
75+ years	5,676	22.0	28,610	20.1

Source: AIHW 2021.

Management of type 2 diabetes is addressed through lifestyle modification (for example, improving diet and physical activity to assist with blood glucose management), oral hypoglycaemic agents (such as biguanides and sulfonylureas), and insulin (Diabetes Australia 2021). Insulin is often commenced when the progression of type 2 diabetes is relatively advanced or non-responsive to oral hypoglycaemic agents (Diabetes Australia 2021). When examining the incidence of insulin-treated type 2 diabetes in Australia, Brisbane South PHN had the third highest incidence rate of all PHNs (Figure 13) (AIHW 2020e).

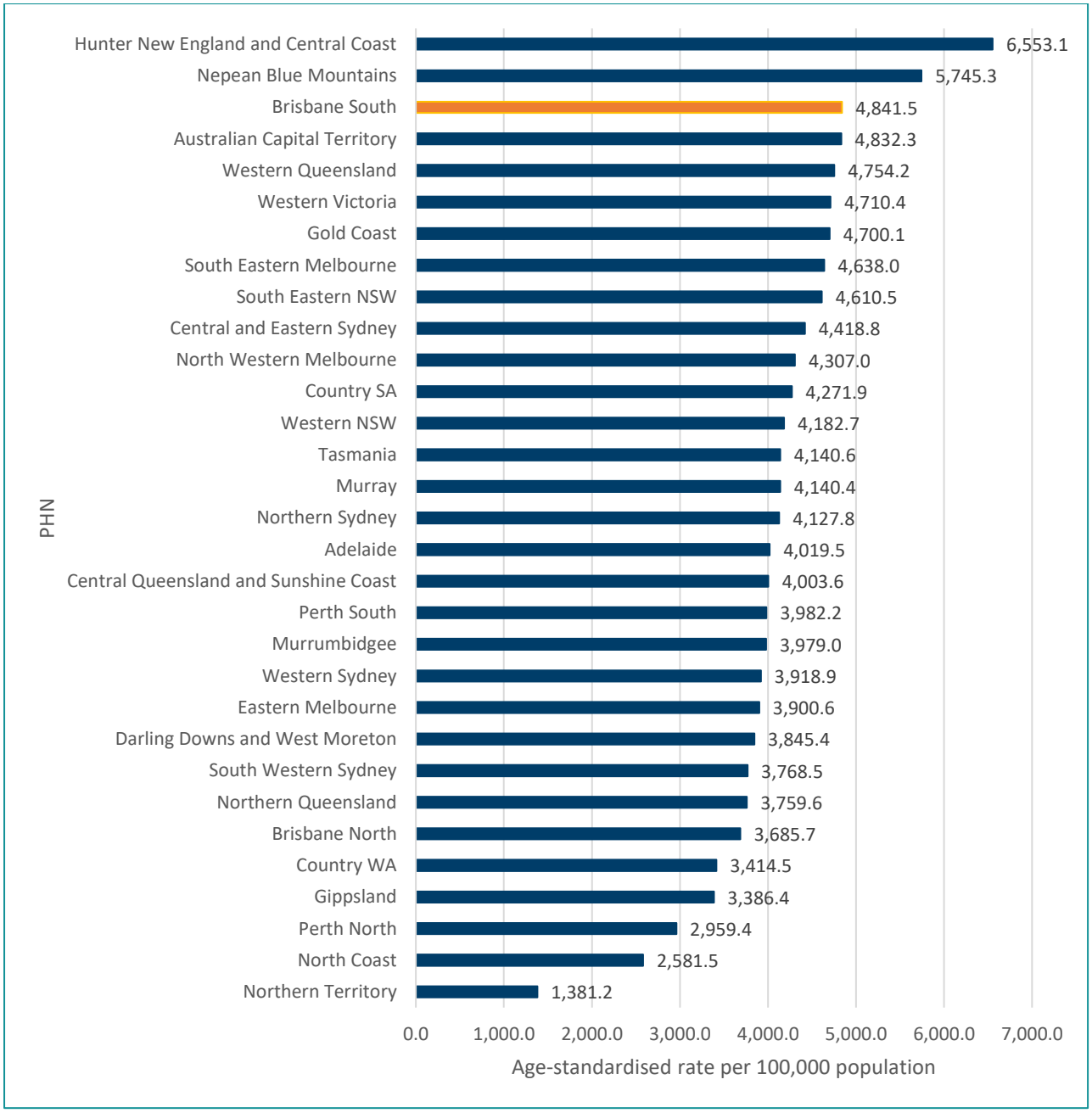

Figure 13. Incidence of insulin-treated diabetes by PHN, 2019
(a) Age-standardised to the 2001 Australian Standard Population
Source: AIHW 2020e.

Cardiovascular Diseases

Heart disease is a broad term used to describe a group of health conditions that affect the hearts' structure and function, such as coronary heart disease, cardiac failure, and arrhythmias (Heart Foundation n.d.). Cardiovascular diseases (CVD) encompass heart diseases, stroke, and other vascular diseases (AIHW 2021). Many CVDs develop from atherosclerosis – the build-up of plaque in the arteries, which results in partial or complete occlusion (blockage) of these arteries. This occlusion prevents oxygen and nutrient-rich blood from reaching the areas beyond the blockage (WHO 2021b). Many CVDs can be prevented through engaging in a healthy lifestyle, with particular risk factors including smoking, limited physical activity, and a diet high in nutrient-poor, high-density foods. While there has been significant progress in reducing the impact of CVDs on the Australian population, it remains one of the largest contributors to the burden of disease (13.6% of total burden in 2015) (AIHW 2020b) and mortality nationally (AIHW 2021).

The estimated prevalence of heart, stroke and vascular disease is shown in Table 12. These figures demonstrate the prevalence of cardiovascular diseases and stroke in Brisbane south were slightly above state benchmarks, noting increased prevalence with increasing age. Further, the prevalence of these conditions is notably higher in males than females, with nearly one-in-three males aged 75+ years expected to be living with heart, stroke, or vascular disease (AIHW 2021).

Table 12. Modelled prevalence of heart, stroke and vascular disease among adults aged 18+ years, by broad age group and sex

Population	Brisbane South PHN		Queensland	
	Number	Proportion (%)	Number	Proportion (%)
Persons				
18-54 years	9,441	1.6	31,003	1.3
55-74 years	21,314	10.4	125,923	12.9
75+ years	13,313	25.2	69,950	24.0
Females				
18-54 years	4,446	1.5	15,679	1.3
55-74 years	9,256	8.8	60,538	12.3
75+ years	5,834	20.0	31,212	19.2
Males				
18-54 years	4,945	1.7	15,324	1.3
55-74 years	12,025	12.0	65,385	13.5
75+ years	7,452	31.52	38,738	29.9

Source: AIHW 2021

Coronary Heart Disease was the leading cause of death in Brisbane south between 2015 and 2019, with 13.6% of all deaths attributable to this cause (AIHW 2021).

Rheumatic heart disease

Rheumatic heart disease (RHD) is a permanent heart disease that effects one or more of the four small heart valves, resulting from Acute Rheumatic Fever (ARF) caused by an autoimmune response to group A streptococcus. Rheumatic heart disease is a highly preventable condition, with particular at-risk populations including First Nations peoples and Pasifika and Māori peoples, with household crowding elevating this risk (Noonan 2021).

An increase in the prevalence of RHD has been noted in Brisbane south, with 34% of the 832 clients with ARF or RHD identifying as Pasifika and Māori, and a further 18% identifying as First Nations. Table 13 demonstrates the rates of prevalence and severity of ARF and RHD in the region compared to Queensland rates. It is noteworthy that the proportion of clients with severe RHD is the highest of all Hospital and Health Service areas in Queensland (Cairns Public Health Unit 2021).

Table 13. Acute rheumatic fever and rheumatic heart disease in Metro South HHS region

	Brisbane South / Metro South	Queensland
Proportion of ARF/RHD clients with RHD	84%	60%
Proportion of ARF/RHD clients who have had or require valvular surgery	44%	14%
Proportion of ARF/RHD clients who have no history of ARF (i.e. established RHD)	49%	26%
Proportion of clients with severe RHD	51%	17%

Source: Rheumatic Heart Disease Program. Cairns Public Health Unit. Queensland Department of Health. 13 September 2021

Chronic Kidney Disease

Chronic kidney disease (CKD) describes a persistent health condition that results in the gradual loss of kidney function. The two major risk factors for the development of CKD are hypertension and diabetes (Kidney Health Australia 2020). While lifestyle modification and medications may assist in slowing the progression of CKD, end stage CKD often results in the requirement for dialysis.

Ten percent of Australian adults demonstrate biomedical signs of CKD (AIHW 2019a). Modelling from 2011-12 data estimates that 9.4% (75,175 people) of the Brisbane south population live with CKD (Table 14). These estimates place Brisbane South PHN as the 10th highest ranking PHN nationally (AIHW 2021).

Table 14. Modelled prevalence of chronic kidney disease among people aged 18+ years, 2011-12

	Persons (18+ years)		Females (18+ years)		Males (18+ years)	
	Proportion	ASR per 100	Proportion	ASR per 100	Proportion	ASR per 100
Queensland	11.3	11.3	11.1	11.1	11.5	11.7
Brisbane South PHN	9.4	10.3	9.6	10.2	9.3	10.4

Source: AIHW 2021

Hospitalisations for renal dialysis were comparatively low across Brisbane south, compared to other PHNs nationally (ranked 20th nationally, 4,324.9 hospitalisations per 100,000 persons ASR) (AIHW 2021). Figure 14 demonstrates that at the regional level, Brisbane South compares favourably to Queensland and national benchmarks for the rate of same-day admissions for renal dialysis. Despite this however, there is great variability at the sub-regional level, with rates in Logan LGA exceeding state and national comparators (PHIDU 2021). This indicates a higher proportion of advanced CKD in the Logan LGA.

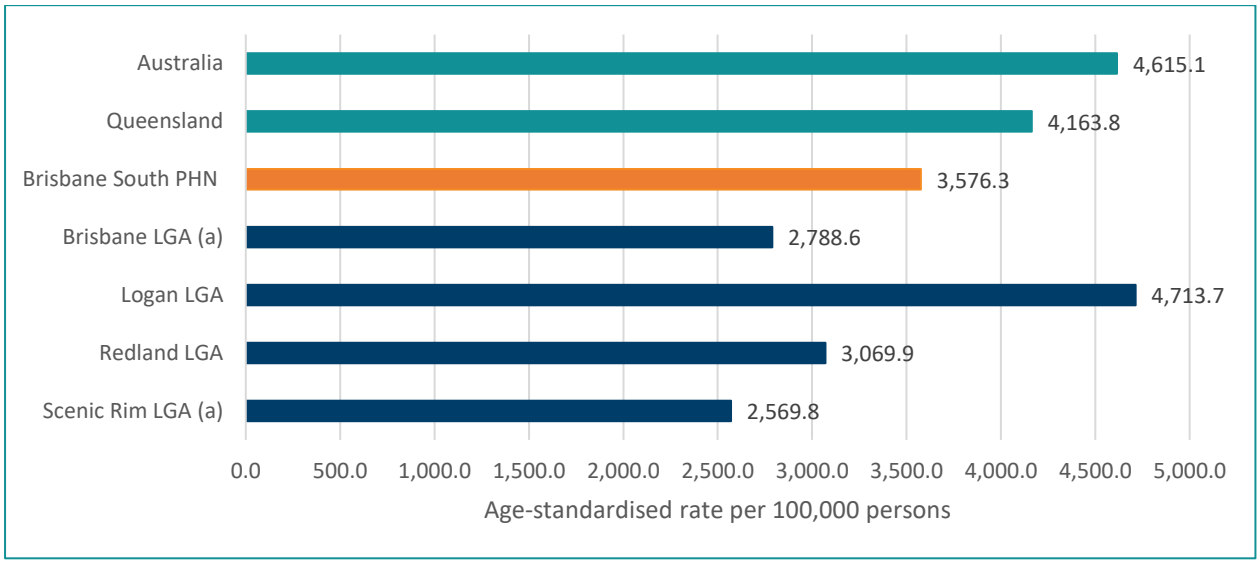

Figure 14. Same day hospitalisations (public hospitals) for renal dialysis, 2018-19
Source: PHIDU 2021.

Mortality rates for kidney failure in Australia were comparatively low, however this may be due to people with CKD being two to three times more likely to die as a result of cardiovascular complications than those without the condition (Kidney Health Australia Statistics 2018). CKD was estimated to contribute to approximately 11% of deaths nationally in 2016. Approximately 75% of

those deaths recorded CKD as an associated cause of death, typically with the primary cause of death listed as a cardiovascular condition or dementia and Alzheimer's disease (AIHW 2018b).

Asthma

Asthma is a life-long condition of the airways characterised by narrowing and swelling which makes breathing difficult, and can trigger coughing, wheezing and shortness of breath. For some people, asthma is a minor inconvenience, while for others it is major problem which interferes with daily activities and may lead to a life-threatening asthma attack (Asthma Australia 2021).

As can be seen in Table 15, at a national level the prevalence of asthma generally increased as people aged with persons aged 45+ years having the highest rates. The percentage of Indigenous persons with asthma was significantly higher across all age groups than non-Indigenous persons, with the difference in prevalence increasing with age. For those aged 55+ years, Indigenous persons were more than twice as likely to have asthma than non-Indigenous persons (AIHW 2020f).

Table 15. Prevalence of asthma in Australia, by age and Indigenous status, 2018-19

Age group	% Indigenous	% Non-indigenous
0 – 14 years	11.5	9.7
15 – 24 years	13.8	10.2
25 – 34 years	15.0	10.6
35 – 44 years	17.0	11.2
45 – 54 years	20.8	12.4
55+ years	25.7	12.1
All ages [(a)]	17.8	11.0

[(a)] Age-standardised to the 2001 Australian Standard Population as at 30 June 2001.
Source: AIHW 2020f

Within Brisbane south, modelled estimates of the number of people with asthma in 2017-18 were 11.0 ASR per 100 persons (equating to approximately 125,000 individuals). LGAs with the highest modelled prevalence were Logan (12.6) and Scenic Rim (12.6). Brisbane South had lower rates of asthma compared to state (11.8 ASR per 100 persons) and national levels (11.2 ASR per 100 persons) (PHIDU 2021).

COPD

Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term used to describe a group of progressive, incurable lung conditions including emphysema, chronic bronchitis and chronic asthma. The condition causes a narrowing of the bronchial tubes in the lungs and makes it difficult to breathe (Lung Foundation Australia 2021).

Within Brisbane south, modelled estimates of the number of people with COPD in 2017-18 were 3.4 ASR per 100 persons (equating to approximately 35,000 individuals. LGAs with the highest modelled prevalence were Logan (3.7) and Scenic Rim (3.6). Brisbane south had a higher prevalence of COPD compared to national levels (2.5 ASR per 100 persons) but lower than state levels (3.5 ASR per 100 persons) (PHIDU 2021).

Chronic Pain and Musculoskeletal Conditions

Chronic or persistent pain is increasingly recognised as a chronic health condition, but its prevalence is difficult to estimate in Brisbane south. Nationally, the prevalence of chronic pain is estimated to be as high as 15.4% for people aged 15 years and over and increasing due to an ageing population (De Morgan, Walker and Blyth 2020). Qualitative data from local health needs assessment consultation highlighted that pain management is an increasing issue across the region.

Musculoskeletal conditions were estimated to contribute to 12.9% of the total burden of disease in Australia in 2015, disproportionately effecting females (14.9%) compared to males (11.0%) (AIHW 2020b).

Musculoskeletal conditions were Australia's most costly health condition based on national health expenditure, consuming an estimated $14 billion of health expenditure in 2018-19 (Figure 15). The majority of this expenditure was on private hospital services and public hospital admitted patient services ($7,437,887,170, 52.9% of total expenditure), with 11% of expenditure on Pharmaceutical Benefit Scheme, 6% associated with general practitioner services, and a further 2% associated with allied health and other services (AIHW 2021).

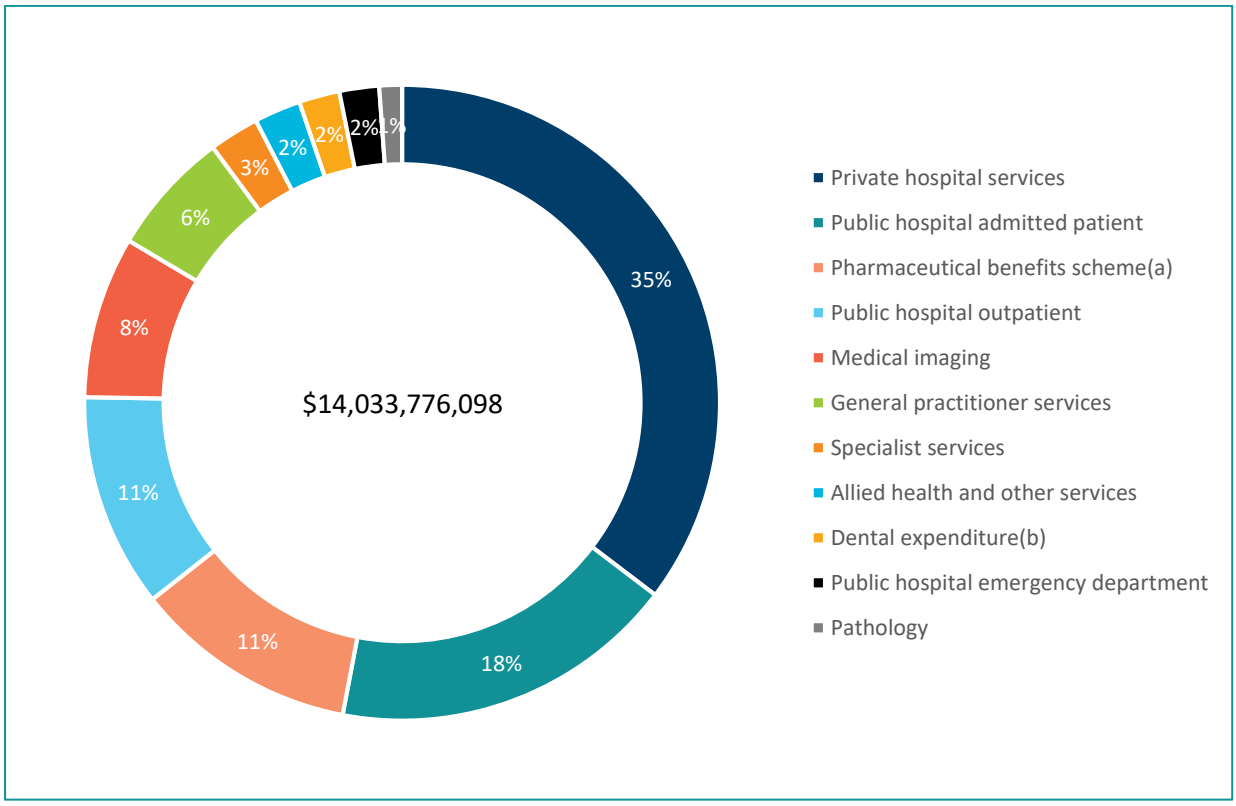

Figure 15. Health expenditure attributable to musculoskeletal conditions, 2018-19

Source: AIHW 2021.

Chronic Viral Hepatitis B and C

Hepatitis is an inflammation of the liver that is caused by a variety of infection viruses and non-infectious agents leading to a range of health problems, some of which can be fatal. There are five main strains of hepatitis, referred to as types A, B, C, D and E. While all types of hepatitis cause liver disease, types B and C lead to chronic disease in hundreds of millions of people globally and together are the most common cause of liver cirrhosis, liver cancer and viral hepatitis-related deaths (WHO 2021c).

Analysis of prevalence and treatment uptake for viral hepatitis shows that an estimated 10,327 people or 0.94% of the population residing in Brisbane south live with chronic Hepatitis B (CHB), with another 8,563 people (0.81%) living with chronic Hepatitis C (CHC) (AIHW 2021).

Geographic locations with particularly high prevalence of CHB included Sunnybank (2.45%), Forest Lake – Oxley (1.71%) and Rocklea – Acacia Ridge (1.67%) SA3s. A higher prevalence of CHC was observed in Springwood – Kingston (1.39%), Forest Lake – Oxley (1.39%) and Holland Park – Yeronga (1.16%). The uptake of CHB treatment was high in Brisbane South PHN (10.7%) by comparison to Queensland (7%) and Australia (9%), however the rate of CHC treatment was lower (35.5%) than the Australian rate of 40% (Table 16) (MacLachlan et al. 2020).

Through consultation it was identified that viral hepatitis together with obesity, type 2 diabetes and alcohol use increased the incidence of liver disease which was higher than average in Brisbane south and lead to higher rates of hospitalisation. There were also perceptions among community and sector stakeholders of gaps in appropriate hepatitis C testing and treatment options in the region, exacerbated by a shortage of general practitioners in some regions.

Table 16. Chronic Hepatitis B (CHB) and Chronic Hepatitis C (CHC) prevalence and treatment uptake in Brisbane south, 2018 (CHB) and 2019 (CHC)

Region	Chronic hepatitis B			Chronic hepatitis C		
	People living with condition	Prevalence (%)	Treatment uptake (%)	People living with condition	Prevalence (%)	Treatment uptake (%)
Brisbane South PHN	10,327	0.94%	10.7%	8,563	0.81%	35.5%
Brisbane LGA						
Brisbane Inner	898	0.98%	7.3%	1,948	2.63%	26.7%
Brisbane Inner – East	246	0.55%	7.3%	236	0.56%	46.2%
Carindale	332	0.68%	9.9%	176	0.38%	43.7%
Centenary	305	0.88%	9.2%	134	0.39%	50.8%
Forest Lake – Oxley	1,198	1.71%	17.0%	870	1.29%	38.8%
Holland Park – Yeronga	628	0.72%	10.4%	952	1.16%	23.8%
Mt Gravatt	1,188	1.41%	9.5%	414	0.52%	29.2%
Nathan	284	0.98%	21.5%	280	1.01%	34.2%
Rocklea – Acacia Ridge	1,053	1.67%	9.8%	431	0.72%	46.8%
Sunnybank	1,202	2.45%	11.6%	312	0.66%	30.7%
Wynnum - Manly	418	0.56%	6.2%	571	0.78%	37.5%
Logan LGA						
Beenleigh	354	0.60%	5.9%	563	0.98%	30.0%
Browns Plains	604	0.86%	14.1%	448	0.66%	47.1%
Jimboomba	236	0.55%	4.7%	255	0.67%	37.3%
Loganlea – Carbrook	482	0.69%	8.7%	557	0.83%	29.5%
Springwood – Kingston	877	1.05%	11.4%	1,160	1.39%	30.4%
Redland LGA						
Capalaba	428	0.52%	7.0%	416	0.52%	44.2%
Cleveland – Stradbroke	400	0.49%	5.8%	675	0.86%	38.9%
Scenic Rim LGA						
Beaudesert	93	0.41%	#	113*	0.51%	48.9%

Data suppressed where number receiving treatment was <6, population was <3000, or average notifications per year <5.
* Data adjusted to a significant proportion of the population diagnosed in a correctional facility.
Source: MacLachlan et al. 2020.

1.2.5.4 Cancers

Cancer is a broad term that describes a chronic health condition that results from abnormal growth of tissues in the body. There are numerous types of cancer, effecting nearly every bodily system (National Cancer Institute 2021). Cancers and other neoplasms are the leading contributor to the burden of disease in Australia (18.3% of total disease burden in 2015) (AIHW 2020b) and are the third most-costly grouping of health conditions according to total health expenditure in 2018 (Figure 16) (AIHW 2021).

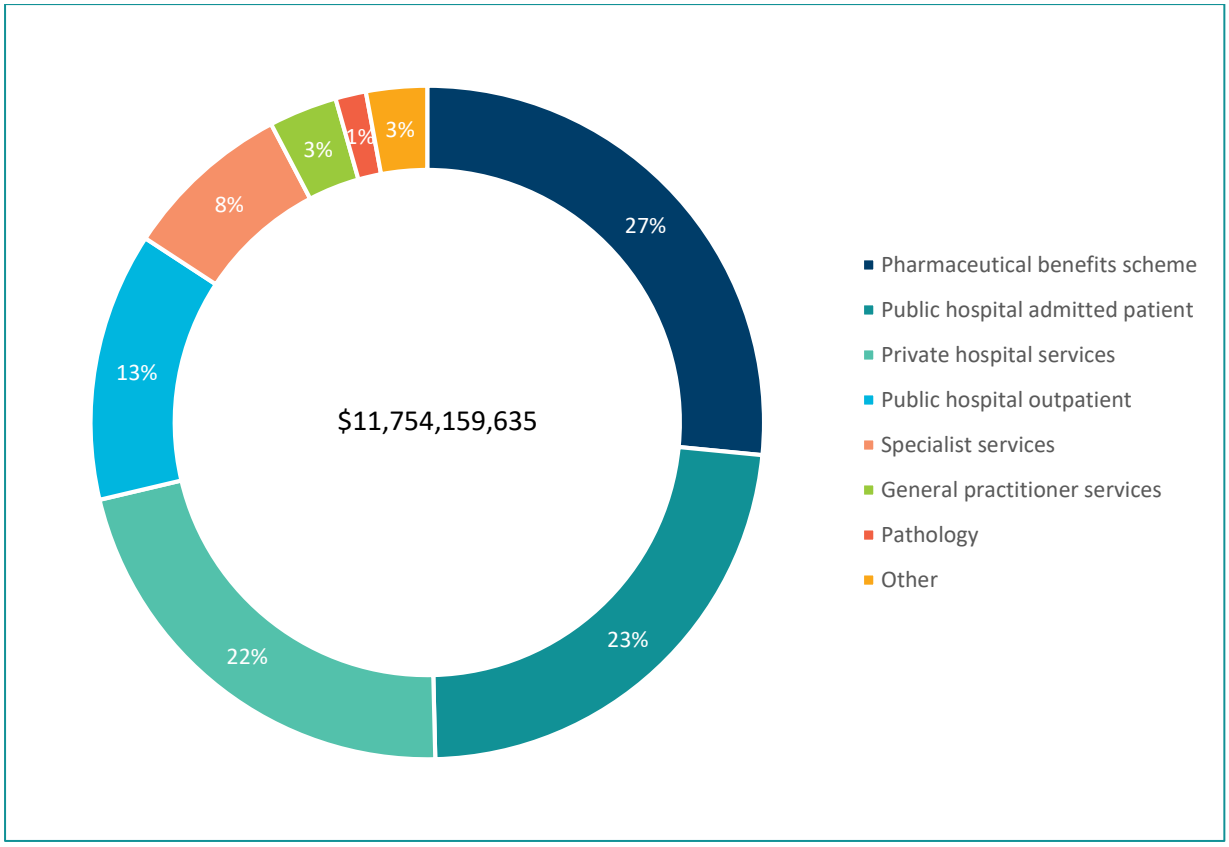

Figure 16. Health expenditure attributable to cancer and other neoplasms, 2018-19
Source: AIHW 2021

Dependent on cancer type, cancers may be largely preventable through health promotion and primary prevention activities (such as lung cancer through smoking prevention, melanoma through appropriate sun protection, and cervical cancer through human papillomavirus vaccination) and detected early through secondary prevention efforts (such as breast cancer screening). Refer to 1.2.4.5 Cancer Screening for further information regarding cancer screening uptake across the region.

Table 17. Incidence and mortality of all cancers combined in Brisbane south, by sex and SA3, 2010-2014

Region	Male		Female		Persons	
	Incidence (ASR per 100,000)	Mortality (ASR per 100,000)	Incidence	Mortality (ASR per 100,000)	Incidence	Mortality (ASR per 100,000)
Australia	**582.7**	**213.2**	**422.9**	**135.0**	**495.7**	**169.2**
Brisbane LGA						
Brisbane Inner	572.8	219.1	428.7	137.3	495.9	172.2
Brisbane Inner - East	591.7	197.5	487	133.2	533.4	161.7
Carindale	625.6	230.5	453.6	113.3	524.4	159.7
Centenary	541.8	201.8	393.5	120.2	458.1	151.6
Forest Lake - Oxley	571.7	256.1	442.2	159.3	497.5	199.8
Holland Park - Yeronga	625.7	209.3	490.1	141.2	543.7	170.5
Mt Gravatt	549.7	216.7	432.1	130.3	479.2	164.9
Nathan	617.3	243	467.2	130.5	530.2	178
Rocklea - Acacia Ridge	558	219.6	421.2	144.7	484.1	177.8
Sherwood - Indooroopilly	604.9	171.5	444.1	119.7	512.7	141.5
Sunnybank	487.9	184.5	410.5	105.1	445	140.3
Wynnum - Manly	649.7	231.6	459.6	136.6	541.3	175.8
Logan LGA						
Beenleigh	665.5	244.7	471.8	131.7	562.5	184.8
Browns Plains	613.8	295.3	444.5	155.1	520.7	216.7
Jimboomba	636.6	221.5	430.9	135.6	536.3	179.3
Loganlea - Carbrook	583.3	239.3	461.6	154.7	514.5	189.5
Springwood - Kingston	577.5	255.4	464.3	168.5	513.8	205.4
Redland LGA						
Capalaba	632.6	225.1	479	149.2	549.8	180.8
Cleveland - Stradbroke	607.5	209.5	452.8	134.5	524.6	167.8
Scenic Rim LGA						
Beaudesert	667.9	237	458.7	146.6	561.1	189.3

Source: AIHW (2019)

Table 17 details the incidence and mortality rates of all cancers in Brisbane south during 2010-2014. This data shows that males had significantly higher incidence and mortality rates of cancer across all SA3s compared to their female counterparts, with Beaudesert and Beenleigh SA3s having the highest incidence rates (668 and 666 ASR per 100,000 persons respectively) while Browns Plains had the highest mortality rate by a significant margin (295 ASR per 100,000 persons). For females, Holland Park – Yeronga and Brisbane Inner – East had the highest incidence rates (490 and 487 ASR per 100,000 persons respectively) while Springwood – Kingston and Forest Lake – Oxley had the highest mortality rates (169 and 159 ASR per 100,000 persons respectively). Heavily impacted by the elevated results of males, across all persons Beaudesert and Beenleigh had the highest incidence rates while Springwood – Kingston and Browns Plains had the highest mortality rates (AIHW 2019b).

As detailed in Table , lung cancer (4th), colorectal cancer (6th), prostate cancer (9th) and breast cancer (10th) all ranked in the top 10 leading causes of death in Australia in 2015-19 demonstrating the significant impact cancers have on health outcomes and the health system in this country (AIHW 2021).

Breast cancer

Breast cancer refers to the development of abnormal cells in the lining of the breast lobules or ducts; and has the potential to spread to other areas of the body. Breast cancer can develop in women, transwomen, non-binary people, and men. There are several risk factors for breast cancer, with modifiable risk factors including insufficient physical activity and alcohol consumption. BreastScreen Australia is the national breast cancer screening program, that invites women aged 50-74 years to receive a free screening mammogram every two years (Cancer Council 2021a).

As is to be expected, rates of breast cancer were significantly higher in females than males. Brisbane Inner – East (79.9), Nathan (76.8) and Sherwood – Indooroopilly (76.4) had the highest incidence ASR per 100,000 persons in the region, while Forest Lake – Oxley (13.7), Loganlea – Carbrook (12.2) and Centenary (12.1) had the highest mortality ASR per 100,000 persons. These rates were all higher than the national incidence (63.5) and mortality rates (11.2) for breast cancer ASR per 100,000 persons (AIHW 2019b).

Cervical cancer

Cervical cancer refers to the growth of abnormal cells in the cervix, the most common of which is squamous cell carcinoma. The major risk factor for cervical cancer is persistent human papillomavirus (HPV) infection. The introduction of the HPV vaccine has seen cervical cancer rates reduce dramatically; however, regular cervical screening is critical for early detection and treatment of abnormal cervical cell growth (Cancer Council 2021b). Changes to the National Cervical Cancer Screening Program in December 2017 saw a shift from cervical screening from every three years, to every five years, in women aged 25 to 74 years who had not previously received an abnormal cervical screening result (RACGP 2018).

Cervical cancer incidence rates were only available in Capalaba (5.3), Cleveland – Stradbroke (5.1) and Springwood – Kingston (7.2) due to suppression of data at SA3 level. All of these regions have significantly higher incidence rates than the national rate of 3.6 ASR per 100,000 persons. Nationally, the mortality rate of cervical cancer was 0.9 ASR per 100,000 persons (AIHW 2019b).

Colorectal (Bowel) cancer

Colorectal, or bowel, cancer is the development of cancer in the inner lining of the bowel. Often, polyps may develop in to invasive cancer; and is typically seen in people over the age of 50 years. Several lifestyle factors, such as a diet high in red meat and processed meats, obesity, and high alcohol consumption can increase the risk of developing bowel cancer. Low risk adults aged 50-74 years are eligible to participate in the National Bowel Cancer Screening Program, which uses the faecal occult blood test to identify early signs of bowel cancer (Cancer Council 2021c).

Within Brisbane south, colorectal cancer incidence ASR per 100,000 persons were highest in Beaudesert (70.3), Jimboomba (66.6) and Holland Park - Yeronga (66.3) SA3s, while mortality ASR per 100,000 persons was greatest in Springwood – Kingston (25.2), Holland Park – Yeronga (23.8) and Beaudesert (23.5). Nationally, the incidence and mortality of colorectal cancer were 59.3 an 20.0 ASR per 100,000 persons respectively (AIHW 2019b).

Lung cancer

Lung cancer is the abnormal growth of cells in the lung tissue. Tobacco smoking and passive smoking, exposure to asbestos, and exposure to occupational substances (such as diesel fumes and soot) increase the risk of developing lung cancer (Cancer Council 2021d).

Within Brisbane south, lung cancer rates were highest in areas of increased disadvantage with Beenleigh (60.6) Springwood – Kingston (58.4) and Beaudesert (56.9) having the greatest incidence ASR per 100,000 persons. A similar trend was apparent in mortality rates with Springwood – Kingston (51.5), Browns Plains (48.6) and Beaudesert (47.0) having the highest mortality ASR per 100,000 persons (AIHW 2019b). Nationally, the incidence rate of lung cancer was 43.4 ASR per 100,000 persons while the mortality rate was 32.0 ASR per 100,000 persons (AIHW 2019b).

Melanoma of the skin

Melanoma is a type of skin cancer that typically develops from overexposure to the sun. Australia has the highest incidence of melanoma globally. Sun protection measures can assist in reducing the risk of developing melanoma, and regular dermatological screening and assessment assists in early detection and treatment (Cancer Council 2021a).

Rates of melanoma were highest in Wynnum – Manly (88.4 per 100,000 persons age-standardised), Capalaba (87.7 per 100,000 persons age-standardised) and Cleveland – Stradbroke (82.7 per 100,000 persons age-standardised), while mortality rates were highest in Loganlea – Carbrook (8.5 per 100,000 persons age-standardised), Carindale (8.1 per 100,000 persons age-standardised) and Wynnum – Manly (8.0 per 100,000 persons age-standardised). National incidence and mortality rates of melanoma were 49.7 and 6.0 per 100,000 persons age-standardised respectively (AIHW 2019b).

1.2.5.5 Disability

As described by the AIHW, disability refers to a level of impairment or limitation in functioning, restriction on undertaking activities of daily living, or impact on participation in social and economic life (AIHW 2021).

- impairment—problems in body function or structure
- activity limitation—difficulties in executing activities
- participation restriction—problems an individual may experience in involvement in life situations.

Disability can be the result of genetic disorders, illness, accidents, ageing or a combination of factors (AIHW 2020g).

While data on the experiences and outcomes of people with a disability in Australia is limited, evidence shows that people with a disability generally experience higher levels of socioeconomic disadvantage and lower levels of health and wellbeing than those without a disability (AIHW 2020g).

Data from the 2016 Census estimated a total of 43,533 people had a profound or severe disability in Brisbane south, approximately 4.8% of the total population. Almost 9 in 10 people with a disability in Brisbane south lived in the community (i.e. their own or family's home), with a small proportion living in long-term accommodation (approximately 6,200 people). Effective community-based services and natural support can enable people with a profound or severe disability to remain at home and out of institutional care. Disability is associated with ageing, and the proportion of older people aged 65 years and over with a profound or severe disability was considerably higher at 19.5% than that of those aged 0 to 64 years (2.9%) (AIHW 2020g).

A breakdown of people with a profound and severe disability living in the Brisbane south community by SA3 is shown in Table 18.

Table 18. People with a profound/severe disability and living in the community by SA3, 2016

Region	People with a profound or severe disability and living in the community			
	No. persons, 0 to 64 years	% Population, 0 to 64 years	No. persons, 65+ years	% Population aged 65+ years
Queensland	-	3.2%	-	13.9%
Brisbane South PHN	25,609	2.9%	20,118	15.1%
Brisbane LGA				
Brisbane Inner	503	1.8%	403	12.6%
Brisbane Inner - East	456	1.3%	386	11.8%
Carindale	752	1.8%	968	14.8%
Centenary	602	2.2%	490	10.7%
Forest Lake - Oxley	2,039	3.4%	1,393	18.6%
Holland Park - Yeronga	1,148	1.9%	1,227	15.7%
Mt Gravatt	1,214	2.1%	1,341	14.0%
Nathan	777	2.4%	741	15.8%
Rocklea - Acacia Ridge	1,176	2.3%	884	15.6%
Sherwood - Indooroopilly	310	2.1%	297	13.1%
Sunnybank	917	2.2%	947	15.8%
Wynnum - Manly	1,468	2.6%	1,278	13.8%
Logan LGA				
Beenleigh	1,580	4.8%	1,009	17.4%
Browns Plains	2,672	4.0%	1,454	19.3%
Jimboomba	1,264	3.3%	690	17.3%
Loganlea - Carbrook	1,773	3.7%	1,274	16.6%
Springwood - Kingston	2,390	3.7%	1,453	15.9%
Redland LGA				
Capalaba	1,749	3.0%	1,369	13.7%
Cleveland - Stradbroke	2,251	3.6%	2,099	13.4%
Scenic Rim LGA				
Beaudesert	529	5.1%	357	13.8%

Source: PHIDU 2021

Overall, this data indicates that younger people in Brisbane south were less likely to have a disability compared to wider Queensland, however older people in Brisbane south experienced higher rates of disability — an additional 1.2% of the older adult population.

At an SA3 level, the data showed:

- higher numbers of younger-aged people with a disability living in Browns Plains, Springwood – Kingston, Cleveland – Stradbroke and Forest Lake – Oxley
- the highest number of older people with a disability living in Cleveland – Stradbroke
- higher proportions of younger-aged people with a disability in Beaudesert, Beenleigh and Browns Plains
- higher proportions of older people with a disability in Browns Plains, Forest Lake – Oxley, Beenleigh and Jimboomba (PHIDU 2021).

An estimated 92,041 people aged 15 years and over Brisbane south provided unpaid assistance to someone with a disability in 2016, which provides an indication of the size of the unpaid carer population in the region. This represents 10.6% of the population aged 15 years and over, which was comparable to the wider Queensland rate of 10.7%.

While regional-level data is not available for several other indicators on the health outcomes experienced by people with a disability, national-level data from 2018 showed:

- Australians born in 2018 can expect to live about 21% of their lives with some level of disability.
- Only 24% of adults with a disability experience very good or excellent health, compared with 65% of people without a disability.
- Almost half (47%) of people with a severe or profound disability see 3 or more health professionals for the same condition.
- Common activities people living with a severe or profound disability in the community require assistance with include mobility (79%), health care (63%), self-care (52%), transport (52%), household chores (49%), cognitive/emotional tasks (47%) and property maintenance (46%).
- People with a disability are more likely to experience psychological distress (32% to 8%), violence (47% to 36%), being overweight or obese (72% to 55%) and having hypertension (54% to 27%).
- People with a disability are less likely to be employed (48% to 80%) (AIHW 2020g).

1.2.5.6 Palliative care and End of life care

Palliative care and end of life care are related yet different concepts. End of life care describes the holistic care and supports for a person living within twelve months of death, be this due to advanced age or a life-limiting condition. Palliative care, on the other hand, is the provision of care for a person with a life-limiting condition, ideally commencing at the early stages of the onset of this condition and potentially lasting years (Palliative Care Queensland 2021).

Palliative care is an approach that improves the quality of life of people facing the challenges associated with life-threatening illness. Palliative care encompasses the prevention and relief of suffering by means of early identification, and the assessment and treatment of pain and other physical, psychosocial and spiritual challenges (AIHW 2021).

The World Health Organization recognises palliative care as an ethical imperative and a human rights issue through the right to health and right to be free from cruel, inhuman or degrading treatment.

Source: WHO 2018a, Worldwide Palliative Care Alliance 2020.

Palliative care increases quality of life and offers significant healthcare savings through reduced emergency department presentations, hospitalisations and reduced lengths of stay when hospitalised (Department of Health 2019c). The Palliative Care Outcomes Collaboration (PCOC) identifies five phases of palliative care, as noted in Figure 17. These phases represent periods in the patient's clinical condition (University of Wollongong 2014), and although not sequential, the first three phases may reflect the effectiveness of care and the urgency of response (AIHW 2021).

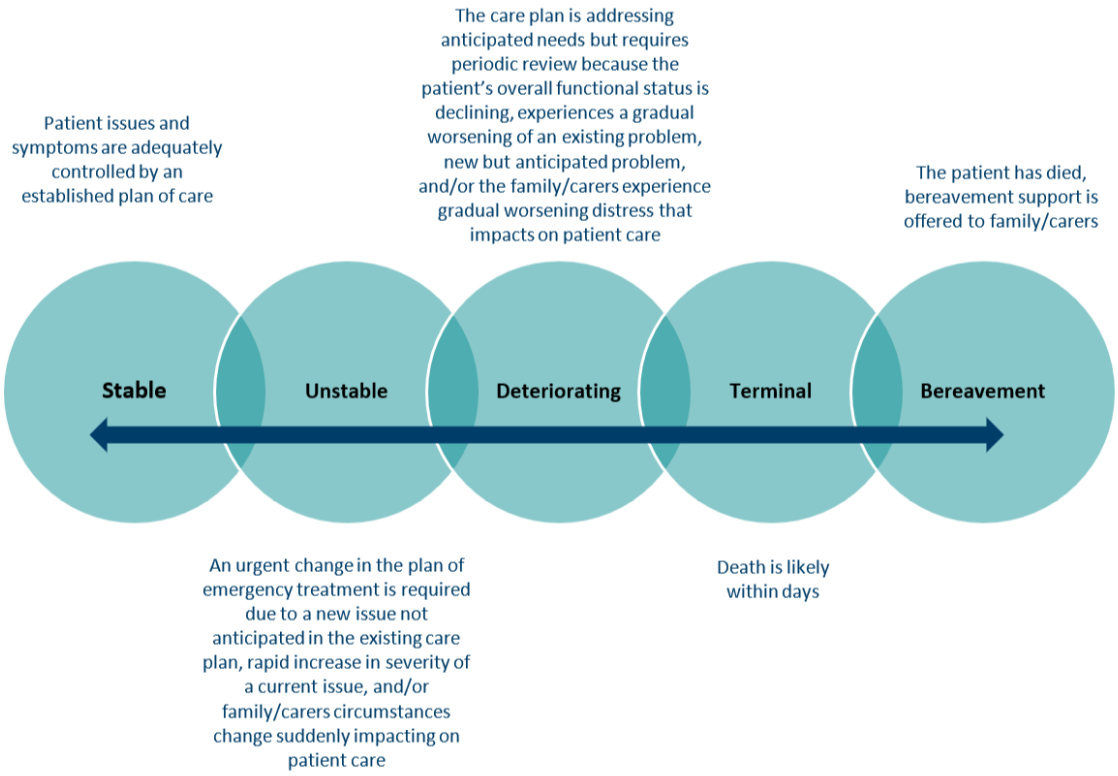

Figure 17. Phases of palliative care

Source: University of Wollongong 2014.

While most palliative care services are required by older peoples (Britt et al 2016), there is a need for palliative care across the lifespan. Palliative care as it relates to older peoples is discussed in Section 3. Older Persons.

Paediatric palliative care describes the care provided to infants, children, and young people who have a life-limiting condition, and support to families and carers. While there are currently no robust estimates of the prevalence of paediatric palliative care needs in Australia, it is recognised that primary care services play an important role in assisting families to care for their loved one in home as much as desired (Armitage & Trethewie 2014). Specialist paediatric palliative care services provide additional levels of care, such as care coordination, and are available through Queensland Children's Hospital and Hummingbird House (Palliative Care Queensland 2021).

While limited localised data is available, consultation with local health providers has identified an emergent issue for adults (typically aged 18 through 64 years) in accessing timely and appropriate end of life and palliative care services, and social support services. Adults receiving a life-limiting diagnosis may face significant financial stressors. This is particularly associated with the need to provide income for family members when both the person with palliative needs can no longer work, and further exacerbated when a spouse becomes a primary care giver. Accessing Centrelink poses a

significant barrier for palliative adults and their family or carers, and may result in people choosing not to engage with the service.

Further, there are notable limitations with this cohort in accessing the National Disability Insurance Scheme (NDIS). For people aged under 65 years who have palliative needs, the NDIS eligibility criteria determine that the person is ineligible unless having a permanent disability. For example, deterioration due to cancer would not meet eligibility thresholds. This creates a significant "missing middle" of supports for adults who are not yet eligible for My Aged Care (65+ years).

1.2.5.1 Mortality

In 2019, an estimated 6,498 people who resided in the Brisbane South PHN region died, at an age-standardised rate of 523.3 deaths per 100,000 persons. This is a slightly lower rate than Queensland at 530.2 deaths per 100,000 people.

Median age at death across Brisbane south was 81 years in 2019 and has seen little change over the last five years. This is slightly higher than the median age at death recorded for wider Queensland of 80 years. Median age at death by SA3 is shown in Figure 18 below. This data shows that several SA3s record a markedly lower median age at death when compared to the wider Brisbane south and Queensland regions, particularly in Jimboomba (72 years), Browns Plains (75 years) and Beenleigh (76 years).

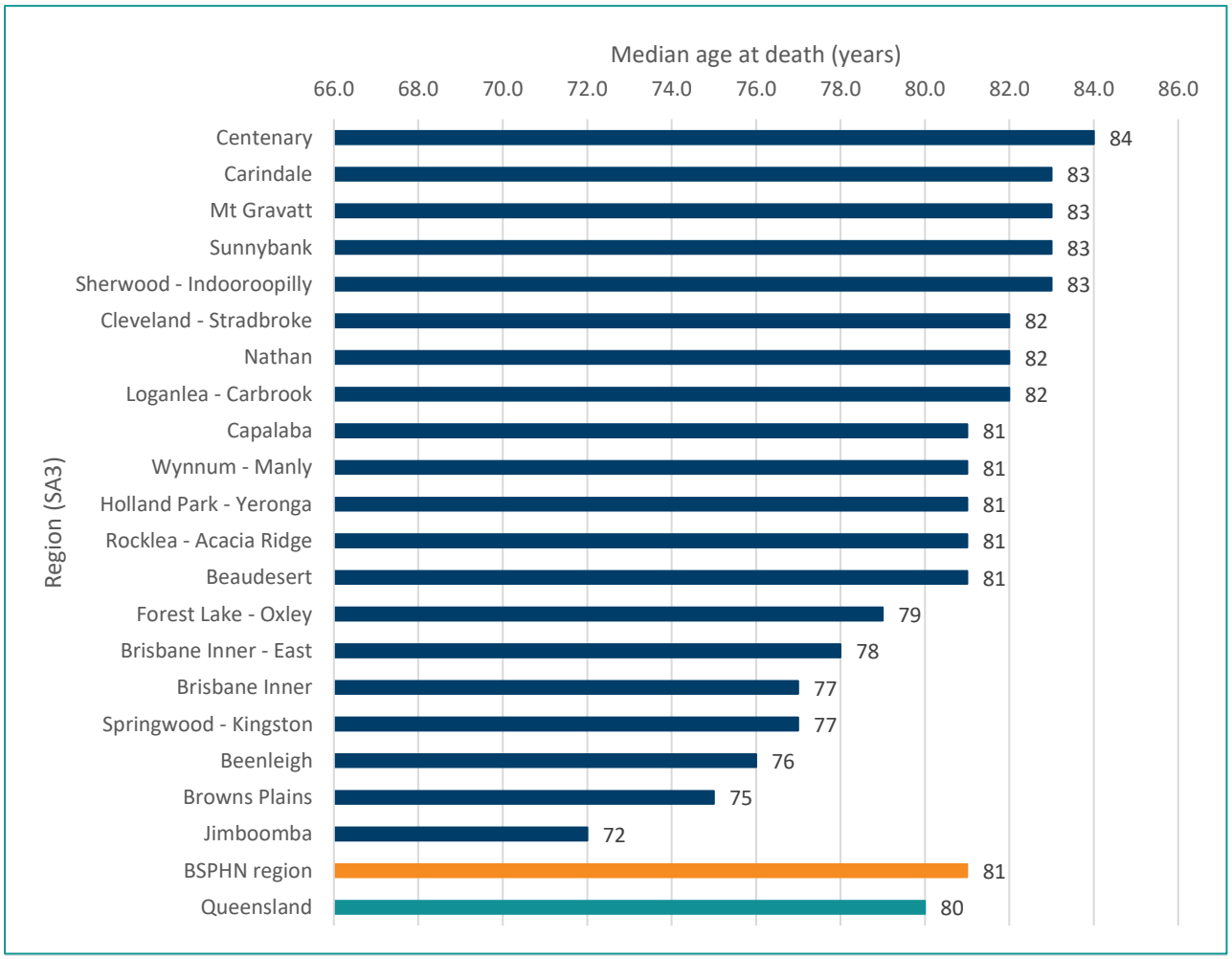

Figure 18. Median age at death (years) by SA3, Brisbane south and Queensland, 2019
Source: AIHW 2021

‘Premature mortality’ refers to the proportion of deaths that occur at an age earlier than 75 years of age. ‘Potentially avoidable deaths’ is a classification of premature mortality that is considered potentially avoidable — these deaths are caused by conditions that are considered potentially preventable and/or treatable through existing health system response. Potentially avoidable deaths include infection, cancer, diabetes, cardiovascular disease, chronic kidney disease, respiratory disorders, perinatal mortality, accidents, injuries and suicide (AIHW 2021).

A total of 11,380 premature deaths were recorded in Brisbane south over the period 2015-2019, which comprises 36.5% of all deaths. This is slightly lower than Queensland where 37.2% of deaths were premature.

Figure 19 shows the rate of potentially avoidable deaths (PAD) per 100,000 population aged under 75 years for both males and females in Brisbane south and Queensland. The data shows the rates of PAD were considerably higher in males than females and Brisbane south experienced lower rates of PAD compared to Queensland for both males and females. The rate of PAD amongst males in Brisbane south had declined in the previous two years while the rate for females remained comparable over time.

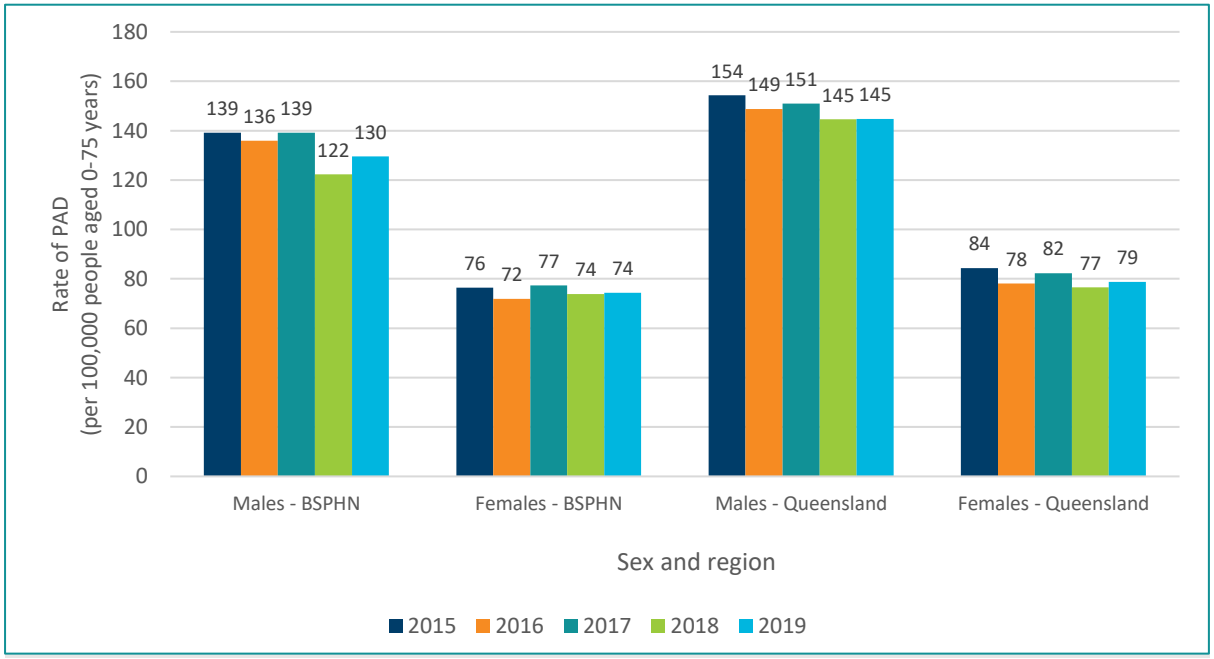

Figure 19. Rate of potentially avoidable deaths per 100,000 population aged 0-75 by sex and region, 2015-2019

Source: AIHW 2021

The top 10 leading causes of death amongst males and females in Brisbane south over the five-year period between 2015 and 2019 for all persons are outlined in Table 19, including the number of deaths, proportion of all mortality and age-standardised rates compared to Queensland.

Table 19. Leading causes of death by number of deaths, % of all causes and age-standardised rate (persons), 2015-2019

Rank	Cause of death	Brisbane South PHN			Queensland
		Deaths	Per cent of all causes	Age-standardised rate (per 100,000)	Age-standardised rate (per 100,000)
1	Coronary heart disease	4,249	13.6	71.4	65.5
2	Dementia including Alzheimer disease	2,686	8.6	44.7	41.9
3	Cerebrovascular disease	2,101	6.7	35.3	34.3
4	Lung cancer	1,731	5.6	30.2	31.1
5	Chronic obstructive pulmonary disease (COPD)	1,281	4.1	22.5	25.4
6	Colorectal cancer	1,077	3.5	18.6	19.4
7	Diabetes	894	2.9	15.4	15.7
8	Suicide	756	2.4	13.1	15.6
9	Prostate cancer	688	2.2	12.0	12.4
10	Breast cancer	615	2.0	10.5	10.4

Source: AIHW 2021

Data on leading causes of mortality also showed that:

- These 10 causes accounted for over half (51.6%) of all deaths in the region
- When common types of cancer were considered collectively, cancer accounted for almost one in five deaths
- Brisbane south showed higher rates of death caused by heart disease, dementia and stroke compared to Queensland
- While the 'ranking' of cause of death is reasonably consistent across males and females, males were more likely to die by coronary heart disease, prostate cancer, suicide or lung cancer, while females were more likely to die by breast cancer, dementia or heart failure (AIHW 2021).

1.3 Health system

1.3.1 Service utilisation

1.3.1.1 Primary health care

Primary health care is described as the front line of Australia's health care system and usually represents a person's entry point to the health system. It includes general practice, specialist and allied health services, and community pharmacies. These services may be delivered in the home or in community-based settings and encompass a broad range of activities and services from prevention and screening to diagnosis, treatment and management of acute and chronic conditions (AIHW 2021).

The health and economic benefits of a robust primary care system are well established. Effective primary care leads to better health outcomes, equity and the overall efficiency of the health system as it can avoid or reduce the community's use of more intensive health services, including emergency department presentations and preventable hospital admissions (WHO 2018b).

Medicare Benefits Schedule (MBS) services

The Medicare Benefits Schedule (MBS) is a list of medical services for which the Australian government provides a Medicare rebate to give patients financial assistance towards the cost of medical services. The MBS aims to support the goals of affordable and universal access, best practice healthcare and value for individual patients and the health system overall (Department of Health 2020a).

Based on the ABS Patient Experience Survey, 83.5% of people living in Brisbane south reported seeing a GP in the preceding 12 months in 2019-20, with about 1 in 10 people reporting they had seen a GP for urgent medical care over this period. An estimated 48.4% of people in Brisbane south reported seeing a dentist or oral health professional, 36.6% saw a medical specialist, 14.2% reported attending an emergency department and 12.9% reported being admitted to any hospital. Most of these rates were reasonably consistent over the previous 5-year trend and were comparable with national rates (ABS 2021b).

About 1 in 10 people in the region (10.7%) reported seeing a GP 12 or more times in the previous year in 2019-20, which was a slight decrease over previous years. This is similar to the national rate but noticeably lower than comparable metropolitan PHNs such as Brisbane North (14.2%) and Gold Coast PHN (14.0%), indicating Brisbane south had a lower proportion of people utilising GP services at a high frequency (ABS 2021b).

Table 20 shows analysis of MBS claims data to highlight the higher rates of MBS-subsidised service utilisation in Brisbane south than metropolitan PHNs for GP attendances, allied health attendances and diagnostic imaging, and lower rate for specialist attendances. This data uses age-standardised rates of MBS service utilisation to allow for more relevant comparison of populations with different age profiles.

Table 20. Utilisation of MBS service types by region, age-standardised rates, 2018-19

MBS service group	Brisbane South PHN	Metropolitan PHNs	Regional PHNs	Australia
GP attendances (total)	643.9	626.3	566.9	604.9
Specialist attendances (total)	79.5	95.5	76.7	88.5
Allied Health attendances (total)	97.7	94.7	84.6	91.2
Diagnostic Imaging (total)	101.8	98.6	95.1	97.1

Source: AIHW 2020h.

Since 2013-14, the rate of MBS services provided in Brisbane South PHN has increased by around 10%, which is around 3% higher growth than seen nationally amongst Metropolitan PHNs (AIHW 2020h).

Figure 20 and Figure 21 show the trends over the time between 2013-14 and 2018-19 for MBS services for GP attendances, allied health attendances, diagnostic imaging, specialist attendances and Nursing and Aboriginal Health Workers. Collectively, these trends highlight a steady increase in the rate of most broad types of MBS services delivered in the primary care setting in Brisbane south, with only specialist attendances remaining roughly stable (AIHW 2020h).

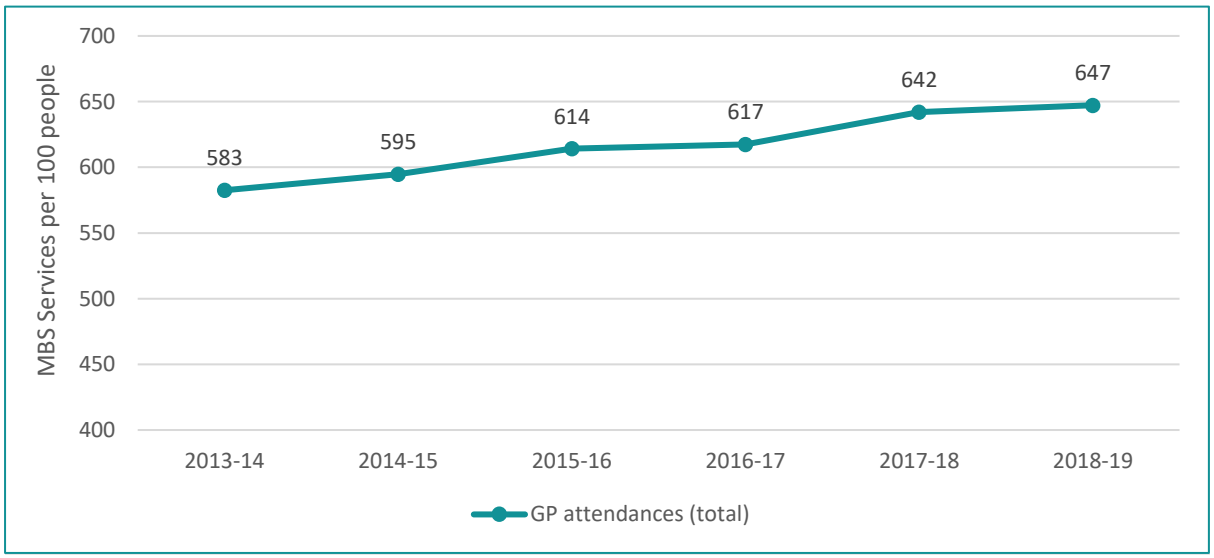

Figure 20. MBS services for GP attendances per 100 population, 2018-19

Source: AIHW 2020h.

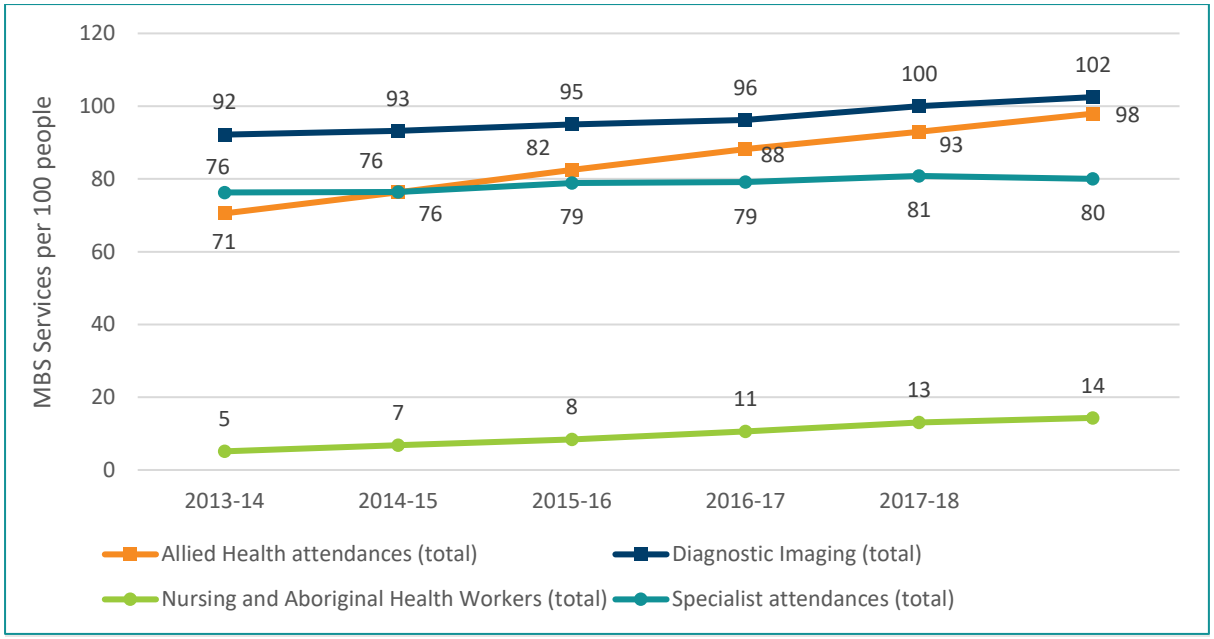

Figure 21. MBS services for non-GP related service type attendances per 100 population, 2018-19

Source: AIHW 2020h.

Figure 22 shows the breakdown of MBS GP services utilised per 100 persons in 2018-19 by SA3. Within the region, utilisation rates of MBS GP services showed considerable variability. Inner city areas such as Brisbane Inner and Sherwood – Indooroopilly SA3s reported low utilisation rates, while areas with greater levels of relative social disadvantage reported higher rates, particularly in Beenleigh, Springwood - Kingston and Loganlea – Carbrook (AIHW 2020h).

Deeper analysis shows that over the period 2013-14 and 2018-19, Beenleigh (20%), Cleveland - Stradbroke (18%) and Wynnum - Manly (18%) had the greatest increase in MBS GP utilisation rates while Jimboomba (-6%) and Beaudesert (1%) either declined or were roughly stable (AIHW 2020h).

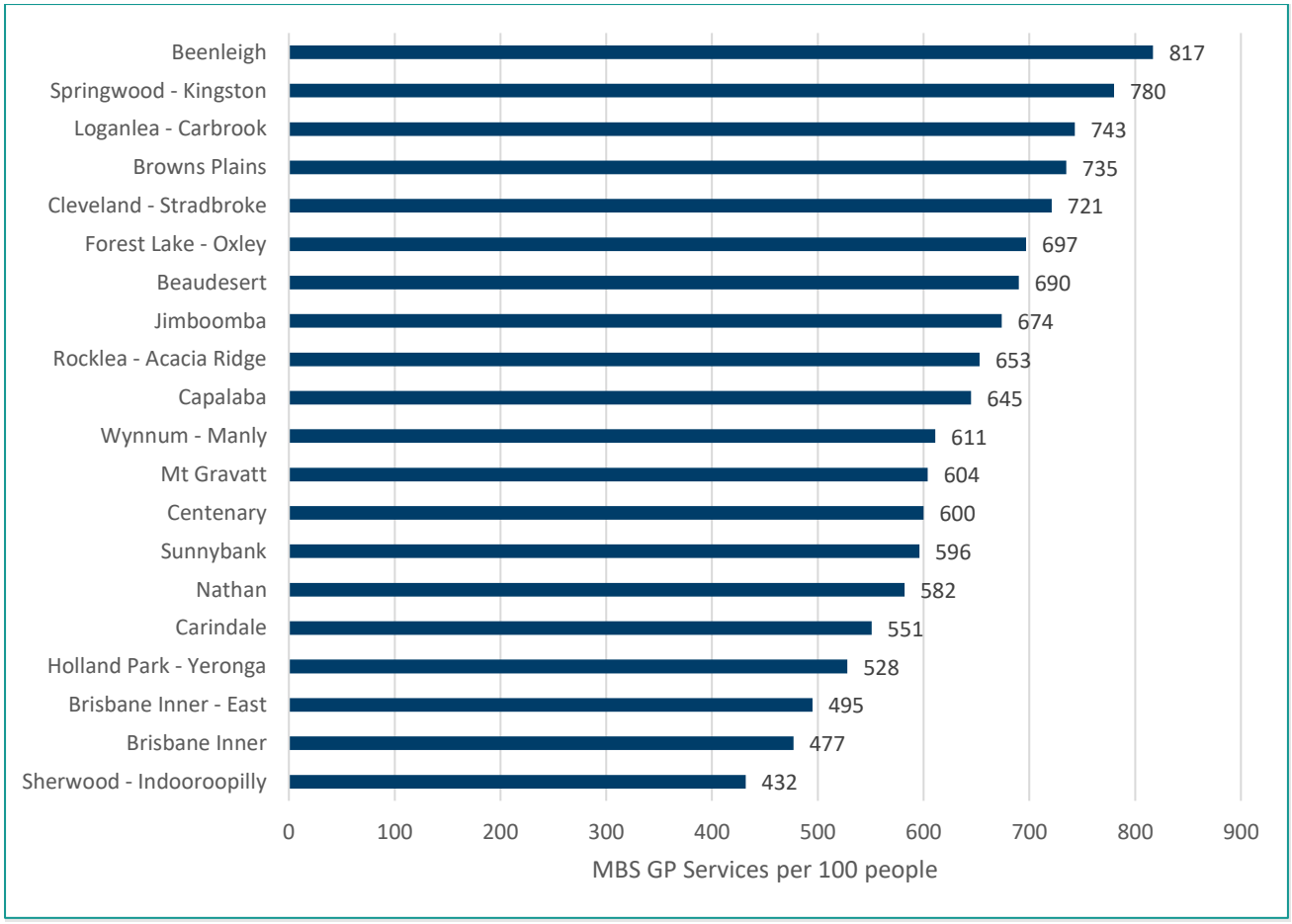

Figure 22. MBS GP services per 100 people in Brisbane south by SA3, 2018-19
Source: AIHW 2020h.

When comparing 2018-19 and 2013-14 rates for SA3s, there is considerable variation in the relative growth of GP service utilisation in that time-period. The change in services claimed per 100 population was highest in Beenleigh (+20%) and Capalaba, Cleveland – Stradbroke and Wynnum – Manly (all +18%), while rates only grew by 1% in Beaudesert and decreased by 6% in Jimboomba (AIHW 2020h).

Table 21 lists the top 10 individual GP MBS services utilised in Brisbane south in 2018-19 based on services per 100 population. The data shows several differences in utilisation rates when compared with other metropolitan PHNs, including:

- higher rates of longer GP consultations, and lower rates of short consultations
- lower rates of non-urgent after-hours services, with higher rates of urgent after-hours services
- higher rates of GP health assessments
- lower rates of 'other non-referred Medical Practitioner attendances', indicating that more services were delivered in general practice by vocationally registered GPs
- comparable rates of chronic disease and mental health treatment planning/management.

Table 21. Top 10 GP-related MBS services utilised in Brisbane South PHN compared to Metro PHNs, 2018-19

MBS service	Services per 100 population		Relative difference (+/-%)
	Brisbane South PHN	Metropolitan PHNs	
GP Standard (Level B)	414.07	401.65	+3.1%
GP Long (Level C)	86.70	78.55	+10.4%
After-hours GP (non-urgent)	44.88	55.12	-18.6%
GP Chronic Disease Management Plan	35.64	34.75	+2.6%
Other Non-referred Medical Practitioner attendances	15.75	21.89	-28.1%
GP Mental Health	14.88	14.77	+0.7%
GP Short (Level A)	11.65	12.62	-7.7%
GP Prolonged (Level D)	7.61	7.33	+3.8%
After-hours GP (urgent)	7.07	5.36	+31.9%
GP Health Assessment	4.27	3.45	+23.8%

Source: AIHW 2020h

Data on GP Chronic Disease Management Plans is available at both PHN and SA3 level and can provide an indication of the extent to which patients with chronic conditions and/or complex care needs have a plan to help them make informed decisions about their own health and/or coordinate care across providers. PHN-level data shows that services for Chronic Disease Management Plans in Brisbane South PHN increased from 19 per 100 people in 2013-14 to 36 per 100 people in 2018-19. Beaudesert (8%) and Jimboomba (7%) SA3s recorded the highest chronic disease management services (MBS items 721 - 732) as a proportion of total services provided. These rates were considerably higher than the proportion claimed within the greater Brisbane South PHN region (3%) (AIHW 2020h).

Key themes raised by community and sector representatives during local consultation regarding the provision of MBS-funded primary health services included:

- Chronic disease management plans requiring a minimum of 10 visits per year to make a long-term difference for patients
- Inability of the MBS to reflect complexity of some patients' care
- Inability of practice nurses in GP setting to claim for assessments and educational support provided to patients
- Limited opportunities to case conference with other health professionals
- Backlog of health screening activities due to delay in help-seeking as a result of pandemic
- GPs not screening patients for certain health issues and uncertain how to manage some chronic conditions in the community (e.g. liver health)
- Lack of healthy lifestyle advice and programs to support people to reduce chronic disease risk
- Need to better enable patients to self-manage their health and navigate the health system
- Fragmentation of care due to patients not having a 'medical home'
- Perceived concerns relating to voluntary patient enrolment in a GP setting, including accessibility, quality of care and patient choice

- Lack of care coordination leading to misdiagnosed health issues
- Potential for greater utilisation of nurses to focus on social prescribing and/or lifestyle interventions.

After-Hours Services

The Department of Health defines 'after hours primary health care' as accessible and effective primary health care for people whose health condition cannot wait for treatment until regular primary health care services are next available (Department of Health 2021a). Widespread availability of after-hours services was associated with reduced demand for acute services, including presentations at emergency departments (Capital Health Network 2018). In 2015, the Australian Government provided After Hours Practice Incentive Payments to accredited general practices to encourage and support the provision of locally tailored after-hour services (Department of Health 2021a).

In Brisbane south, the highest age-standardised rate (ASR) of GP after-hours service were observed in Beenleigh (89 per 100 people ASR), Browns Plains (76 per 100 people ASR) and Loganlea - Carbrook (72 per 100 people ASR) where availability was greatest, while the lowest utilisation rates were in Brisbane Inner - East (31 per 100 people ASR), Brisbane Inner (33 per 100 people ASR), Holland Park - Yeronga (33 per 100 people ASR) and Sherwood - Indooroopilly (33 per 100 people ASR) where availability was lower (Figure 23). Despite 100% of GP practices in Beaudesert offering after-hours services, this region had the second lowest utilisation rate (32 per 100 people ASR). This may reflect other reported barriers to access, such as remoteness and limited transportation options (AIHW 2020i).

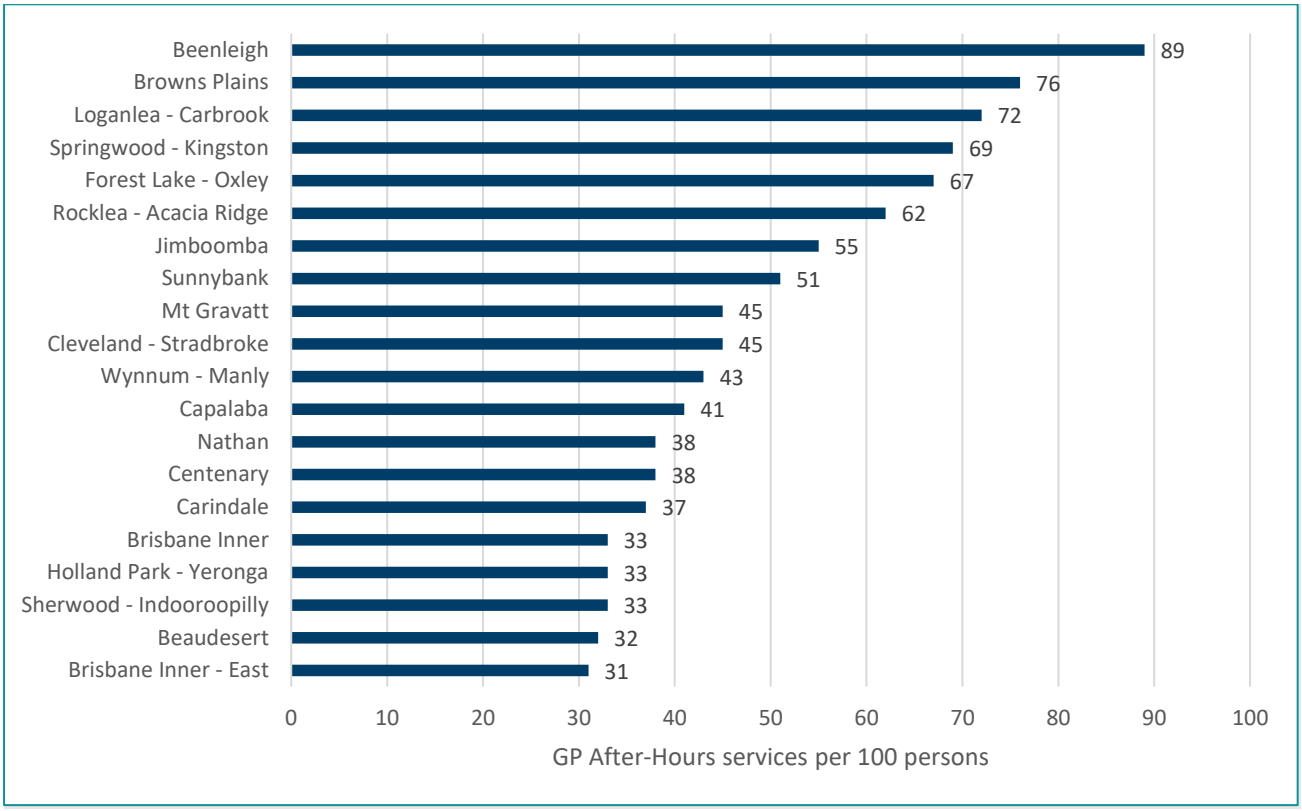

Figure 23. GP after hours service utilisation per 100 people in Brisbane south by SA3, 2018-19
Source: AIHW 2020i

In the 2020-2021 period, 212,749 Brisbane south residents sought a total of 387,557 non-urgent GP after hours services at a cost more than $22 million paid through Medicare and over $1 million in out-of-pocket costs to patients (Table 22). While the use of crude rates limits comparability, the SA3s of Brisbane Inner, Brisbane Inner-East, and Holland Park – Yeronga demonstrated the lowest rates of non-urgent GP after hours services in the region. Residents from Beenleigh, Beaudesert, and Springwood – Kingston demonstrated the highest uptake of GP non-urgent after-hours services in the region.

Table 22. Medicare-subsidised services for GP After-hours Non-urgent Care, 2020-21

SA3	Percentage of people who used service (%)	No. of patients	No. of services	Services per 100 people	Total Medicare benefits paid ($)	Total provider fees ($)
Brisbane LGA						
Brisbane Inner	12.18%	10,561	18,320	21.13	$1,098,714	$1,273,642
Brisbane Inner - East	11.75%	5,467	9,028	19.40	$532,995	$641,047
Carindale	13.61%	7,622	12,641	22.57	$751,351	$889,896
Centenary	15.97%	5,437	9,380	27.56	$543,081	$590,093
Forest Lake – Oxley	24.32%	19,425	36,947	46.25	$2,046,642	$2,088,684
Holland Park – Yeronga	11.95%	9,633	15,980	19.82	$938,717	$1,056,261
Mount Gravatt	17.10%	13,856	23920	29.52	$1,382,652	$1,440,853
Nathan	12.79%	5,482	9,411	21.96	$562,218	$601,628
Rocklea – Acacia Ridge	24.15%	16,304	29,631	43.89	$1,663,230	$1,682,889
Sherwood - Indooroopilly	14.15%	8,153	13,619	23.63	$794,625	$929,305
Sunnybank	20.00%	10,769	19,531	36.28	$1,121,198	$1,136,557
Wynnum – Manly	12.94%	9,694	17,063	22.78	$1,033,579	$1,188,285
Logan LGA						
Beenleigh	30.56%	14,118	28,648	62.02	$1,615,172	$1,622,846
Browns Plains	26.84%	24,209	45,531	50.49	$2,566,754	$2,580,767
Jimboomba	22.13%	13,282	24,135	40.21	$1,343,171	$1,357,327
Loganlea - Carbrook	29.08%	19,012	38,744	59.26	$2,205,147	$2,232,473
Springwood - Kingston	25.33%	20,316	38,990	48.61	$2,225,423	$2,245,530
Redland LGA						
Capalaba	14.62%	11,054	17,951	23.75	$1,085,447	$1,204,496
Cleveland - Stradbroke	17.12%	15,863	26,863	29.00	$1,580,385	$1,663,906
Scenic Rim LGA						
Beaudesert	17.50%	2,652	4,775	31.50	$274,219	$277,894

Source: AIHW 2021

For urgent GP after-hours services (Table 23), a total of 30,881 residents sought 41,001 occasions of urgent care services, at a cost of $4.97 million dollars to Medicare and approximately $2,000 total out-of-pocket costs to patients. Conversely to non-urgent after-hours services, the Beaudesert SA3 demonstrated the lowest uptake of services. Sherwood – Indooroopilly and Cleveland – Stradbroke

SA3s also demonstrated low uptake of urgent GP after-hours services. Like non-urgent services, Springwood – Kingston and Beenleigh demonstrated high uptake of these services, as did Wynnum – Manly and Browns Plains SA3s.

Table 23. Medicare-subsidised services for GP After-hours Urgent Care, 2020-21

SA3	Percentage of people who used service (%)	No. of patients	No. of services	Services per 100 people	Total Medicare benefits paid ($)	Total provider fees ($)
Brisbane LGA						
Brisbane Inner	2.28%	1,974	2,673	3.08	$327,224	$327,552
Brisbane Inner - East	2.80%	1,302	1,652	3.55	$198,477	$198,677
Carindale	3.44%	1,928	2,450	4.37	$294,693	$294,694
Centenary	1.83%	623	802	2.36	$103,855	$103,857
Forest Lake - Oxley	2.26%	1,801	2,404	3.01	$300,489	$300,592
Holland Park - Yeronga	2.80%	2,261	2,902	3.60	$358,281	$358,409
Mount Gravatt	2.85%	2,308	2,958	3.65	$362,515	$362,592
Nathan	2.93%	1,258	1,620	3.78	$203,473	$203,501
Rocklea – Acacia Ridge	2.46%	1,664	2,120	3.14	$267,840	$267,879
Sherwood - Indooroopilly	1.17%	675	852	1.48	$108,151	$108,390
Sunnybank	2.39%	1,287	1,736	3.23	$217,363	$217,425
Wynnum - Manly	3.50%	2,620	3,488	4.66	$418,242	$418,242
Logan LGA						
Beenleigh	3.75%	1,734	2,430	5.26	$282,564	$282,955
Browns Plains	3.41%	3,075	4,166	4.62	$495,982	$496,077
Jimboomba	1.54%	926	1,225	2.04	$147,400	$147,497
Loganlea - Carbrook	3.24%	2,116	2,972	4.55	$355,888	$356,005
Springwood - Kingston	4.26%	3,414	4,669	5.82	$556,373	$556,471
Redland LGA						
Capalaba	2.88%	2,180	2,788	3.69	$334,564	$334,564
Cleveland - Stradbroke	1.75%	1,621	2,062	2.23	$253,457	$253,602
Scenic Rim LGA						
Beaudesert	0.57%	86	110	0.72	$13,828	$13,828

Source: AIHW 2021

Stakeholder engagement and consultation identified a high demand of phone-based supports, such as 13 HEALTH, healthdirect, Cancer Council, and PalAssist. The effects of COVID-19 have exacerbated this increased demand on telephone support services.

Allied health and nursing

Table 24 lists the top 10 MBS services categorised as Allied Health or Nursing and Aboriginal Health Workers that were utilised in Brisbane south in 2018-19. Due to the smaller numbers, the size of the relative differences calculated should be treated with caution, however the data does show several key points when compared with other metropolitan PHNs, including:

- higher rates of services were delivered by Practice Nurses, Aboriginal Health Workers and Nurse Practitioners
- higher rates of allied health services relating to chronic disease management such as exercise physiology, dietetics, and physiotherapy were delivered
- lower rates of podiatry services were delivered.

Table 24. Top 10 MBS allied health and nursing services utilised in Brisbane South PHN compared to Metro PHNs, 2018-19

MBS service group	MBS service	Services per 100 population		Relative difference (+/-%)
		Brisbane South PHN	Metropolitan PHNs	
Allied health	**Other Psychologist**	13.04	12.86	+1.4%
Allied health	**Physiotherapy**	12.43	11.89	+4.5%
Nursing / AHW	**Practice Nurse/Aboriginal Health Worker**	11.44	8.33	+37.3%
Allied health	**Podiatry**	10.33	12.94	-20.2%
Allied health	**Clinical Psychologist**	10.14	10.72	-5.4%
Allied health	**Dietetics**	2.50	1.86	+34.4%
Allied health	**Exercise physiology**	2.36	1.61	+46.6%
Nursing / AHW	**Nurse practitioners**	2.13	1.99	+7.0%
Allied health	**Other Allied Mental Health**	1.86	1.67	+11.4%
Allied health	**Chiropractic Services**	1.18	1.94	-39.2%

Source: Australian Institute of Health of Welfare 2020

Local issues relating to allied health services highlighted through consultation and survey with community members and stakeholders include:

- continuity of care of patients between private practice allied health and GP settings
- quality of chronic disease management provision
- accessibility and appropriateness of allied health services via telehealth
- lack of telehealth resources for allied health professionals
- limited community-based nursing available for people aged under 65 years.

Community Pharmacy and Medications Safety

Serious medication-related problems (MRPs) can lead to a range of life-threatening issues such as haemorrhage, exacerbation of heart failure, renal failure or acute asthma, causing unplanned hospitalisations, serious and costly health complications or death. The Pharmaceutical Society of Australia's (PSA) *Medicine Safety: Take Care* (2019) report revealed that each year in Australia 250,000 people are hospitalised and 400,000 people present to emergency departments at an annual cost of $1.4 billion as a result of 'medication errors, inappropriate use, misadventure and interactions' (PSA 2019).

MRPs occur for a range of systemic reasons including:

- consulting time constraints of doctors and pharmacists
- the involvement of multiple prescribers and dispensers in consumer care
- increased reliance on medications to manage chronic illness (increased complexity of care)
- weaknesses in the recording and presentation of the necessary information in clinical records
- lack of economic incentives to proactively identify and address MRPs (PSA 2019).

Local issues relating to utilisation of pharmacy and medications highlighted:

- low uptake of prescription monitoring system QScript amongst health professionals
- conflicting messaging regarding opioid prescribing
- communication of pharmacy shortage updates to GPs

Polypharmacy is defined as the use of five or more medicines concurrently. Polypharmacy is often associated with multimorbidity, and increased risk of medication safety concerns (WHO 2019). When examining local prevalence of polypharmacy is adults aged 75+ years, the rates of polypharmacy in older adults aged 75+ years was comparable to Queensland and national rates. However, there is notable variation within the Brisbane South PHN region, the Australian Commission on Safety and Quality in Health Care (ACSQHC) noted that in 208-19, the Jimboomba SA3 recorded the highest rate of people with polypharmacy. Jimboomba also recorded the second highest rate of MBS-subsidised medication management reviews nationally (Table 25) (ACSQHC 2021a).

Table 25. Medicines use in older peoples (75+ years), 2018-19

SA3 name	Number of people dispensed 5 or more medicines (age-sex standardised rate per 100,000 persons)	Number of people who had at least one medication management review (age-sex standardised rate per 100,000 persons)
Australia	40,226	5,392
Queensland	40,540	5,481
Brisbane South PHN	40,420	5,681
Brisbane LGA		
Brisbane Inner	30,473	5,672
Brisbane Inner - East	39,086	5,200
Carindale	36,292	4,596
Centenary	36,305	4,891
Forest Lake - Oxley	40,740	5,154
Holland Park - Yeronga	36,856	6,059
Mt Gravatt	39,397	5,584
Nathan	37,363	4,969
Rocklea - Acacia Ridge	42,623	6,848
Sherwood - Indooroopilly	34,590	3,932
Sunnybank	39,326	4,652
Wynnum - Manly	42,263	4,511
Logan LGA		
Beenleigh	42,032	6,860
Browns Plains	47,263	6,136
Jimboomba	72,059	12,816
Loganlea - Carbrook	44,544	6,934
Springwood - Kingston	41,881	6,421
Redland LGA		
Capalaba	44,395	7,512
Cleveland - Stradbroke	36,869	4,551
Scenic Rim LGA		
Beaudesert	29,652	5,052

Source: Australian Commission on Safety and Quality in Health Care 2021

1.3.1.2 Tertiary Health Care

Lower urgency emergency department presentations

Emergency departments (EDs) provide critical care for people who need urgent and very often life-saving medical services. However, a significant proportion of people presenting to EDs may not need urgent care but use these services in lieu of primary care. Lower urgency ED presentations are those assessed as semi-urgent or non-urgent (triage categories four and five), did not arrive by emergency services and did not result in an admission to hospital or death of the patient. They are considered an indicator of accessibility to effective primary care services. In Australia, approximately one in three ED presentations were classified as lower urgency in 2018-19, a slight decrease on 2015-16 (35% vs. 38%) (AIHW 2020j).

A total of 83,769 lower urgency ED presentations were recorded in 2018-19 for people who reside in the Brisbane south region. Just over half (52%) were recorded in-hours when primary care services are likely to be open and available (i.e. weekdays from 8am to 8pm and Saturdays from 8am to 1pm), with the remaining recorded in the after-hours period. The rate of lower urgency presentations of 72.0 per 1,000 people in Brisbane south makes it the third lowest rate of lower urgency ED presentations amongst all PHNs nationally, and lower than the rate of comparable metropolitan PHN areas of 89.9 per 1,000 people (AIHW 2020j).

As shown in Figure 24, Brisbane south's provision of lower urgency ED care consistently decreased year-on-year between 2015-16 and 2018-19 (AIHW 2020j). This equates to a total of almost 11,000 fewer lower-urgency ED presentations occurring in 2018-19 than 2015-16 (AIHW 2020j).

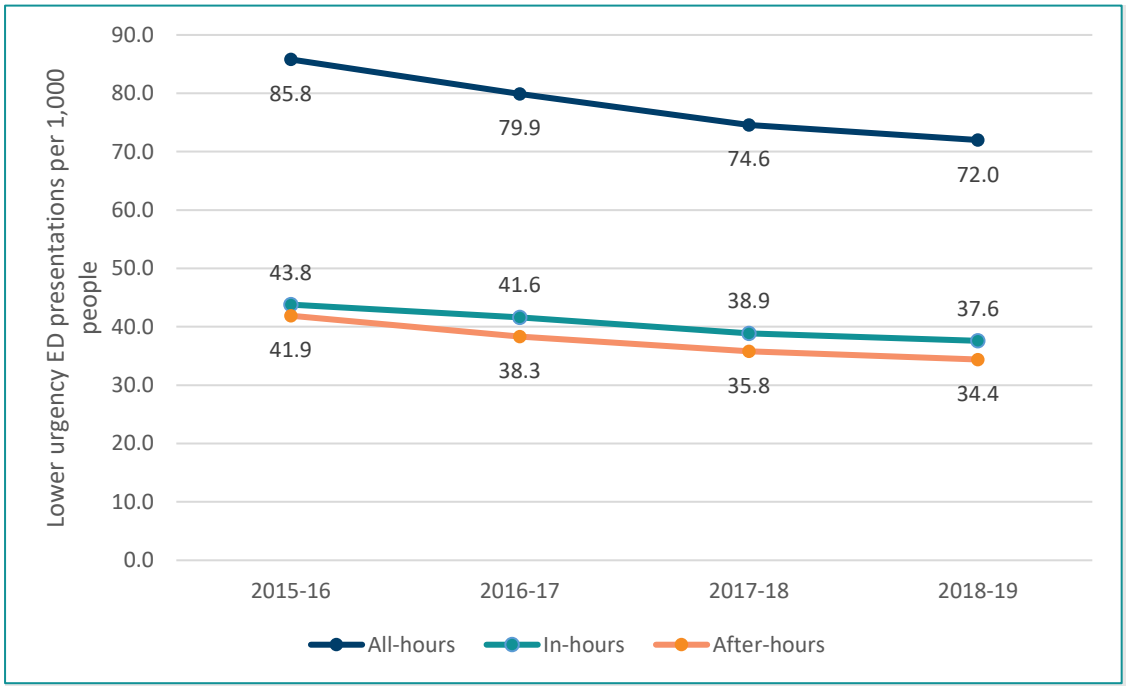

Figure 24. Rate of lower urgency ED presentations per 1,000 in Brisbane South PHN region by time of presentation, 2015-16 to 2018-19

Source: AIHW 2020j

Age is a factor closely associated with the rate of utilisation of lower urgency ED presentations. Children under the age of 15 years record rates almost twice the rate of the total population, at 136.7 per 1,000 population compared to 72.0 per 1,000 population (Figure 25). These elevated rates were observed across both in- and after-hours services, with this age group attributing 38% of all lower urgency ED presentations. This is similar to national trends, indicating that this age group of patients, as well as their parents, carers and guardians, are a key target demographic in reducing unnecessary ED presentations. Utilisation rates continue to decline with age across the lifespan (AIHW 2020j).

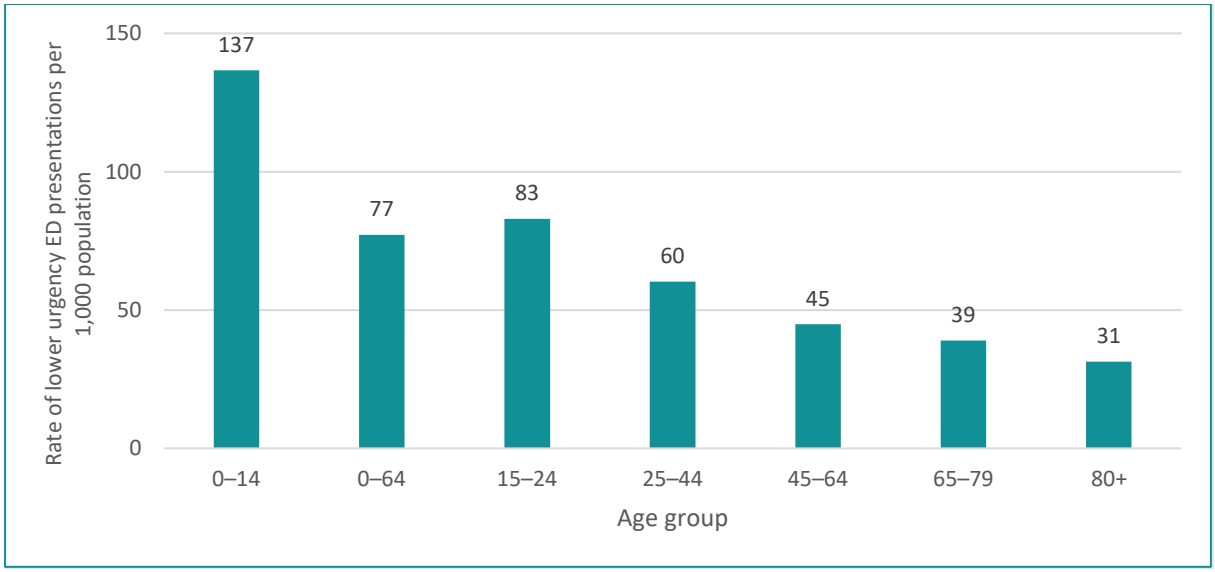

Figure 25. Rate of all-hours lower urgency emergency department presentations per 1,000 population in Brisbane South PHN region by age group, 2018-19
Source: AIHW 2020j

Males were also more likely to record lower urgency ED presentations than females both in-hours and after-hours. At an SA3 level, the highest rates of lower urgency ED presentations were observed in Brisbane Inner (90.8), Holland Park - Yeronga (83.3 presentations per 1,000 population), Nathan (82.9 presentations per 1,000 population) and Springwood - Kingston (81.9 presentations per 1,000 population). In contrast, Beaudesert (20.0 presentations per 1,000 population) and Sherwood - Indooroopilly (41) had the lowest rates (Figure 26) (AIHW 2020j).

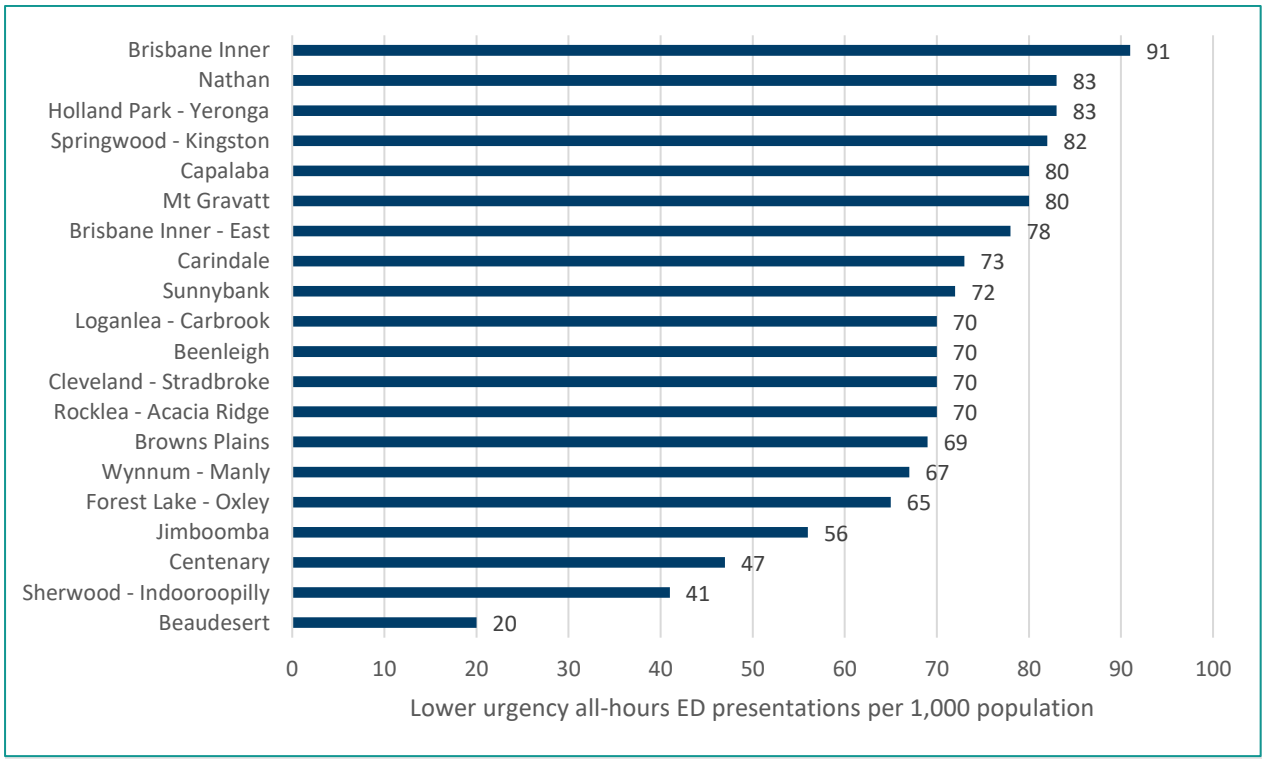

Figure 26. Rate of all-hours lower urgency emergency department presentations per 1,000 population in Brisbane south by SA3, 2018-19
Source: AIHW 2020j

Issues identified through survey and consultation with community members and local stakeholders identified long wait periods within EDs in local hospitals, with insufficient beds and workload issues of staff working in hospitals.

Potentially Preventable Hospitalisations

Potentially preventable hospitalisations (PPHs) provide an indicator of public hospital admissions that potentially could have been avoided through prevention and early disease management delivered in the primary care setting. This does not necessarily mean that the hospitalisation itself was unnecessary, but rather that optimal management of the individual at an earlier stage could have prevented the worsening of the condition and the need for hospitalisation. Higher rates of PPHs are indicative of both a need to improve primary care services and other local factors such as high burdens of disease and associated lifestyle and risk factors (Queensland Health 2020). PPHs are categorised around three groups of conditions:

- Vaccine-preventable conditions, including pneumonia, influenza and other conditions that can be prevented through immunisation (e.g. hepatitis B, chicken pox, tetanus)
- Acute conditions that can be avoided through timely and appropriate non-hospital care such as urinary tract infections (UTIs), cellulitis, ear, nose and threat infections and dental conditions
- Chronic conditions that can be prevented through a healthy lifestyle and effective management in primary care, such as chronic obstructive pulmonary disease (COPD), heart failure, diabetes complications and asthma.

In 2018-19, a total of 27,958 PPHs were reported for the Brisbane South PHN region, at an age-standardised rate of 2,564 per 100,000 population. This rate is lower than the rate of PPHs for wider Queensland (2,734 per 100,000) but higher than the national rate (2,338 per 100,000). It ranks Brisbane South PHN 12th highest amongst all 31 PHNs across Australia.

Until 2018-19 the number of PPHs for all types of conditions had steadily increased in Brisbane South PHN over recent years, with a noticeable decrease in PPHs recorded in 2018-19 (Figure 27).

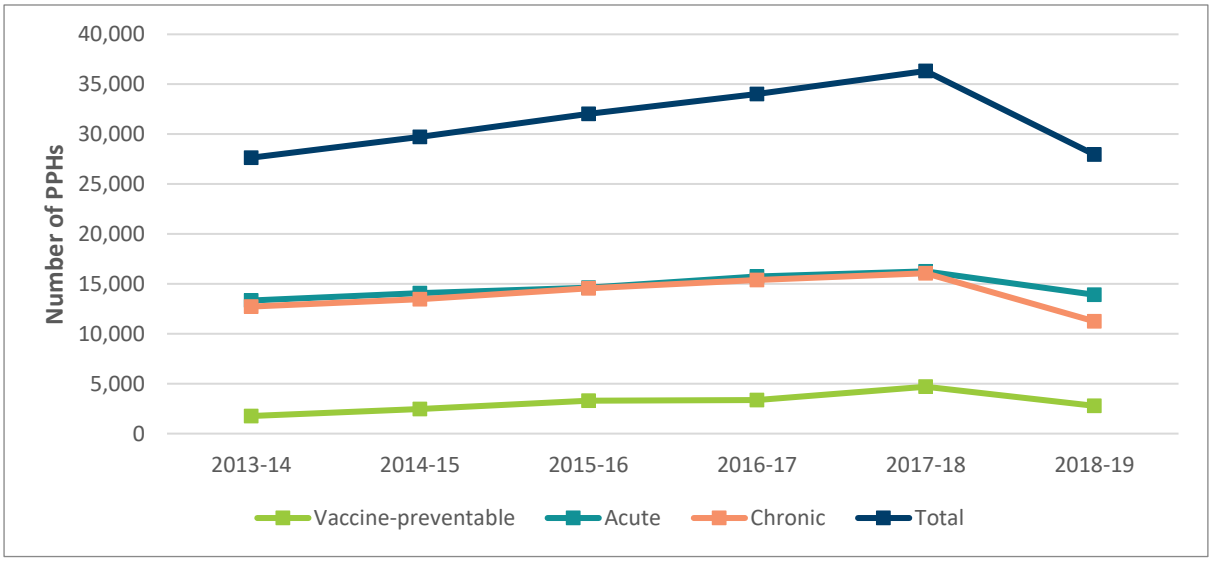

Figure 27. Number of potentially preventable hospitalisations (PPHs) by type in Brisbane South PHN region, 2013-14 to 2018-19
Source: PHIDU 2021, AIHW 2019c

Table 26 shows the rate of PPHs recorded in Brisbane South PHN in 2018-19 by type of condition and compared to Queensland rates. The data shows that the most common conditions leading to PPHs in Brisbane South PHN include UTIs and kidney infections, cellulitis, COPD and ear, nose and throat infections, following a pattern that is similar to state-wide rates. Two conditions where rates of PPHs are higher in Brisbane South PHN than state-wide are ear, nose and throat infections and other vaccine-preventable conditions.

Table 26. Rate of Potentially Preventable Hospitalisations (PPH) per 100,000 population by condition, 2018-19

Disease	Brisbane South PHN	Queensland
Urinary tract infections	333.3	353.2
Cellulitis	281.5	330.0
COPD	265.2	295.8
Ear, nose and throat infections	240.9	225.0
Heart failure	188.2	195.0
Diabetes complications	177.3	193.5
Convulsions and epilepsy	171.2	185.6
Asthma	139.7	133.9
Pneumonia and influenza	131.2	144.4
Other vaccine-preventable	122.1	88.7
Dental conditions	109.1	119.1
Other chronic	105.8	93.0
Iron deficiency anaemia	104.3	155.3
Angina	93.6	122.5
Other acute	89.6	98.4

Source: PHIDU 2021

Areas within Brisbane south with the highest rate of PPHs included four of the five SA3s located within Logan LGA (Beenleigh, Browns Plains, Loganlea - Carbrook, and Springwood - Kingston) and Forest Lake - Oxley in Brisbane LGA (Figure 28) (AIHW 2019c).

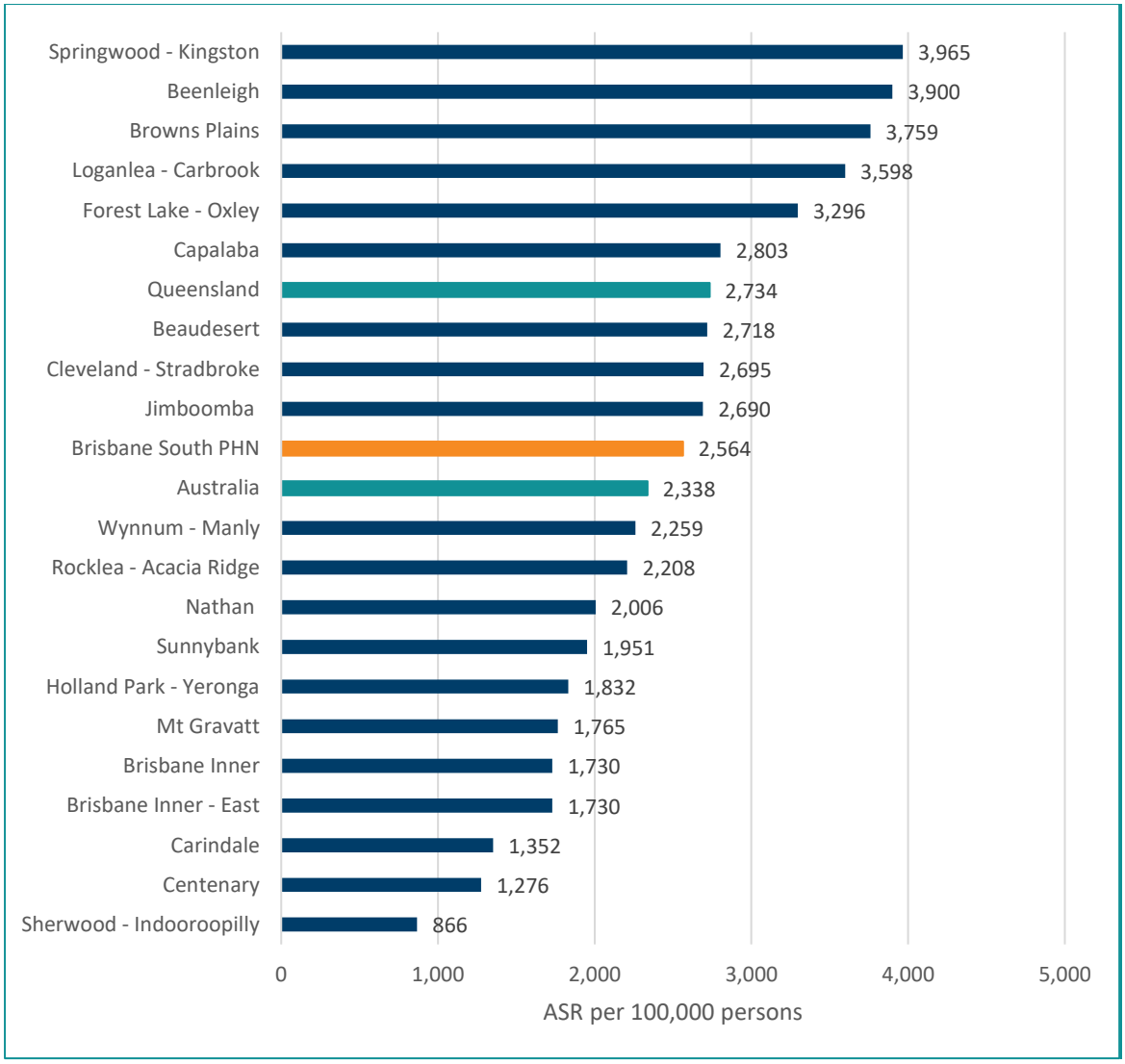

Figure 28. Potentially preventable hospitalisations (ASR) per 100,000 persons in Brisbane south, 2017-18
Source: *PHIDU 2021*

Analysis of particularly high rates of PPHs (where rate ratio is >2 when compared to Brisbane South PHN rate) within SA3s by specific conditions shows that PPHs for:

- COPD are over two times higher for people residing in Beenleigh
- Iron deficiency anaemia are almost two times higher for people residing in Forest Lake – Oxley
- Dental conditions are over 2.5 times higher for people residing in Beaudesert
- Ear, nose and throat infections are about two times higher in Beenleigh
- Other-vaccine preventable conditions (not pneumonia and influenza) is over 3 times higher in Forest Lake – Oxley, and about two times higher in Sunnybank and Springwood – Kingston

Key themes raised by community and sector representatives during local consultation regarding the interface between the primary health setting and tertiary care services included:

- System fragmentation between (public) HHS services and (private) general practice
- More integration required including primary health-led team-based models of care
- Insufficient detail provided in discharge summaries when patients discharged to GP for review and ongoing management

- inadequate capacity of EDs, inpatient beds and public rehabilitation facilities leading to issues with rehabilitation and discharge planning back to primary care setting.

1.3.1.2 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) aims to provide Australians aged under 65 years with a permanent and significant disability, their family and carers, with equitable, individualised supports. This may include supports from mainstream or community services, access to early intervention supports, and informal supports from family and carers (NDIS 2019). The NDIS rolled out in the Brisbane south region from 1 July 2018. This major policy change has drawn out the critical importance of the interfaces between the disability and primary care sectors.

Available information allows for the comparison of NDIS participants against the number of people aged zero to 64 years with a profound or severe disability living in the community, noting that the comparison involves data points at two differing time periods. The higher the ratio of NDIS participants to people with a disability in a particular location, the lower the gap in disability support services and subsequent demand on health, psychosocial and community support services.

As seen in Figure 29, NDIS coverage in the Brisbane South PHN region was highest in areas with higher educational attainment and socioeconomic advantage. For example, Sherwood - Indooroopilly had around one NDIS participant in 2021 for every person with a profound or severe disability in 2016. This ratio was substantially lower in areas with lower educational attainment and socioeconomic advantage, some of which also had high disability prevalence as noted in an earlier section. Four regions located within the Logan LGA as well as Beaudesert had 0.6 NDIS participants for every person with a profound or severe disability (National Disability Insurance Scheme 2021).

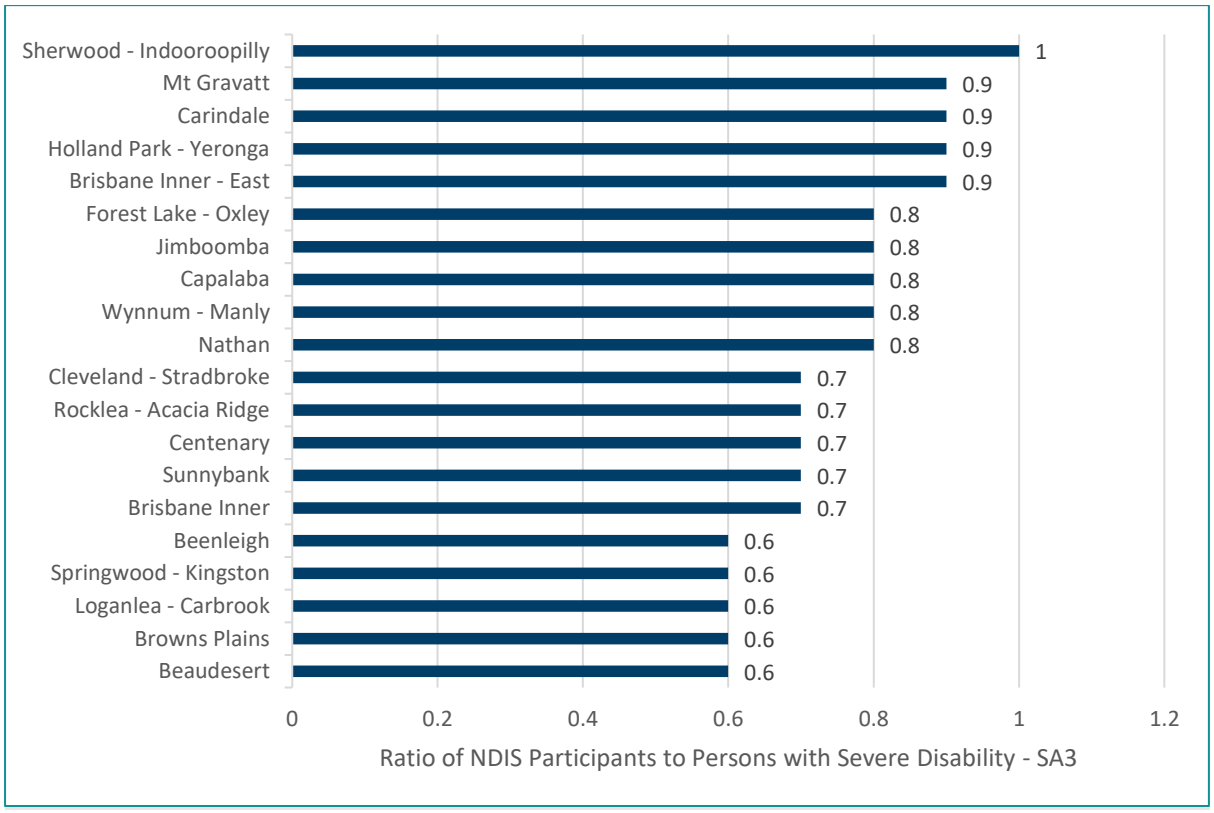

Figure 29. Ratio of NDIS participants (2021) to persons aged 0 - 64 years with a profound or severe disability living in the community (2016) by SA3

Source: NDIS 2021

Accessibility and navigation to the NDIS was reported as a key system issue by local stakeholders, due to limited literacy of the NDIS among health professionals without an NDIS caseload.

1.3.2 Service experience

1.3.2.1 Patient-rated experience of service

Service experience refers to the perspective of health consumers about the performance of health services and systems in meeting their needs and expectations. It often considers several aspects of the experience of finding and receiving health care services, such as acceptability, accessibility, quality and safety. A positive service experience helps to involve consumers in their care, build their capacity, which in turn can lead to better decisions about their healthcare (AIHW 2020k).

Most people in the Brisbane south region report having a preferred GP at 78.5% of the population, slightly higher than the national rate of 76.6%, indicating a reasonably high level of acceptability with the care being provided in the primary care setting (ABS 2021b).

Table 27 below provides a snapshot of several indicators relating to the experience of patients who had utilised MBS-funded health services in the preceding 12 months during 2019-20 in Brisbane south, with national rates for comparison.

Table 27: Indicators of self-reported patient experience, Brisbane south and Australia, 2019-20

Patient experience indicator (self-report, in the preceding months)	Region (%)	
	Brisbane South PHN	Australia
Needed to see a GP but did not	13.9	13.2
Could not access their preferred GP	26.2	28
Felt they waited longer than acceptable to get an appointment with a GP	17.8	18.6
Waited four or more hours between making an appointment and seeing a GP for urgent care (a)	33.3	36.7
Referred to a medical specialist and waited longer than they felt acceptable to get an appointment	24.9	23.2
Felt their GP always or often listened carefully	92.4	92.3
Felt their GP always or often showed respect for what they had to say	94.7	94.6
Felt their GP always or often spent enough time with them	90.5	90.9
Avoided or delayed seeing a GP due to cost	4.4	3.8
Avoided or delayed filling a prescription due to cost	7.5	6.6
Saw three or more health professionals for the same condition	15.0	16.8

Data notes: (a) data for this item is from 2017-18; all other items 2019-20 data
Source: AIHW 2021

While the differences observed between these data are not statistically significant, it does highlight that a relatively small but not insignificant proportion of patients in Brisbane south are avoiding or delaying accessing healthcare when they need to, waiting too long for care and/or not feeling positively about the patient-GP relationship.

Key issues identified by community members and local stakeholders through survey and consultation include:

- GPs reportedly rushing patients during appointments, with more time needed with patients to better coordinate care
- Difficulty finding allied health professionals
- Ongoing lack of support for people with chronic conditions, exacerbated by COVID-19
- Referrals to tertiary health services are being returned due to minor issues, with primary care providers having to repeatedly submit referrals
- Importance of feelings of trust and comfort with services and health professionals

1.3.2.2 Accessibility barriers

Out-of-pocket costs to patients are one of the traditional barriers for service utilisation. Medicare does not always cover the full cost of medical services, and with health care providers able to set their own costs, patients often need to contribute to the cost of services.

In 2016-17, 32% of patients in Brisbane south faced out-of-pocket expenses, slightly lower than that seen nationally (34%). More socially disadvantaged areas within Logan LGA had a substantially lower proportion of patients with out-of-pocket costs than more advantaged areas in Brisbane LGA. The breakdown by SA3 in Figure 30 demonstrates a vast range in proportion of patients with out-of-pocket costs from 10% in Browns Plains and Beenleigh to 67% in Brisbane Inner – East.

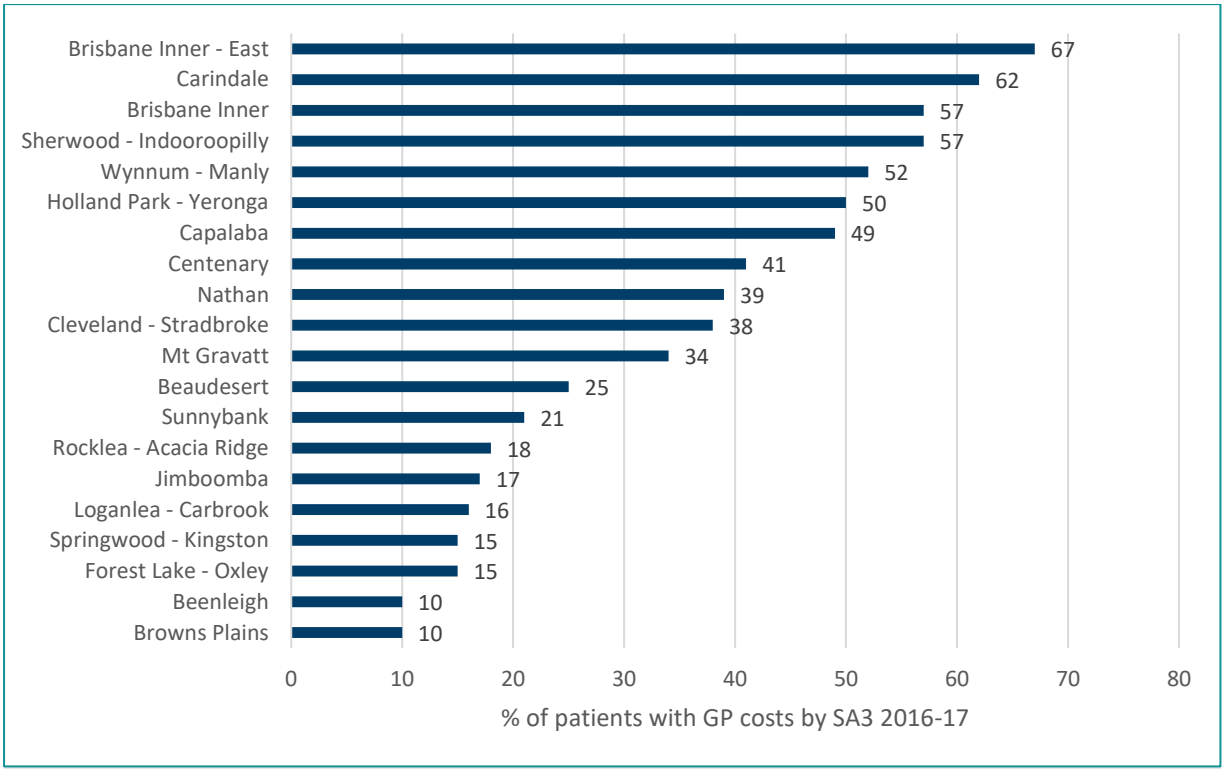

Figure 30. Proportion of patients with out-of-pocket GP costs in Brisbane south by SA3, 2016-17
Source: AIHW 2018c

Out-of-pocket costs for specialist attendances in primary care is much more common, with 70% of patients reporting contribution to the cost of seeing a specialist in 2016-17 in Brisbane south. Similar trends within the region are observed by relative social disadvantage, with Browns Plains (52%), Beenleigh (56%) and Springwood – Kingston (57%) reporting lower rates of specialist costs compared

to higher rates in Sherwood – Indooroopilly (83%), Centenary (81%), Brisbane Inner – East (80%) and Carindale (80%).

Key themes raised by community and sector representatives during local consultation regarding financial accessibility of primary health services included:

- Lack of access to bulk billing GP clinics within the region with gap payments increasing
- Freezing of Medicare rebates has led to inequitable access to quality health care for disadvantaged patients
- Private billing is not affordable for many patients on low incomes, even if patients are prepared to travel for services
- Gap payments for private allied health services have increased considerably as an unintended consequence of introduction of NDIS competition
- Lack of affordability of medications, medical devices and services not covered by Medicare (e.g. dental care)
- Need for in-home visiting care to increase accessibility
- Technology-related limitations placing limitations on some people to engage in telehealth

1.3.2.3 Transport barriers to access

Difficulties in transport can be significant barriers to accessing timely and appropriate health care. Ongoing engagement with the Beaudesert community has identified transport limitations are a notable contributing factor in difficulties accessing services that are beyond the Beaudesert region. Long travel times, the cost of travel, difficulties navigating the transport system, and a lack of transport options for people who live outside of the Beaudesert town centre pose significant challenges to accessing health care and other services and supports. Often, these transport barriers have been reported to prevent people from accessing the care that is needed.

Engagement over a number of years with the Southern Moreton Bay Islands communities has also revealed significant transportation barriers. The Southern Moreton Bay Islands are accessible by ferry or barge from the Southern Moreton Bay Island Ferry, located in Redland Bay. The neighbouring islands of North Stradbroke Island and Coochiemudlo Island are not accessible via the ferry that services the Southern Moreton Bay Islands, and are accessible from Cleveland Point and Victoria Point respectively. Bus networks operate within the Redlands City Council to provide public transportation; however, many island residents own a vehicle both on their island and on the main land. Major transportation issues identified by the SMBI communities include:

- Transport to, from, and between the islands, on to other mainland locations.
- Limited transportation on the islands.
- Cost of transportation ($5-$18 return for the passenger ferry), particularly for families on limited budgets that must commute to and from the mainland. This cost is escalated ($106 return) for those using the vehicle barge.
- The time taken to travel, particularly for those who rely on public transport when on the mainland.
- Factors are compounded when unwell or caring for someone who is unwell (Brisbane South PHN 2019).

Inala - Richlands/Wacol (7 ASR per 100 persons), Logan Central/Woodridge, Redland Islands and Kingston/Slacks Creek (6 ASR per 100 persons) PHAs had the highest rates of people who often have difficulty or cannot get to places needed with transport. These rates are higher than the Brisbane

South PHN and QLD rates of 4 ASR per 100 persons (Public Health Information and Development Unit 2018).

1.3.2.4 Private health insurance

In Australia, private health insurance is a voluntary form of insurance that provides financial assistance for the cost of specific health services. Depending on the type of cover, private health insurance can fully or partly cover the costs of hospital services and/or the costs of other general treatment health services that Medicare generally does not, such as dental, optical, physiotherapy and chiropractic care.

There are many reasons why private health insurance has the potential to be beneficial for most consumers, with the main reasons for taking up a policy including mitigating the risk associated with unexpected, potentially large, health care costs, having more choices in healthcare options, obtaining faster treatment through private providers than would be possible on a public waiting list, obtaining government incentives and minimising taxation (AIHW 2020l).

Private health insurance membership rates have remained relatively stable in Australia since 2000, with approximately 45% of people insured (Figure 31). Coverage was greatest among people aged between 60 and 79 years (54 – 56%), while younger people in the 20 to 24 years and 25 to 29 years age groups had the lowest rates of coverage (30% and 24% respectively). Rates of coverage were relatively comparable across both males and females (AIHW 2020l).

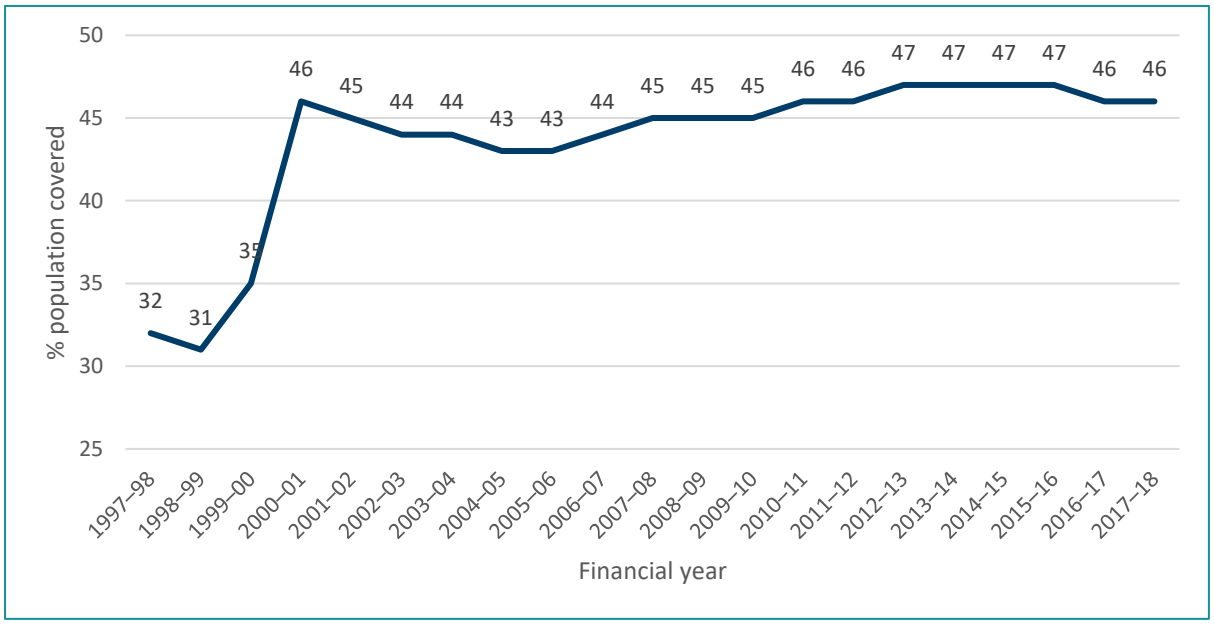

Figure 31. Private health insurance membership in Australia, 1997-18 to 2017-18
Source: AIHW 2020l

1.3.3 Service mapping

1.3.3.1 Primary health care

General Practice

As of October 2021, there were 332 general practices located within the Brisbane South PHN region, six more than in 2018. Table 28 outlines the geographical variation of general practices per 100km^2 across the region. There was strong regional variation within metropolitan and densely populated

SA3s. For example, Brisbane Inner and Holland Park - Yeronga demonstrated greater than 80 practices per 100km^2. This is in contrast to regional locations such as Beaudesert, Jimboomba and Cleveland - Stradbroke were more sparsely serviced (0.4, 2 and 6 practices per 100km^2 respectively) (healthdirect 2021, Brisbane South PHN 2021).

Table 28. General Practices in Brisbane south, 2021

Region	Number of general practices	Land area (km^2)	Practices per 100km^2
Brisbane South PHN	332	3,770	[a]
Brisbane LGA			
Brisbane Inner	12	13.6	88
Brisbane Inner - East	10	15.6	64
Carindale	15	26.5	57
Centenary	8	17	47
Forest Lake - Oxley	26	63.7	41
Holland Park - Yeronga	23	27.6	83
Mt Gravatt	24	79.4	30
Nathan	10	24.5	41
Rocklea - Acacia Ridge	17	85.2	20
Sherwood - Indooroopilly	5	21.3	23
Sunnybank	22	22.2	99
Wynnum - Manly	14	82.9	17
Logan LGA			
Beenleigh	15	60.2	25
Browns Plains	18	169.6	11
Jimboomba	13	582.4	2
Loganlea - Carbrook	16	88.7	18
Springwood - Kingston	29	57.2	51
Redland LGA			
Capalaba	19	89.3	21
Cleveland - Stradbroke	30	481	6
Scenic Rim LGA			
Beaudesert	6	1,628	0.4

[a] As Beaudesert, Jimboomba and Cleveland - Stradbroke contribute 71% of the PHN land area but only 14% of the population, an average at PHN level would not reflect access for the average client in the PHN region.
Source: Healthdirect 2021, Brisbane South PHN 2021

After-hours services

In 2020, 81% of practices across Brisbane south delivered after-hours services, with a higher proportion of practices in lower socio-economic areas such as Beaudesert (100%), Loganlea - Carbrook (100%) and Springwood - Kingston (97%) offering after-hours services than in higher socio-economic areas such as Sherwood - Indooroopilly (60%) and Brisbane Inner (67%). When looking at concentration of practices per 100km^2, more densely populated areas such as Sunnybank and

Holland Park - Yeronga had the highest number of after-hours practices (Brisbane South PHN 2021, healthdirect 2021). Refer to Table 29.

Table 29. After-hours services in Brisbane south, 2020

Region	Number of After-hours Practices	% of Total Practices	After-hours Practices per 100km²
Brisbane South PHN	270	81%	[a]
Brisbane LGA			
Brisbane Inner	8	67%	59
Brisbane Inner - East	8	80%	51
Carindale	12	80%	45
Centenary	7	88%	41
Forest Lake - Oxley	20	77%	31
Holland Park - Yeronga	21	91%	76
Mt Gravatt	17	71%	21
Nathan	8	80%	33
Rocklea - Acacia Ridge	13	76%	15
Sherwood - Indooroopilly	3	60%	14
Sunnybank	17	77%	77
Wynnum - Manly	10	71%	12
Logan LGA			
Beenleigh	14	93%	23
Browns Plains	15	83%	9
Jimboomba	9	69%	2
Loganlea - Carbrook	16	100%	18
Springwood - Kingston	28	97%	49
Redland LGA			
Capalaba	16	84%	18
Cleveland - Stradbroke	22	73%	5
Scenic Rim LGA			
Beaudesert	6	100%	0

[a] As Beaudesert, Jimboomba and Cleveland - Stradbroke contribute 71% of the PHN land area but only 14% of the population, an average at PHN level would not reflect access for the average client in the PHN region.

Source: Brisbane South PHN 2021, healthdirect 2021

Accreditation

General practice accreditation seeks to align general practices with recognised service delivery principles to reduce variation in care. Implementing a quality improvement culture within general practice and other health services supports the provision of safe and effective care, and continued development of health professionals. Over 90% (309) of general practices in Brisbane South were accredited or working towards accreditation as of September 2021 (Brisbane South PHN 2021).

Digital Health

Digital Health is defined as the use of information and communication technologies for health covering a wide range of areas, from secure and smooth information transfer across providers to improve integration of care, to the use of predictive analytics for improving patient care and outcomes.

As at November 2021, 323 (97%) of General Practices in Brisbane south used a digital clinical information system (CIS) and 307 shared data with Brisbane South PHN.

My Health Record is one of the cornerstones of Australia's digital health strategy. It is a secure online summary of an individual's health information and helps practitioners to access timely information about patients such as discharge summaries and pathology and diagnostic imaging reports to create continuity of care and timely information sharing to improve patient care (ADHA 2021a).

As at August 2021, 320 GPs (96%) and 277 pharmacies in Brisbane south had registered for My Health Record. As of September 2021:

- 76 general practices are using smart forms
- 44 general practices are using e-referrals
- 170 general practices are using telehealth
- 36 allied health practices are using telehealth

In 2020 driven by the COVID-19 pandemic, Brisbane South PHN launched a RACF and GP Video Conferencing Trial Program. The findings from this program demonstrated that 5 out of 97 RACFs within Brisbane South PHN are registered to access the My Health Record, illustrating this technology has not yet been adopted and is not being used at any scale for delivering meaningful person-centred care outcomes.

Further detailed information is available in *S1: Digital Health supplement.*

Community Pharmacy

Community pharmacies dispense prescriptions and provide other health professionals with advice on medication selection and usage, and provide people with advice and support regarding the proper use of medicines and other self-management practices (Pharmacy Society of Australia 2021).

In 2020, there were 247 community pharmacies (40 more than in 2018) located across the Brisbane South PHN's region. Similar to general practices, they were concentrated in metropolitan and densely populated areas with Brisbane Inner and Holland Park - Yeronga having more than 60 pharmacies per 100km^2, while 0.2, 2 and 4 pharmacies per 100km2 were available in Beaudesert, Jimboomba and Cleveland - Stradbroke (

Table 30) (healthdirect 2021, Brisbane South PHN 2021).

Table 30. Community Pharmacies in Brisbane south, 2020

Region	Number of Community Pharmacies	Land Area (km²)	Practices per 100km²
Brisbane South PHN	247	3,770	a
Brisbane LGA			
Brisbane Inner	9	13.6	66
Brisbane Inner - East	7	15.6	45
Carindale	11	26.5	42
Centenary	7	17.0	41
Forest Lake - Oxley	17	63.7	27
Holland Park - Yeronga	17	27.6	62
Mt Gravatt	17	79.4	21
Nathan	5	24.5	20
Rocklea - Acacia Ridge	10	85.2	12
Sherwood - Indooroopilly	5	21.3	23
Sunnybank	11	22.2	50
Wynnum - Manly	15	82.9	18
Logan LGA			
Beenleigh	12	60.2	20
Browns Plains	18	169.6	11
Jimboomba	9	582.4	2
Loganlea - Carbrook	13	88.7	15
Springwood - Kingston	23	57.2	40
Redland LGA			
Capalaba	17	89.3	19
Cleveland - Stradbroke	21	481.0	4
Scenic Rim LGA			
Beaudesert	3	1,628.0	0.2

a As Beaudesert, Jimboomba and Cleveland - Stradbroke contribute 71% of the PHN land area but only 14% of the population, an average at PHN level would not reflect access for the average client in the PHN region.

Source: healthdirect 2021, Brisbane South PHN 2021

Tertiary Health Care

Metro South Health is the major provider of public health services, and the largest hospital network, in Brisbane south. At least one Metro South Health hospital is located in each of the LGAs within the Brisbane south PHN region (Metro South Health 2021).

Mater Health Services and Children's Health Queensland are also key providers of public and private health services in Brisbane south, with hospitals located in both Brisbane and Redland LGAs (Mater Health 2021, Children's Health Queensland 2020).

As at October 2021, 15 hospitals were identified in the Brisbane South PHN region (Table 31), as well as an additional 12 community health centres (CHC) (Brisbane South PHN 2021).

Table 31. Tertiary health care facilities within the Brisbane South PHN, 2020

Hospitals		Community Health Centres	
Public	Private		
• Beaudesert Hospital • Logan Hospital • Mater Public Hospital • Princess Alexandra (PA) Hospital • Queensland Children's Hospital • QEII Jubilee Hospital • Redland Hospital	• Greenslopes Private Hospital • Mater Private Hospital • Mater Mothers' Private Hospital, Brisbane • Mater Mothers' Private Hospital, Redland • St Vincent's Private Hospital • Sunnybank Private Hospital • Belmont Private Hospital • Canossa Private Hospital	• Beenleigh CHC • Browns Plains CHC • Corinda CHC • Eight Mile Plains CHC • Inala CHC • Logan Central CHC	• Logan Central CMHC • Marie Rose Centre • Redland Health Service Centre • Southern Queensland Centre of Excellence - Inala • Woolloongabba CHC • Wynnum-Manly CHC

Source: Brisbane South PHN 2021

Consultation with Logan City Council highlighted that Council-commissioned modelling shows the demand for inpatient services, emergency care and specialist outpatient services is projected to outstrip supply of health services in Logan over the next 15 years.

Brisbane South PHN's Community Advisory Council also identified the vast infrastructure available in the tertiary health setting that is available to support primary care-led or integrated models, including the planned or ongoing expansions of the Logan, Princess Alexandra and Redland Hospitals.

Local stakeholders identified the following issues with tertiary level health services in the region through the HNA survey:

- lack of social work services based within hospital settings
- long wait times to access outpatient clinics.

1.3.3.2 Workforce

The primary health care workforce is large and varied, including general practitioners, nurses and a range of allied health professionals such as physiotherapists and optometrists.

Based on the National Health Workforce Dataset, there were an estimated 28,652 registered health professionals working primarily in clinical roles in Brisbane south in 2020 (Department of Health 2019d). Of these, about 1 in 4 health professionals reported primarily working in the broad primary health care setting, which includes private GP and specialist practices and medical centres, Aboriginal health services and community pharmacy — this excludes health professionals working in hospitals and outpatient settings, community-based services (e.g. domiciliary, public health clinics, disability services, aged care) and other settings (e.g. emergency services, businesses, educational facilities) (AIHW 2021).

Table 32 shows the change in size of the health workforce working in primary care by type of profession between 2013 and 2020. The data indicates there has been a considerable increase in the size of the primary care workforce over the 7-year period across all professions, led by Nurses and Midwives (+48.3%) and Allied health (+44.4%) (AIHW 2021).
Of the 2,097 Medical Practitioners working in the primary care setting, 1,113 reported a specialty of General Practice. Approximately 78% of Nurses and Midwives were Registered Nurses (RNs) (AIHW 2021).

Table 32. Health professionals reporting primary care as predominant setting of role

Profession	Size of workforce (2013)	Size of workforce (2020)	% change in workforce 2013 to 2020
Medical Practitioners	1,633	2,097	+28.4%
Nurses and Midwives	661	980	+48.3%
Allied health	1,710	2,469	+44.4%
Dental Practitioners	612	811	+32.5%
Pharmacists	663	762	+14.9%
Total	5,279	7,126	+35.0%

Source: AIHW 2021

In 2019, there were 1,445 GP (1,345 FTE) and 634 nurse practitioners (435 FTE) across Brisbane south, with approximately 94% employed in clinical roles (RACGP 2020).

Beaudesert had the highest rate of GP FTE across the PHN followed by Holland Park - Yeronga (213 and 167 FTE per 100,000 persons) while Browns Plains and Jimboomba (Logan LGA) had the lowest rates (80 and 63 FTE per 100,000 persons). Nurse practitioner rates were also highest in Beaudesert and Holland Park - Yeronga (62 and 62 FTE per 100,000 persons), with rates less than half that observed in Sherwood - Indooroopilly, Brisbane Inner and Nathan (22, 27 and 27 per 100,000 persons) (Table 33) (RACGP 2020).

It is important to note that higher FTE of GPs and nurse practitioners in areas such as Beaudesert does not necessarily equate to higher levels of access for people in these areas, as the sparsity of practices and pharmacies by km^2 paired with transport limitations pose significant barriers for certain groups to access services.

Table 33. Health Workforce in Brisbane south, 2019 (RACGP 2020)

Region	Total GP FTE	GP FTE per 100,000 persons	Total nurse FTE	Nurse FTE per 100,000 persons
Brisbane South PHN	1345	114	495	42
Brisbane LGA				
Brisbane Inner*	51	128	17	43
Brisbane Inner - East	49	108	12	27
Carindale	59	107	24	43
Centenary	37	110	12	34
Forest Lake - Oxley	96	122	37	47
Holland Park - Yeronga	133	167	47	60
Mt Gravatt	82	102	36	46
Nathan	38	89	12	27
Rocklea - Acacia Ridge	62	93	24	37
Sherwood – Indooroopilly*	25	125	4	22
Sunnybank	71	133	21	40
Wynnum - Manly	62	84	24	32
Logan LGA				
Beenleigh	54	120	18	39
Browns Plains	70	80	35	39
Jimboomba	36	63	20	35
Loganlea - Carbrook	80	123	28	43
Springwood - Kingston	107	133	46	57
Redland LGA				
Capalaba	89	118	26	35
Cleveland - Stradbroke	113	123	44	48
Scenic Rim LGA				
Beaudesert	32	213	9	62

Source: RACGP 2020

Research undertaken by SEEK into health workforce supply indicates the annual growth rate in job advertisements for various roles within the health sector is increasing in Queensland, ranging from +2% in management and +4% in nursing, through to +9% in specialist services, +14% in allied health and +16% in aged and disability support (SEEK 2021). Challenges identified in the supply of a capable health and medical workforce at a national level include:

- roll out of NDIS and increased public investment in mental health services has increased competition for workforce candidates
- workforce shortages exist across most health professions, particularly in regional and rural areas
- many workforce positions are filled from other positions causing displacement and disruption
- surge in demand for qualified health professionals across nursing, psychology and GPs for telehealth and online services

- new industry entrants in allied health not keeping up with demand due to limited spaces available to gain training in these fields and levels of remuneration available.

Building a fit for purpose health workforce for the future will require the PHN to respond to a range of emerging challenges and strategic workforce needs including:

- demand and supply of health workforce
- changing models of care and associated new/revised workforce roles
- digital health requiring more virtual approaches and a significant focus on maintaining person-centred interactions
- consumer expectations of receiving treatment close to home and in accordance with their wholistic needs
- existing healthcare funding frameworks incentivising particular work/activities, resulting in gaps in care
- balancing the important (complex and chronic disease management) vs urgent in a pandemic environment.

Key workforce-related issues raised by community and sector representatives during local consultation include:

- upskilling required around use of telehealth
- lack of understanding of what services are available and how to refer to them
- impact of COVID-19 on quality of workforce training (e.g. registrars) when exclusively undertaken via telehealth
- availability and access to supports and services for health workforce through COVID-19
- gaps in understanding around patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) within health services.

1.3.3.3 Quality Improvement

The Royal Australian College of General Practitioners (RACGP) defines quality improvement as an ongoing activity undertaken within a general practice with its purpose being to monitor, evaluate or improve the quality of health care services provided to patients (RACGP 2020).

In August 2019, the Commonwealth Government introduced the Practice Incentives Program Quality Improvement (PIP QI) to encourage practices to undertake quality improvement activities, with the aim to enhance patient health outcomes through the provision of high-quality care. For a general practice to be eligible for the PIP QI, it must:

- Be accredited against the RACGP Standards for general practices (fourth or fifth edition)
- Register to participate in PIP QI using their Provider Digital Access (PRODA) through their Health Professional Online Services (HPOS)
- Collect the PIP QI Eligible Data Set from their general practice clinical information system, and electronically submit this to their local PHN on at least a quarterly basis
- Work in partnership with their local PHN to implement continuous quality improvement activities (RACGP 2020).
-

With the introduction of PIP QI, the following Practice Incentive Payments were superseded:

- Asthma Incentive
- Diabetes Incentive

- Cervical Screening Incentive
- Quality Prescribing Incentive.

The PIP QI Eligible Data Set includes 10 specified Quality Improvement Measures (QIMs). Brisbane South PHN performance against national performance is noted in (Table 34). These results demonstrate that collectively general practices in the region complete measures related to weight status (QIM 3) and alcohol consumption (QIM 7). The measures also identify targeted opportunities for improvement in the ongoing use of quality improvement measures in general practice (Department of Health 2019e).

Table 34. Brisbane South PHN PIP QI Quality Improvement Measure performance, 2020-21

Quality Improvement Measure	Brisbane South PHN (%)	Australia (%)
QIM 1: Proportion of regular clients with diabetes with an HbA1c result recorded in their GP record within the previous 12 months, all ages		
HbA1c recorded: type 1 diabetes	55.4	59.0
HbA1c recorded: type 2 diabetes	70.4	73.4
HbA1c recorded: undefined diabetes	63.8	66.3
QIM 2: Proportion of regular clients with a smoking status record and result in their GP record, 15 years age and over		
Smoking Status Recorded	65.5	66.1
Current smoker	14.6	14.7
Ex-smoker	20.4	22.4
Never smoked	65.0	62.9
QIM 3: Proportion of regular clients with height and weight recorded in their GP record and a derived BMI result, 15 years age and over		
Height & Weight Recorded	25.5	23.6
BMI Underweight	2.3	2.0
BMI Healthy	26.5	25.8
BMI Overweight	31.4	32.5
BMI Obese	39.8	39.8
QIM 4: Proportion of regular clients aged 65 years and over with an influenza immunisation status recorded in their GP record within the previous 15 months, 65 years age and over		
Immunisation status recorded	59.6	64.2
QIM 5: Proportion of regular clients with diabetes with an influenza immunisation status recorded in their GP record within the previous 15 months, all ages		
Immunisation status recorded	53.7	58.2
QIM 6: Proportion of regular clients with COPD with an influenza immunisation status recorded in their GP record within the previous 15 months, 15 years age and over		
Immunisation status recorded	63.3	66.8
QIM 7: Proportion of regular clients with an alcohol consumption status recorded in their GP record, 15 years age and over		
Alcohol Status Recorded	60.4	56.2
QIM 8: Proportion of regular clients with a record of the necessary risk factors in their GP record for CVD risk assessment, 45-74 years age		
CVD Risk Factors Recorded	44.6	48.5
QIM 9: Proportion of regular female clients with an up-to-date cervical screening test record in their GP record within the previous 5 years, 25-74 years age		
Screening test recorded	37.1	37.4
QIM 10: Proportion of regular clients with diabetes with blood pressure recorded in their GP record within the previous 6 months, all ages		
BP recorded	56.7	58.7

Source: AIHW 2021

1.3 Health equity

1.3.1 First Nations people

Australia's First Nations people generally experience poorer health outcomes than other Australians, with Aboriginal and Torres Strait Islander communities reporting shorter life expectancy, higher rates of chronic disease and higher prevalence of risk factors. Closing the Gap is a commitment to addressing the health inequities experienced by Aboriginal and Torres Strait Islander people through more effective and culturally appropriate mainstream health services supported by a strong Aboriginal-controlled primary health care system.

More analysis of the health and service needs relating to First Nations people in the Brisbane south community is provided in Section 4: First Nations Health.

1.3.2 People from Multicultural backgrounds

There is a need for comprehensive and coordinated responses to chronic conditions for CALD communities. Local consultation with community members and sector stakeholders identified health inequities experienced by various CALD communities experiencing higher rates of chronic conditions, and driven by challenges to meeting the needs of people from CALD backgrounds:

- Lack of interpreting services to assist in booking patients for appointments and for allied health services, and adverse service experience linked to low quality interpreting
- Low levels of engagement in preventive health and screening in some CALD communities
- Low health literacy around treatment and self-management
- Limited data collection around country of birth and language spoken at home
- Access to community pharmacy to receive repeat prescriptions to manage chronic conditions

More analysis of the health and service needs relating to multicultural communities in the Brisbane south community is provided in Section 5: Multicultural Health.

1.3.3 LGBTQIA+ community members

There are limited publicly available data relating to lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+) residents in the Brisbane South PHN region (Ansara 2016). However, it is estimated that 11% of the Australian population identify as LGBTQIA+ (Australian Human Rights Commission 2015). If this statistic was uniformly applied across the Queensland population it equates to up to 120,000 LGBTQIA+ residents in the Brisbane South PHN region.

The people, and health needs, of these communities are diverse. While successful progress has been made in recent years to laws, policies, and reforms affecting LGBTIQ peoples in Australia, people from LGBTIQA+ communities may continue to encounter numerous challenges (Australian Human Rights Commission 2014; Australian Human Rights Commission 2015). These challenges include discrimination, violence, and exclusion. LGBTIQA+ peoples experience disproportionate rates of mental health, suicide, and alcohol and other drug concerns (Rosenstreich 2013; National LGBTI Health Alliance 2016; National LGBTI Health Alliance 2016; Couch et al 2007).

Furthermore, unique considerations are necessary in the areas of sexual health, and aged care. A lack of understanding of these considerations, coupled with existing structural barriers to accessing health services may place LGBTIQA+ peoples at an increased risk of poorer health outcomes than their non-LGBTIQ peers (National LGBTI Health Alliance 2016).

Local consultation with community members and sector stakeholders identified the importance of improving access to health care that is knowledgeable and respectful of LGBTQIA+ needs and issues,

such as acknowledging gender identity. Local system and service issues identified for LGBTQIA+ community members include:

- Limited safe spaces in Brisbane south for people who identify as LGBTQIA+ to connect
- Opportunities for improving primary care providers knowledge and skills in working with LGBTQIA+ peoples to provide culturally safe care
- Gaps in services specifically for LGBTQIA+ communities
- Limited LGBTQIA+ representation amongst general practice workforce
- Limited number of advocates available due to advocacy fatigue and vicarious trauma

1.3.4 People experiencing or at risk of homelessness

Homelessness is a complex issue, with many potential causes and widespread effects on the people who experience this issue. Homelessness may take various forms – from sleeping rough, to couch surfing, and living in overcrowded conditions or temporary housing (ABS 2012). Many people may also cycle between marginal housing and homelessness (Homelessness Taskforce 2008). There are many different factors that can impact on homelessness, including:

- a shortage of affordable housing
- long-term unemployment
- mental health concerns
- substance abuse
- family and relationship breakdowns
- domestic and family violence.

Around 6,000 people within the Brisbane South PHN region experience homelessness, at a rate that is higher than the Queensland level. These rates are up to five times higher in the inner Brisbane area, with one SA3 (Brisbane Inner) accounting for almost 4 in 10 of the region's homeless population (QGSO 2021). Key issues raised by community and sector representatives during local consultation include:

- Insufficient community-based services to address the health needs of the homeless and housing insecure population
- Need to improve accessibility, timeliness and coordination of care for people experiencing homelessness
- Need for greater involvement of nurses in homelessness services to support individuals with co-occurring physical and mental health issues and complex psychosocial needs
- Limited workforce capability relating to trauma-informed care
- Lack of outreach or mobile medical services, such as GP attendance, wound care and blood tests
- Health and housing vulnerability experienced by people transitioning into community out of correctional facilities.

1.3.5 People with disability

Around 5% of the population of Brisbane south, over 50,000 people, require assistance for a profound or severe disability, with these proportions varying by geography across the region. The health service data available does not readily identify trends for people with a disability and without. However, Australian research suggests that people with an intellectual disability are more likely to record potentially preventable hospitalisations (PPHs), as well as live with multimorbid conditions and record premature and potentially avoidable death. Rates of PPHs were as much as 8 times higher amongst people with intellectual disability for some acute conditions.

Several factors leading to adverse health outcomes experienced by people with an intellectual disability are suggested to include limited engagement with and uptake of preventive health care, limited family and social support, low vaccination coverage, non-adherence to treatment, mental health concerns and limited health literacy (Weise, Srasuebkul and Trollor 2021).

Key issues raised by community and sector representatives during local consultation include:

- Need for comprehensive health checks for people with disabilities who often experience accessibility issues in primary and tertiary care
- Barriers to accessing COVID-19 testing and vaccination centres due to a physical or intellectual disability
- Lack of services for people who aren't accessing or are unable to access the NDIS
- People with a disability experiencing transactional health care.

1.3.6 Rural and remote communities

People living in rural and remote communities often face barriers to accessibility of health services, experience poorer health outcomes and have shorter life expectancy than those living in urban areas (AIHW 2018b).

Based on the ABS's Remoteness Area classification, the SA2 of Redland Islands had the highest proportion of the population living in outer regional (38%) and remote areas (23%) in BSPHN. The resident communities of the Southern Moreton Bay Islands experience disproportionate health and social outcomes compared to people living on the mainland, with the largest resident populations of the remote Southern Moreton Bay Islands (SMBI) being Russell and Macleay Islands, followed by North Stradbroke Island/Minjerribah. A specific needs assessment of these communities identified an ageing population (over 70% aged 45 years and over) who are living longer, reduced birth rates, low educational attainment and high levels of housing insecurity and poverty (Griffith University 2019).

Local stakeholders have identified the healthcare challenges regarding early intervention, prevention, treatment and management for people living in the remote areas of the Brisbane South PHN region due to both geographic, demographic and socioeconomic factors. They also highlighted the need for greater equity of access and care for people in these remote areas, including enhanced in-person health supports rather than merely digitally-enabled services.

1.4 Health priorities and options

1.4.1 Identified needs

Considering the comparative, felt, expressed and normative needs of the Brisbane south region, several primary health-related priority unmet needs emerged during triangulation.
In order of priority, as determined through the prioritisation process, these needs included:

1. A need to focus on the social determinants of health - these are associated with health behaviours and health outcomes.
2. Several geographic areas within the Brisbane south region experience higher levels of health needs - Beaudesert SA3, Southern Moreton Bay Islands, North Stradbroke Island, and Logan LGA (particularly Jimboomba SA3).
3. Chronic disease continues to have considerable impact and burden on communities in Brisbane south. These include cardiovascular diseases, respiratory diseases (asthma and COPD), musculoskeletal conditions and cancers.

4. Several priority populations within the community experience disproportionate health and wellbeing outcomes - First Nations peoples, peoples from multicultural backgrounds, people who identify as LGBTQIA+, people experiencing homelessness, people transitioning into community from correctional facilities.
5. A need to focus on health behaviours, as these mediate health outcomes as protective or risk factors. These include nutrition, physical activity and alcohol consumption.

1.4.2 Current activities

1.4.2.1 General practice quality improvement

Brisbane South PHN plays a vital role in the capability enhancement and building of capacity of general practices for the identification and supporting of patients' needs to improve health outcomes for the community. The *HealthPathways* activity aligns with the needs assessment priority to develop a quality improvement culture in primary health care services by encouraging the use of digital health systems. The activity aims to improve access to and decrease demand of acute services, improve patient experiences and yield high general practitioner and practice nurse adoption of clinical best practice.

The Digital Health Enablement activity, which encourages the use of digital health systems, aims to facilitate the development of a clinical culture that embraces meaningful use of digital health technologies. The expected outcomes involve data quality improvement and the generation of actionable data, increased uptake and usage of digital health technologies and initiatives, and improvements in digital health literacy of providers and patient outcomes.

1.4.2.2 Person-centred care

Person-centred care is a key aspect of primary health care delivery. It involves adopting ways of caring for both people and their families that are meaningful and valuable to the individual. These can include listening to, informing and involving people in their care and being supportive of, and encouraging self-management. Brisbane South PHN recognises the link between health literacy and self-management, and therefore the need to embed a team-based and person-centred approach within the primary health sector of the region. By commissioning services which provide patients with digital health tools and resources, improvement in self-management and health literacy is supported, as well as the expression of their preferences and needs.

Brisbane South PHN also recognised the need for person-centred care for those experiencing, or those at risk of, a chronic condition. With the support and integration of Metro South Hospital and Health Service initiatives, Brisbane South PHN aims to deliver a care coordination service that supports people with chronic health conditions and psychosocial risk factors to enhance their self-efficacy and self-management to prevent unnecessary and avoidable health deterioration and increasing risk of needing tertiary health services.

1.4.2.3 Building Digital Health

Brisbane South PHN aims to facilitate the development of a clinical culture that embraces meaningful use of digital health technologies across the entire region. This aligns with the health needs assessment priority to encourage the use of digital systems and embed a quality improvement culture in primary health care settings within the region. Positive outcomes can be achieved through supporting general practices in the adoption and use of digital health technologies that support clinical decision making and referral pathways. Along with this, providing support to increase their use of interoperable structured data and consistent terminology in healthcare applications to enhance data quality and analysis that enables decision support, proactive planning and quality improvement.

1.4.2.4 Workforce development and education

Brisbane South PHN's Workforce Development and Education program aims to provide primary health care providers and support staff with opportunities to improve their knowledge, skills and confidence, maintain professional currency and support new workforce models. This program aligns with the needs assessment priority to contribute to the provision of a skilled and accessible health care workforce within the region. Focus topics include; person-centred, and culturally appropriate service provision; identification, and appropriate service response for people experiencing domestic and family violence; identification and management of chronic conditions, mental health concerns, and alcohol and other drug misuse; cancer screening; end of life care; children and youth; immunisation and general practice management and leadership. At the completion of the program, primary health providers will have improved knowledge of the topics, and improved skills and confidence in delivery related services.

1.4.2.5 Practice Nurse Support Program

In order to contribute to the provision of a skilled and accessible health care workforce within the region, Brisbane South PHN's Practice Nurse Support Program has been implemented. The aim of the program is to up-skill the practice nurse workforce, leading to improved patient wellbeing through prevention, early intervention and self-management of chronic conditions. The delivery of educational workshops to new, returning and transitioning practice nurse on a range of topics aims to improve their knowledge, expertise and satisfaction, as well as improve access to online educational material and mentor support.

1.4.3 Options for future activity

To address these identified priorities, Brisbane South PHN will:

- Partner, collaborate and lead system reform, delivering measurable and meaningful health and wellbeing impact. These reforms may include place-based healthcare neighbourhoods and voluntary patient registration.
- Integrate and coordinate care systems within a holistic social determinants framework.
- Improve the health and wellbeing outcomes of our community, with a focus on addressing health inequities and inequalities. This may include a focus on building capability of primary care providers to meet the cultural and clinical needs of priority population groups such as First Nations peoples and people from multicultural backgrounds.
- Enable strong and connected primary care to create a person-centred system that improves health access, experiences and outcomes. Brisbane South PHN will continue to focus on the development of quality improvement approaches to consumer care and optimising health enablers, such as the uptake of digital health technologies and workforce development and education.

2. Child, youth and families

As an individual grows and develops from infancy to older age, their health and service needs change and varies across different populations. Experiences throughout an individual's infancy and childhood can determine the trajectory of their future health and wellbeing. Investments in the early years of a child's life, such as immunisations and developmental screenings, can ensure that positive health and wellbeing outcomes in the future for both the individual, and the wider community (AEDC 2019a). Family composition is an indicator of potential health need, and therefore is important to address the dynamic of families across the region in order to improve health outcomes for individuals and the wider community.

2.1 Strategic environment

2.1.1 National

In 2020, the Australian Government released the *National Action Plan for the Health of Children and Young People 2020-2030* (Department of Health 2019f), to guide approaches and strategies for the health and wellbeing of individuals aged 0-24 years for the 10-year period. This document follows the *National Framework for Protecting Australia's Children 2009-2020* (2009). The Action Plan recognises the importance of investing in the health and wellbeing of Australia's future generations, as well as the several factors that influence their life and development, such as parents and caregivers. By adopting a life course approach, the range of health needs, influences and risks of children and young people at different stages of life are recognised through the Action Plan. This enables specific investments to be made to maximise physical, mental, and social health at every age.

The five priority areas from the *Action Plan* have been developed with an aim to improve Australia's children and young people's health outcomes. These priority areas are:

- Improve health equity across populations
- Empower parents and caregivers to maximise healthy development
- Tackle mental health and risky behaviours
- Address chronic conditions and preventive health
- Strengthen the workforce

Within the *Action Plan*, there is emphasis on the importance and need for collaboration and coordination between stakeholders to improve outcomes at both an individual and system level. Guiding principles of the Action Plan are:

- Prevention and early intervention
- Strengths-based approaches
- Supportive environments
- Health equity
- Proportionate universalism

It has been shown that having a strong and positive family unit can have benefits on a universal scale. These benefits include facilitating children to form social networks, provision of resources, providing a caring and safe place to learn and explore, and teaching them about the world and rules that govern it. Strong cohesion among families can lead to the development of emotional bonds, boundaries, shared interests, and an ability to make decisions together. Poor cohesion is associated with negative outcomes for the child and the family; such as decreased ability to cope with problems, increased social withdrawal, anxiety and depression, aggressive behaviour, and delinquency (AIHW 2020m).

The Mental Health Commission has recently released the *National Children's Mental Health and Wellbeing Strategy*, which aims to deliver an optimal child mental health system. The strategy highlights that at least half of all adult mental health concerns arise prior to age 14 years, demonstrating the need to support child mental health and wellbeing. The strategy outlines four focus areas for action – family and community, education settings, the service system, and evidence and evaluation, each with several associated activities (Figure 32).

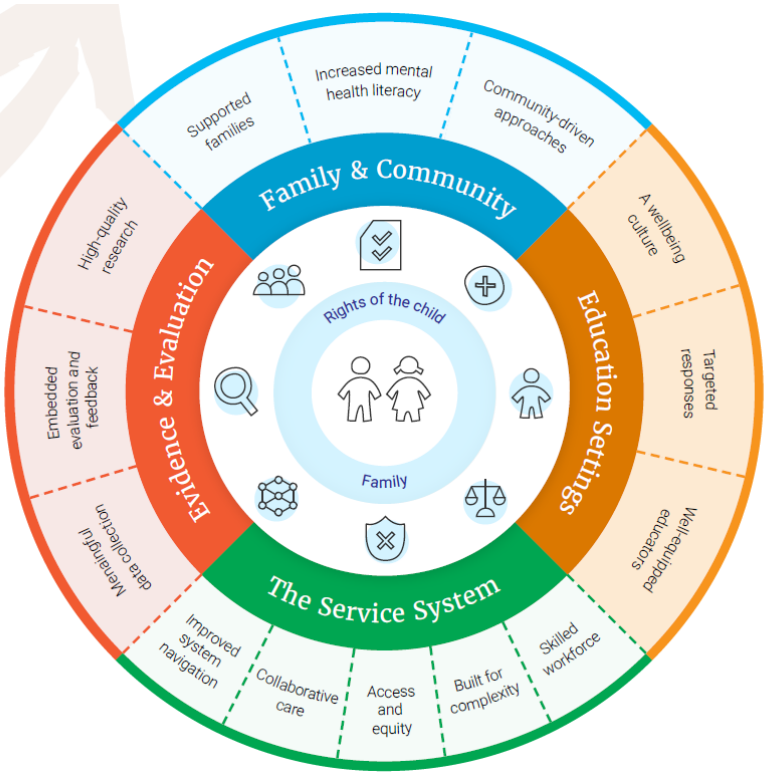

Figure 32. National Children's Mental Health and Wellbeing Strategy
Source: Australian Government Mental Health Commission 2021

The strategy calls for a significant paradigm shift in how children's mental health and wellbeing is viewed, as noted below:

- a change in language that refers to a wellbeing continuum that supports early intervention
- a change in status to give child mental health parity with physical health
- a change to ensure access and equity in all systems with priority access given to children 0-12 years of age
- a change towards needs-based access to services
- a change in the collective understanding of the roles of families, communities, services and educators (Australian Government Mental Health Commission 2021 p.24)

2.1.2 State

The *Children's Health and Wellbeing Services Plan 2018-2028* (2017) aims to improve the health status of Queensland's young people, while maintaining equity of health outcomes and improving the access to services across the population. There are five key health services directions outlined in the document:

- Promoting wellbeing and health equity
- Improving service design and integration
- Evolving service models
- Delivering services closer to home
- Pursuing innovation

The strategy also identifies several challenges that will be faced by Children's Health Queensland in the future; population size and demographics, health status and demand for health services, evolution of the Children's Health Queensland role, models of service delivery, policy frameworks and funding, and advances in research, technology and innovation.

Queensland's Department of Health developed a strategy that seeks to offer children and young people the most opportunities for best start in life, by bringing together government agencies, service providers and the community in *A great start for our children: State-wide plan for children and young people's health services to 2026.* Within the strategy, short-, medium- and long-term strategies are set out to improve the health and wellbeing outcomes of young people and children in Queensland. The five service directions that are the focus of this plan align with the *Children's Health and Wellbeing Services Plan 2018-2028* as above (Queensland Health 2017).

Focussing on the health and wellbeing of Aboriginal and Torres Strait Islander children and families is a high priority for the Queensland Government. In 2017 the Queensland Government and Family Matters collaborated to produce a 20-year strategy; *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037.* The strategy outlines a framework for the required transformational change that needs to occur in the next 20 years, representing a long-term commitment from the state government and the Indigenous community to work together. Aboriginal and Torres Strait Islander children and young people continue to experience disadvantages in health and wellbeing outcomes, and do not experience the same opportunities as their non-Indigenous counterparts. This strategy seeks to close the gap by addressing health, mental health and disability, housing, early childhood and education, employment and training, domestic and family violence and violence against women and financial resilience.

Queensland Education identifies "a great start for all children" as its first goal in its *Strategic Plan 2021-25*. This encompasses strategies to support access to kindergarten to assist in school readiness, and investing, developing, and delivering service models too support children's wellbeing (Queensland Education 2021).

2.1.3 Regional

Together, Brisbane South PHN, Metro South Health, Children's Health Queensland, Queensland Government Department of Education and Training, and Logan Together align their commitment to health and early education through the *Our Children and Communities Matter Alliance*. The *Our Children and Communities Matter Report* (2021) advocates for the investment in health development, learning, and establishing the foundations for future wellbeing by addressing vulnerability in the early years to generate improved outcomes across the life course. *Our Children and Our Communities* outlines several strategies that are currently being implemented across Brisbane south, including:

- Community Maternity and Child Health hubs

- Nurse Home Visiting
- Thriving and On Track (TOTs) – early childhood education capability building for child developmental screening and early intervention
- Community hubs (Gateways) – soft-entry playgroups and clinics
- Pop-up clinics or TOTs in prep/kindergarten.

Additionally, the report advocates for whole-of-government action and collaboration between key agencies to progress several key initiatives, including:

- Targeted Allied Health for children in early childhood education centres
- Scaling up Maternity and Child Hubs and Nurse Home Visiting
- Continuing and expanding the Thriving and On Track program
- Expanding network of community gateways
- Care coordination across the child health system
- Implementing a learning and development approach through project management and data analytics.

2.1.4 Sector

When looking to leading frameworks outside of the health-oriented arena for children and young people aged zero through 24 years, the Australian Research Alliance for Children and Youth (ARACY) *The Nest* framework provides a holistic approach to meeting the health and wellbeing needs of children and young people. *The Nest* framework articulates the six domains that need to be achieved and adequately resourced for optimal wellbeing of children and young people are noted below:

- Valued, loved and safe
- Material basics
- Healthy
- Learning
- Participating
- Positive sense of identify and culture.

Although many of the domains above sit on the periphery of a more traditional health-centric approach to wellbeing, Brisbane South PHN are ideally positioned to integrate health responses with the broad range of services and systems that children, young people, and families currently access. *The Nest* provides a detailed blueprint that articulates the needs of children and young people, but principally is committed to:

- **The child at the centre** - starting from the perspective of the whole child, ensuring the child or young person has agency, focusing on what is required to ensure their overall wellbeing beyond established disciplines and service boundaries.
- **Privileging Aboriginal and Torres Strait Islander knowledge** - recognising that Aboriginal and Torres Strait Islander agencies are well placed to meet the needs of Aboriginal and Torres Strait islander children and young people and such agencies require the funding, accountability and authority to do so.
- **A long-term, evidence-informed approach** - recognising there is no quick fix for the complex issues facing children and young people, adopting long-term views, strategies, monitoring and evaluation processes.

- **Prevention and early intervention** - although tertiary action will always be required, the maximum benefits will be achieved by shifting our efforts towards preventing problems and intervening early through a proportionate universalism approach.
- **A life stage approach** - our work will have the strongest impact when focused on the early years, yet we need to continue to combine this with focus on the middle years and young people, particularly at transitional points in their lives.
- **Systemic change using an outcomes approach** - agreement to work toward a shared vision, in collaboration with agencies, professions, governments and young people themselves. Collectively using shared outcomes frameworks, reforming funding arrangements and increasing the use of implementation science (Goodhue et al. 2021).

2.2 Health status

2.2.1 Demography

The social and physical environments of a child, including during foetal development, are key determinants of health and wellbeing across the lifespan. Safe and healthy environments that incorporate responsive caregiving and nurturing ensure children develop to their full potential (Queensland Health 2020).

The proportion of children and youth (0 to 17 years) was slightly higher in Brisbane south region compared to Queensland. Brisbane LGA had the greatest number of children and youth in the PHN region while Logan LGA had the greatest proportion of children and youth in the region (Table 35) (ABS 2016).

Table 35. Children and youth (0-17 years) in Brisbane South PHN region, 2016 and 2041

		Population, 2016	% Population, 2016	Projected Population, 2041	% Population, 2041
Age 0 to 14 years					
Queensland		954,598	20%	1,274,310	18%
Brisbane South PHN		318,317	19%	398,129	17%
LGA	**Brisbane (54%)**	113,247	18%	131,044	16%
	Logan	71,664	23%	114,592	21%
	Redland	29,016	19%	30,222	16%
	Scenic Rim (34%)	2,693	19%	3,618	16%
Age 15 to 24 years					
Queensland		649,335	13%	869,724	12%
Brisbane South PHN		248,844	15%	307,220	13%
LGA	**Brisbane (54%)**	97,433	15%	112,668	13%
	Logan	44,987	14%	71,691	13%
	Redland	19,011	13%	20,484	11%
	Scenic Rim (34%)	4,415	15%	2,176	10%

Source: ABS 2016. QGSO 2018

2.2.2 Socioeconomic

Family income is a key variable influencing health outcomes resulting from lifestyle, behaviours, and access to and use of health services. It is known that children raised in poverty often face emotional and social instability, and an absence of early learning and exploration opportunities required for brain develop (Griffith University 2019). Children who have not received adequate early childhood intervention are more likely to have poor physical and mental health outcomes, reduced cognitive ability, and become parents themselves before they are ready (Brisbane South PHN 2021).

The *Our Children and Our Communities Matter* report (2021) highlights those children from the most disadvantaged communities were five times as likely to be living away from home, 1.6-2 times as likely to have health risk factors, and 6.5 times as likely to be vulnerable in their language/cognitive skills as from the least disadvantaged communities. Additionally, pregnant women living in the most disadvantaged communities were 6.8 times as likely to smoke as those from the least disadvantaged communities.

The pattern of family income distribution across Brisbane south was similar to that of Queensland. Approximately 72-74% of Queensland families had a family income of less than $156,000.35, which was comparable in Brisbane south. While the region and state were similar overall, there were substantial differences in family incomes across SA3s within the Brisbane South PHN region (QGSO 2017).

There are approximately 280,000 families living in the Brisbane South PHN region. The composition of families is an indicator of potential health need. For example, families with no children may indicate a higher proportion of older persons or younger couples who will have different needs to families with children and/or single parent families (QGSO 2017).

Brisbane South PHN had a family composition profile similar to Queensland. Around half of families in Brisbane south were couples with children (46%), which was slightly higher than the state (43%). A third of families were couples with no children (35%), which was slightly below the state average (39%). The distribution of one-parent families was the same in the Brisbane South PHN region compared to the state (17%) (QGSO 2017).

Learning or earning

Young people who fail to engage in school, work or further education/training run a significant risk of school failure, unemployment, risky health behaviours and mental health problems, social exclusion, and economic and social disadvantage over the life course (PHIDU 2021). As such, the proportion of young people aged 15 to 24 years either 'learning or earning' is an important indicator of current behaviours impacting future socioeconomics and health need.

In Brisbane south in 2016, 84.1% of people aged 15 to 24 years were either learning or earning, equating to approximately 126,000 of the total 150,000 individuals in this age group. These rates were relatively on par with national levels (84.3%) and higher than state levels (81.8%). Within the region (PHIDU 2021).

Key themes raised by community and sector representatives during local consultation regarding the socioeconomic factors impacting the health status of children, youth and families included:

- financial barriers being a key challenge in accessing the Children's Health Service across the region
- concerns in educational performance (reading, grammar, numeracy, spelling and writing) in the Logan LGA
- the low level of working age population who have completed Year 12 in the Redland LGA, particularly in the Southern Moreton Bay Islands
- Browns Plains being a key growth area experiencing rising need and subsequent demand for children's health services.

2.2.3 Risk factors and primary prevention

As shown in Table 36, the Brisbane south region performed favourably by comparison to Queensland and Australia with regards to most behavioural indicators impacting child, youth and family health status.

Table 36. Behavioural factors impacting child, youth and family health status in Brisbane south at a glance

Indicator	Brisbane South PHN	Priority SA3s	Result	Queensland	Australia
Mothers who smoked during pregnancy (%)	9%	Beenleigh	24%	9%	10%
Birth rate (ASR per 1,000 persons)	13	Browns Plains	17	12	-
Proportion of mothers who had at least one antenatal visit in the first trimester (%)	71%	Cleveland - Stradbroke	48%	-	65%
HPV immunisation rate of males aged 15+ years (%)	74%	Beenleigh Loganlea - Carbrook	62%	74%	76%
HPV immunisation rate of females aged 15+ years (%)	78%	Beenleigh Loganlea - Carbrook Sunnybank	72%	79%	80%
Children aged 5 to 17 years with insufficient fruit intake (%) [a]	31%	NA	NA	31%	NA
Children aged 5 to 17 years with insufficient vegetable intake (%) [a]	97%	NA	NA	96%	NA
Children aged 5 to 17 years performing insufficient physical activity (%) [b]	55%	NA	NA	53%	NA
Children aged 5 to 17 years sunburnt in the past 12 months (%)	42%	NA	NA	49%	NA

a. Based on National Health and Medical Research Council's (NHMRC) Australian Dietary Guidelines 2013
b. Based on Department of Health Australia's Physical Activity and Sedentary Behaviour Guidelines 2020

Source: AIHW 2018m, Public Health Information and Development Unit 2020, Queensland Health 2021.

2.2.3.1 Perinatal health risk factors

Brisbane South PHN residents demonstrated particularly favourable outcomes with regards to the proportion of mothers having at least one antenatal visit in their first trimester (Table 36) (Queensland Health 2021).

Maternal age and health status

In Australia, the average age of all women (including first time mothers) has been increasing over the past few decades. Giving birth later in age may be associated with higher risks of pregnancy complications, such as preterm birth. There are also several advantages for mother and baby associated with increased maternal age, such as a greater likelihood of being of a higher socioeconomic status (AIHW 2021). Approximately 23.5% of all mothers in Brisbane South PHN region were aged 35 years or older, with Gold Coast PHN (24.7%) and Brisbane North PHN (25.7%) having higher proportions of older mothers (Figure 33).

Maternal obesity is a major challenge in obstetric practice, which can result in negative health outcomes for both the mother and child during pregnancy and later in life. Maternal risks during pregnancy include gestational diabetes and preeclampsia, while risk factors for the foetus include stillbirth and congenital anomalies. Later in life, obesity during pregnancy puts women at higher risk of heart disease and hypertension while for the child their future risk of obesity and heart disease are increased. In addition, both women and their offspring are at risk of type 2 diabetes (Leddy et al. 2008). Within the Brisbane south region, 20.2% of mothers birthing in 2018 were obese prior to pregnancy (Figure 33) (Queensland Health 2020).

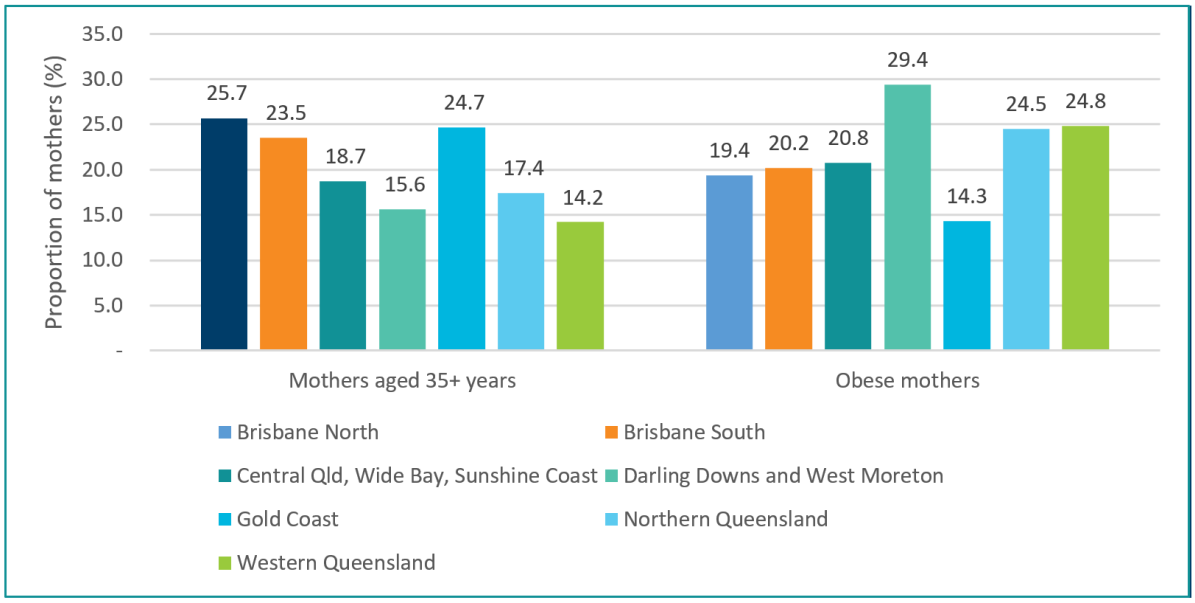

Figure 33. Maternal age at birth and obesity, 2018
Source: Queensland Health 2020

Gestational diabetes mellitus (GDM) is a form of diabetes that occurs during pregnancy. It is diagnosed when higher than normal blood glucose levels first appear during pregnancy, and usually occurs around the 24th to 28th week of gestation. While maternal blood glucose levels usually return to normal after birth among women diagnosed with gestational diabetes, it does place them and their baby at increased risk of developing type 2 diabetes later in life (Diabetes Australia 2021).

Trends over time at the Queensland state level indicate a significant increase in the proportion of mothers with gestational diabetes (Figure 34) (AIHW 2019d), potentially due in part to changes to recommended diagnostic criteria that were introduced in 2014. However, factors such as the increasing rates of maternal obesity and older maternal age could also be contributors to this rise (ACSQHC 2021b).

It was estimated that over the 2012-2016 time-period, approximately 9.8% of mothers in the Brisbane south region had gestational diabetes, which was comparable to the prevalence observed across Queensland (Metro South Health 2018).

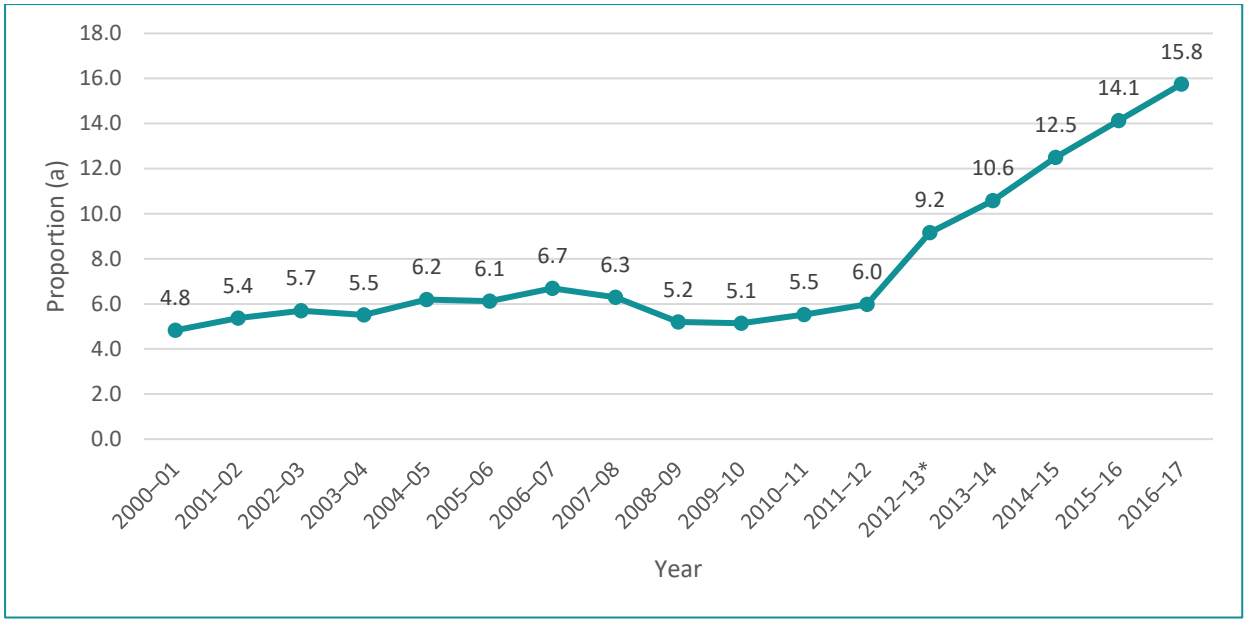

Figure 34. Incidence of gestational diabetes in Queensland, 2000-01 to 2016-17

(a) Incidence proportions age-standardised to the 30 June 2001 Australian female resident population aged 15–49.

Source: AIHW 2019d

Smoking during pregnancy

Smoking during pregnancy is harmful to both the mother and unborn child, and increases the risk of complications and negative health outcomes. These increased risks to the mother include miscarriage, stillbirth, ectopic pregnancy, problems with the placenta and pre-eclampsia. Increased risks to the child include dying from Sudden Infant Death Syndrome (SIDS), being born too early when not fully developed, being born underweight (which increases the risk of delayed development and disease), having birth defects, being harder to settle and having feeding problems, having middle ear infections or permanent hearing impairment, and long-term damage to the lungs, brain and blood (Department of Health 2021b).

While the proportion of mothers who smoked during pregnancy in the region was on par with Queensland levels, mothers aged under 29 years were more than twice as likely to smoke (13%) by comparison to those aged 30 years and over (6%) (Queensland Health 2017). Sub-regional estimates suggest that Brisbane LGA was likely to have a lower proportion of mothers who smoked during pregnancy (4.8%), and the Logan LGA a notable higher proportion of mothers who smoked during pregnancy (15.9%) compared to the Brisbane south regional estimate (11.8%) (Table 37) (PHIDU 2021).

Table 37. Maternal smoking during pregnancy, 2016-18 modelled estimates

Region		Number	Proportion (%)
Queensland		21,222	11.8
Brisbane South PHN		3,388	8.7
LGA	**Brisbane** [a]	1,147	4.8
	Logan	2,259	15.9
	Redland	508	10.6
	Scenic Rim [a]	58	14.6

a Brisbane South PHN proportion

Source: PHIDU 2021

Antenatal care

Antenatal care is a planned visit between a pregnant woman and a midwife or doctor to assess and improve the wellbeing of the mother and baby throughout pregnancy. Antenatal care is associated with positive maternal and child health outcomes and does not include visits where the sole purpose of the visit is to confirm the pregnancy. Women who attend antenatal care visits during the first trimester of their pregnancy have a higher likelihood of receiving effective health interventions than those who do not.

In Brisbane South 36.7% of mothers failed to attend an antenatal care appointment during the first 10 weeks of their pregnancy in 2015. Mothers in Logan (49.1% not attended) and Redland (41.7% not attended) LGAs were least likely to attend, while mothers in Brisbane LGA (33.5% not attended) were most likely to attend (Table 38) (PHIDU 2021).

Table 38. Women who did not attend an antenatal care appointment during the first 10 weeks of pregnancy, 2015

Indicator		Number	Proportion (%)
Queensland		85,246	47.2
Brisbane South PHN		16,460	36.7
LGA	**Brisbane** [a]	8,015	33.5
	Logan	6,997	49.1
	Redland	2,002	41.7
	Scenic Rim [a]	159	40.2

a Brisbane South PHN proportion
Source: PHIDU 2021

Infant feeding

Breastfeeding provides infants with a multitude of health benefits, such protection against infections and illness, enhanced cognitive development, and reduced risk of chronic diseases (such as coeliac disease). Current guidelines in Australia recommend exclusive breastfeeding from birth to six months of age, with breastfeeding to continue through to 12 months of age and beyond. Solids are recommended to be introduced from six months of age, and no earlier than four months, when breastmilk alone cannot sustain nutrient requirements (NHMRC 2012).

Table 39 shows the modelled estimates of infant feeding practices across the Brisbane south region. These figures demonstrate that rates of exclusive breastfeeding are relatively high at three months of age, particularly for Brisbane (76.5%) and Redland (75.9%) LGAs, however, these rates decline to approximately 25% at six months. Rates of exclusive breastfeeding at three months may be lower in the Logan and Scenic Rim LGAs compared to Brisbane South PHN and Queensland rates; however, Logan LGA observed the highest estimated proportion of infants fully breastfed at six months of the four Brisbane South PHN LGAs. The proportion of infants commencing solids early (before four months) was relatively low across the region and comparable to Queensland.

Table 39. Infant feeding, 2014-15 modelled estimates

		Fully breastfed at three months (%)	Fully breastfed at six months (%)	Children who first ate soft, semi-solid, or solid food before four months (%)
Queensland		71.8	23.5	12.0
Brisbane South PHN		73.5	24.9	11.7
LGA	**Brisbane** [a]	76.5	23.7	11.0
	Logan	66.8	27.1	12.7
	Redland	75.9	22.2	11.6
	Scenic Rim [a]	69.1	22.8	12.2

a Brisbane South PHN proportion
Source: PHIDU 2021

2.2.3.2 Child and youth risk factors

Sun exposure

The proportion of children aged five to 17 years who had been sunburnt in the past 12 months in the Brisbane south region was considerably lower than state and national levels. This relatively favourable sun exposure can be attributed to children in regional locations being more likely to have been sunburnt in the past 12 months when compared to children in major cities (Queensland Health 2021).

Physical activity

A higher proportion of children and young people aged five to 17 years in Brisbane south were engaged in inadequate levels of physical activity compared with Queensland children. Physical activity levels reduced with age, 70% of young people aged 12 to 17 years were insufficiently active compared with children aged five to 11 years (44%) (Queensland Health 2021).

Nutrition

Based on the *Australian Dietary Guidelines 2013,* 31% of children aged 5 to 17 years in Brisbane south consumed insufficient fruit and 97% consumed insufficient vegetables. These results are on-par with state averages, where 31% consumed insufficient fruit and 96% consumed insufficient vegetables (Queensland Health 2021).

Immunisation

As of June 2021, Brisbane South PHN did not meet the national immunisation target (95%) for children aged one, two or five years old (94.97%, 92.78%, and 94.57%, respectively). Beaudesert, Beenleigh, Browns Plains, Forest Lake - Oxley, Loganlea - Carbrook, Springwood - Kingston and Sunnybank SA3s did not meet the national immunisation target for children in any age group (Department of Health 2019g).

2.2.5 Situational Risk Factors

2.2.5.1 Domestic and family violence

Domestic and family violence is a major national health and welfare issue that has lifelong impacts for victims and perpetrators. According to the ABS's 2017 *Personal Safety Survey,* 2.2 million Australians have experienced physical and/or sexual violence from a partner and 3.6 million Australians have experienced emotional abuse from a partner. In addition, 2.2 million Australians have experienced sexual violence since the age of 15 years (AIHW 2021). In 2015, it was estimated that 1.6% of total disease burden in Australia was attributable to domestic and family violence, particularly with respect to anxiety and depressive disorders, suicide and self-harm, homicide, alcohol use disorders, and pregnancy loss (AIHW 2018b).

During the period of 2006 to 2012 there was an average of 23 deaths per year in Queensland linked to domestic and family violence, equating to 44% of the state's homicides for that period (DV Connect n.d.).

The combined health, administration and social welfare costs of violence against women in Australia have been estimated to be $21.7 billion per year, with projections suggesting that if no further action is taken to prevent violence against women, costs will accumulate to $323.4 billion over a thirty-year period from 2014-15 to 2044-45 (PricewaterhouseCoopers Australia 2015).
Publicly available information relating to domestic and family violence in Brisbane south relates to Breach of Domestic Violence Protection Orders. There are two Police Districts, Logan (LPD) and Brisbane South (BSPD) that span across the region (although boundaries do not directly align) that give an indication of the prevalence of domestic and family violence.

Breaches of Domestic Violence Order rates notably increased in both the LPD (47 to 99 per 100,000 persons (+53%)) and BSPD (18 to 31 per 100,000 persons (+42%)) between July 2016 and May 2021. While these increases were significant, they aligned with state trends and when considering percentage increase, were lower than increases seen at state level. Regions within the two police districts with the highest rates of Domestic Violence Order breaches were Logan Central (188 per 100,000 persons) and Mount Ommaney (110 per 100,000 people) respectively (Table 40) (Queensland Police Service 2021).

Table 40. Breach of Domestic Violence Protection Orders, July 2015 – May 2021

Region	Incidents per 100,000 persons		% increase 2015/16 to 20/21
	2015-2016	2020-2021 (a)	
Queensland	37	61	65%
Logan Police District	47	99	53%
South Brisbane Police District	18	31	42%

Table notes:
a. 2020 - 2021 data spans July 2020 - May 2021
Source: Queensland Police Service 2021

Key themes raised by community and sector representatives during local consultation regarding the health behaviours of children, youth and families included:

- lower perceptions of safety in Logan LGA by comparison to LGAs in the PHNs remit
- low proportion of children obtaining milestone child health checks – 18 months, 3 and 4 years

- a perceived increase in vaping, domestic and family violence, and problem gaming and device addiction.

2.2.5.2 Children and young people who have experienced abuse or neglect

The vast majority of children and young people in Australia are raised in safe environments; however, some experience abuse and/or neglect. Abuse and neglect faced in childhood and adolescence has been associated with significant long-term poor outcomes, such as mental health concerns, substance misuse, reduced social skills, and an increased likelihood of criminal offending (Chartier et al 2007; Scott 2014). In 2015, it was estimated that 2.2% of the total burden of disease was attributable to childhood abuse and neglect, most heavily associated with anxiety, depression, and suicide and self-harm (AIHW 2020m).

The prevalence of abuse and neglect is difficult to quantify, due to limitations in agreed terminology and data collection methods; and at present, there is no population-level studies of abuse and neglect prevalence or incidence. While child protection data may provide some level of insight into the extent of substantiated maltreatment of children, these proxy measures are also indicative of the capacity of the child protection system and capture only those cases brought to the attention of child safety services (Scott 2014).

In Australia, First Nations children and young people are disproportionately impacted by abuse and/or neglect. This is evident through the rate of children and young people aged 0 to 17 years who were the subject of child protection substantiations in 2019-20 (Table 41), when the rate among First Nations people was almost seven times higher at 43.0 per 1,000 persons by comparison to 6.3 per 1,000 persons among non-First Nations persons. First Nations children and youth had higher rates of substantiation across all abuse types (AIHW 2021).

The most common form of abuse and neglect across both First Nations and non-First Nations children and youth was emotional abuse (4.7 per 1,000 persons), with First Nations substantiations for emotional abuse being 20.2 per 1,000 persons and substantiations for non-First Nations individuals being 3.6 per 1,000 persons (Table 41). Emotional abuse made up 54% of substantiated investigations of abuse or neglect in 2019-20, followed by neglect (22%), physical abuse (14%) and sexual abuse (9%). A higher proportion of girls (13%) were subject to sexual abuse than boys (6%), while boys had a slightly higher percentage of substantiations for neglect and physical abuse (AIHW 2021).

Table 41. Children and young people aged 0 to 17 years in Australia who were the subject of child protection substantiation, by First Nations status and abuse type, 2019-20

Abuse type	Rate per 1,000 persons		
	First Nations	Non-First Nations	All children
Physical	6.1	0.9	1.2
Sexual	2.9	0.6	0.8
Emotional	20.2	3.6	4.7
Neglect	13.6	1.1	1.9
Total substantiated	**43.0**	**6.3**	**8.7**

Source: AIHW 2021

2.2.5.3 Children and young people under child protection services

Australia's child protection systems assist approximately 3% of all children and youth aged 0 to 17 years each year. Some children are unable to live safely at home as they may be at risk of being abuse or neglect, or their parents may be unable to provide adequate care. Children and their families may receive services to keep children with their family, or be subject to investigations of reports of child abuse/neglect, protection orders, and/or placement in out-of-home care such as with a relative or foster carer.

In 2019-20 in Queensland, approximately 23,000 children were the subject of an investigation of a notification of child abuse and/or neglect, at a rate of 19.2 per 1,000 persons. Additionally, approximately 13,000 children were on care and protection orders, at a rate of 11.5 per 1,000 persons, and approximately 11,000 were in out-of-home care at a rate of 9.6 per 1,000 persons. The rate of children receiving child protection services in Queensland was lower than national averages across all service types, with the rate of children receiving any type of child protection service being 28.8 per 1,000 persons in Queensland by comparison to 31.0 per 1,000 persons in Australia (Table 42) (AIHW 2021).

Table 42. Children receiving child protection services in Queensland and Australia by service type, 2019-20

Service type	Queensland		Australia	
	Number	Per 1,000 persons	Number	Per 1,000 persons
Children who were the subject of an investigation of a notification	22,776	19.2	117,940	20.9
Children on care and protection orders	13,188	11.5	71,983	12.8
Children in out-of-home care	11,051	9.6	56,456	10.0
Children receiving child protection services	**34,036**	**28.8**	**174,719**	**31.0**

Source: AIHW 2021

First Nations children are over-represented among children receiving child protection services, with more than 51,000 First Nations children receiving services at a rate of 156 per 1,000 persons in 2018-19. This equated to 1 in 6 First Nations children receiving some form of child protection service during this period. Additionally, 1 in 18 First Nations children were in out-of-home care on 30 June 2019, two thirds of whom were living with relatives, kin or other First Nations caregivers (AIHW 2020n).

Youth justice supervision

Children and young people who have been abused or neglected are at greater risk of engaging in criminal activity and of entering the youth justice system. In Australia in 2018-19, more than half of young people who had been in youth justice supervision had also received child protection services in the 5 years between 1 July 2014 and 30 June 2019. Approximately one-third were the subject of a substantiated notification for abuse or neglect, one in four were placed on a care and protection order and 22% were placed in out-of-home care in the last 5 years (AIHW 2020n).

Aligning this strong correlation with the experiences of abuse and/or neglect among First Nations children and the high rates at which they receive child protection services, it is hardly surprising that the rate of First Nations young people aged 10 to 17 years under youth justice supervision during

2018-19 who had received child protection services in the last 5 years was significantly higher than that of non-First Nations individuals. In fact, the rate among First Nations youth for all supervision types was 16 times higher (351.9 per 10,000 persons) than non-First Nations youth (22.6 per 10,000 persons) (Table 43) (AIHW 2020n).

Table 43. Young people aged 10 – 17 years under youth justice supervision during 2018-19 who had received child protection services in the 5 years from 1 July 2014 – 30 June 2019, by Indigenous status and service type

Service type	Rate per 10,000 persons		
	Indigenous	Non-Indigenous	All young people
Supervision only	129.7	11.0	17.8
Supervision with child protection	222.2	11.7	23.9
All supervision	351.9	22.6	41.7

Source: AIHW 2020n

2.2.4 Health Outcomes

2.2.4.1 Perinatal mental health

Perinatal mental health describes the parent and caregiver's mental health needs in the perinatal period, from conception through to 12-24 months post-partum. Infant mental health increasingly recognises the importance of the psychosocial wellbeing of the infant, particularly as it relates to attachment and bonding with the parent(s) and caregiver(s). Mental health concerns are common in the perinatal period, with an estimated 20% of women and 10% of men likely to experience anxiety and/or depression, and one to two in every 1,000 women may experience psychosis in this period (PANDA 2017).

Across all Hospital and Health Services (HHS) in Queensland, Metro South HHS demonstrated the highest number of birthing women, with nearly 15,000 mothers giving birth in 2019. The most common reported medical condition among the 59,559 mothers birthing in this time-period was depressive disorder, in 5.5% of mothers (Queensland Health 2020).

2.2.4.2 Pre-term birth and birthweight

Pre-term birth describes a live birth prior to 37 weeks pregnancy, and associated with a greater risk of poor health outcomes for the infant (WHO 2018). Children who are born closer to their due date are less likely to need neonatal special care, and are at a relatively reduced risk of encountering learning difficulties when commencing school (ACSQHC 2021c). Preterm birth may be spontaneous or planned. Factors such as gestational diabetes may result in a planned preterm birth; whereas factors such as social disadvantage and smoking during pregnancy are associated with spontaneous preterm birth (Department of Health 2019h). Approximately 9% of infants across the Brisbane South PHN region in 2019 were born preterm, which is the third highest rate of the seven Queensland PHNs (Figure 35).

A healthy birthweight is clinically defined as an infant weight 2,500 – 3,999 grams. The majority of infants born in Brisbane south were of a healthy birthweight (84.2%) (Queensland Health 2020).

A low birthweight (less than 2500g) may result from insufficient maternal nutrition, smoking during pregnancy, and pre-term birth. Low birthweight babies are at an increased risk of disability, poor health, and death than other babies. Additionally, there is an increased risk of developmental delays

in childhood, and poor adult health status, such as type 2 diabetes (AIHW 2018d). In the Brisbane south region 6.8% (1,025 infants) were born in 2018 with a low birthweight, the equal second lowest rate of low birthweight of the seven Queensland PHNs (Queensland Health 2020). Sub-regional data (SA3s) indicate that the highest proportion of low birthweight babies included Beenleigh (7%), Springwood – Kingston (6%), Beaudesert (6%), Browns Plains (6%), and Brisbane Inner (6%) (AIHW 2018e).

High birthweight (or macrosomia), clinically defined as a birthweight 4,000g and above, is associated with maternal risk factors such as gestational diabetes, and may increase the risk of poor health outcomes for the infant. Approximately 9% of infants born in the Brisbane south region were of a high birthweight, the second lowest proportion of all PHNs across Queensland (Queensland Health 2020).

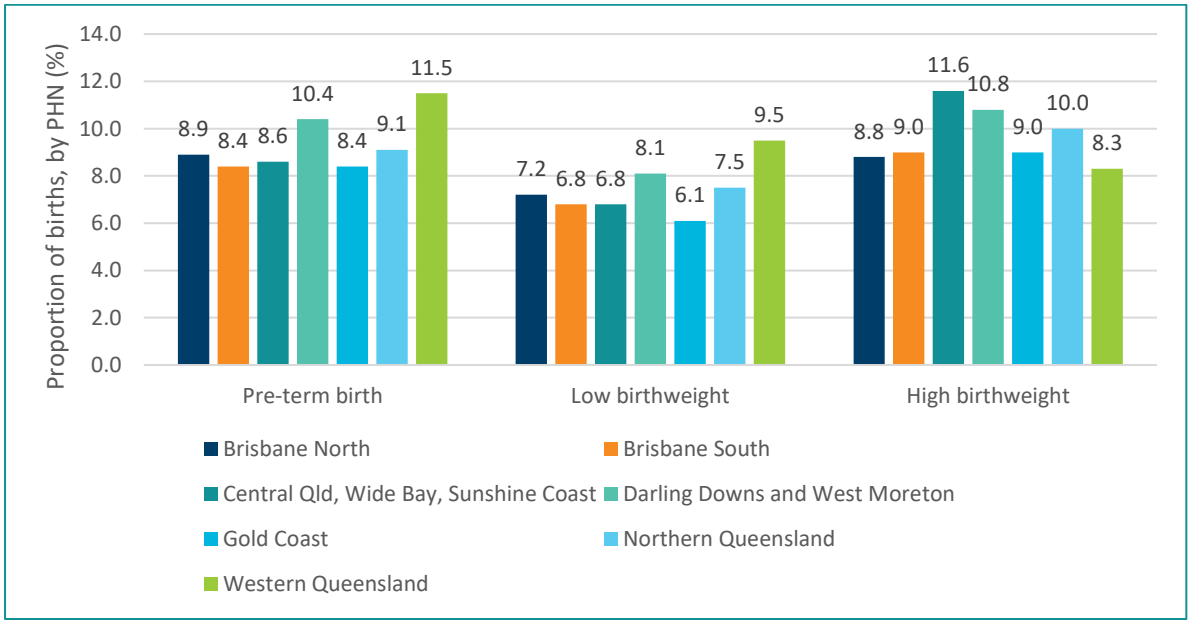

Figure 35. Neonatal outcomes by PHN, 2020
Source: Queensland Health 2020

2.2.4.3 Overweight and obesity

Overweight and obesity in childhood raises the risk of poor health outcomes into adulthood. Obese children demonstrate an increased risk of developing several health conditions, such as asthma and cardiovascular diseases compared to non-obese children (AIHW 2018e).

Almost one in 10 (9%) children aged five to 17 years in Brisbane south were overweight or obese in 2014-16, similar to the 8% recorded in Queensland. Children aged five to 11 years within Brisbane south were 1.5 times as likely to be obese, when compared to children 12 to 17 years (Queensland Health 2021).

2.2.4.4 Early child development

Childhood development describes how a child grows emotionally and physically, learning necessary skills to communicate, think, and socialise. Early childhood development is heavily influenced by life events and situations in the first five years of life, as well as other factors such as nutrition and physical activity (Raising Children Network 2020). Delays in childhood development, particularly those that are undetected or untreated, may impact on later life health and wellbeing.

The Australian Early Development Census (AEDC) estimates the prevalence of developmental vulnerability on one and two or more vulnerability scales – physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge. The AEDC results have been correlated with later health, wellbeing, and academic success. Communities within Brisbane south that are reported to have a relatively high proportion of children that are developmentally vulnerable on two or more domains are shown in Table 44 (AEDC 2019b).

Table 44. Communities where at least 20% of children were vulnerable on two or more domains, 2018

Community	Vulnerable on one or more domains		Vulnerable on two or more domains	
	% vulnerable in 2018	2012 vs 2018 (%)	% vulnerable in 2018	2012 vs 2018 (%)
Mount Gravatt / Nathan	47.5	25.3	31.7	26.0
Kingston	46.8	10	27.5	3.9
Inala	45.9	3.4	26.9	2.1
Logan Central	35.8	-8.2	26.8	-2.5
Kangaroo Point	37.0	22.7	25.9	16.4
Woodridge	37.7	-2.5	25.4	0.4
Loganholme	40.7	11.0	25.3	10.2
Slacks Creek	35.6	1.7	24.7	3.2
Macleay Island and Surrounds	41.2	-1.7	23.5	9.2
Marsden	38.9	-0.1	23.1	0.9
Cedar Vale	32.5	4.8	22.5	5.5
Browns Plains	35.7	-1.0	22.4	3.0
Beaudesert	31.0	0.0	21.4	3.5
Loganlea	38.6	2.9	20.9	0.7
Capalaba	35.2	8.6	20.0	2.9
Gleneagle	26.7	-9.7	20.0	10.9

Key: Significant decline, No significant change, Significant improvement

Source: AEDC 2019

2.2.4.5 *Mental health and suicidality*

While PHN-level data regarding mortality by suicide in children and young people was not available, national data indicates that the greatest number and age-specific rate per 100,000 persons was recorded among 18 to 24 year-olds, with a considerable increase in the rate of death by suicide in this age group between 2010 and 2020 (+5.6 age-specific rate per 100,000 persons; 52% increase) (Table 45) (AIHW 2021).

Table 45. Suicide (ICD 10 X60-X84, Y87.0) by year of registration of death among children and young people in Australia, 2010-20

Age	2010*		2020*		Increase (2010 to 2020) *	
	Number	Rate#	Number	Rate#	Number	Rate#
14 years and below	13	0.5	26	0.8	13	0.3
15 to 17 years	68	7.9	73	8.3	5	0.4
18 to 24 years	239	10.8	381	16.4	142	5.6

* Deaths counted according to year of registration of death, not necessarily the year in which the death occurred
# Age-specific rate (per 100,000 persons)

Source: AIHW 2021.

Key themes emerging from community and sector representatives during local consultation regarding the health outcomes of children, youth and families included:

- Poor perinatal outcomes in vulnerable communities, particularly in Logan LGA.
- A rapidly increasing need for developmental screening and early intervention.
- Growing concerns regarding domestic and family violence and maltreatment:
    - a perceived increase in the incidence of domestic and family violence
    - young person to parent violence
    - young women seeking information on sexual violence.
- A perceived increase in:
    - mental health presentations for 12 to 14-year-olds
    - child behavioural difficulties and inadequate school readiness
    - children and youth with highly complex health needs.
- A perceived increase in concerns relating to mental health and suicide, particularly:
    - youth experiencing eating disorders or disordered eating behaviours
    - intentional self-harm
    - anxiety
    - depression
    - suicidality
    - alcohol and other drug misuse.
- Increased concerns regarding obesity in children and young people.

2.3 Health system

2.3.1 Service utilisation

2.3.1.1 Primary healthcare

Antenatal care

As highlighted in Table 36, 71% of expectant mothers in Brisbane south attended at least one antenatal visit in the first trimester. These results are higher than the national average of 65%, but some regions within Brisbane South PHN's remit recording considerably worse outcomes, notably Cleveland – Stradbroke SA3 with only 48% (AIHW 2021).

While PHN-level data wasn't available regarding the provision of antenatal services, Queensland and national data show relatively stable service delivery between 2018 and 2020. As with all health services, antenatal services adapted to the onset of the COVID-19 pandemic and subsequent restrictions by introducing telehealth (phone and video conference) service modalities (AIHW 2021).

In 2020 in Queensland, 95% of antenatal services were delivered face-to-face and 5% online. While this proportion is small it does equate to approximately 17,000 of the total 316,000 appointments delivered. Queensland mothers were less likely to utilise telehealth compared to mothers across Australia, with 8% of services nationally being delivered via this modality. This may be due to Queensland mothers being less inclined to take up telehealth services, or as a result of Queensland experiencing fewer COVID-19 related lockdowns and service restrictions than other states (AIHW 2021).

Pregnancy and Birth

In Australia in 2017, 66% of women who gave birth before 39 weeks gestation did so via caesarean section or had labour induced, decreasing to 62% at 38 weeks and 57% at less than 37 weeks. Among those who gave birth via caesarean, 33% did so before 39 weeks gestation, 31% did so before 38 weeks and 35% did so before 37 weeks (Table 46) (AIHW 2021).

Table 46. Women who gave birth via caesarean section or who had labour induced, for 6 jurisdictions (excluding NSW and NT) (a) in Australia by gestational age, 2017

	<37 weeks	<38 weeks	<39 weeks
Percentage of women who gave birth via caesarean section[(b)]	35%	31%	33%
Percentage of women who had labour induced[(c)]	22%	31%	33%
Percentage of women who gave birth via caesarean section or had labour induced[(d)]	57%	63%	66%

(a) 6-jurisdiction total based on jurisdictions that were included in Indicator 15. Excludes NSW, as data were not provided, and NT, as data were not published.
(b) Includes women who had no established labour and gave birth by caesarean section.
(c) Includes women who had: induced labour and gave birth vaginally (including non-instrumental, forceps and vacuum extraction); or, induced labour and gave birth by caesarean section.
(d) Includes women who had: no established labour and gave birth by caesarean section; induced labour and gave birth vaginally (including non-instrumental, forceps and vacuum extraction); or induced labour and gave birth by caesarean section.

Source: AIHW 2021.

Medicare-subsidised services

Medicare subsidises several public health services across Australia, including in Brisbane south. These services include general practice, specialist, allied health, diagnostic imaging and nursing services, as well as services provided by Aboriginal Health workers (AIHW 2020h).

In 2018-19, 340,395 consumers aged zero to 24 years in Brisbane south attended a Medicare-subsidised general practice service (81% of the total population of 0- to 24-year-olds). These attendances occurred at a rate of 436 services per 100 persons in the population, equating more than 1.8 million appointments and $86 million paid in Medicare benefits (AIHW 2020h).

Dental care

Good oral health is central to a person's overall health and wellbeing, positively affecting their quality of life, social interactions and self-esteem. Good oral health in children is a strong indicator of good oral health in adults, and with most dental diseases being largely preventable, children's interaction with dental care providers plays an important role in maintaining good oral health (AIHW 2021).

The Australian Dental Association (ADA) recommends children have their first dental visit when their first teeth appear in the mouth, or by age one, whichever comes first. It is recommended that young children attend a dental consultation every 6 months as they continue to grow. Once children are older and have routinely good oral hygiene, their dentist may suggest moving to 12-monthly appointments (ADA 2021).

In 2019, the Australian Government paid benefits averaging $60 per services provided under the Child Dental Benefits Schedule (AIHW 2021). Under the Child Dental Benefits Schedule eligible children up to 18 years of age are eligible for up to $1,013 of general dental treatment over a two-year period (ADA 2021).

In Australia in 2014-15, 40% of children aged 2 to 14 years had attended a dental consultation in the last 6 months, with an additional 33% having attended at some point in the last 2 years. 21% of children in this age group had never attended a dental consultation. Among youth aged 15 to 24 years, 47% had attended a dental consultation in the previous 12 months, with an additional 24% having attended at some point in the previous 2 years. 27% of youth had not had a dental consultation in more than 2 years, and 3% reported having never had a dental consultation (Figure 36) (AIHW 2021).

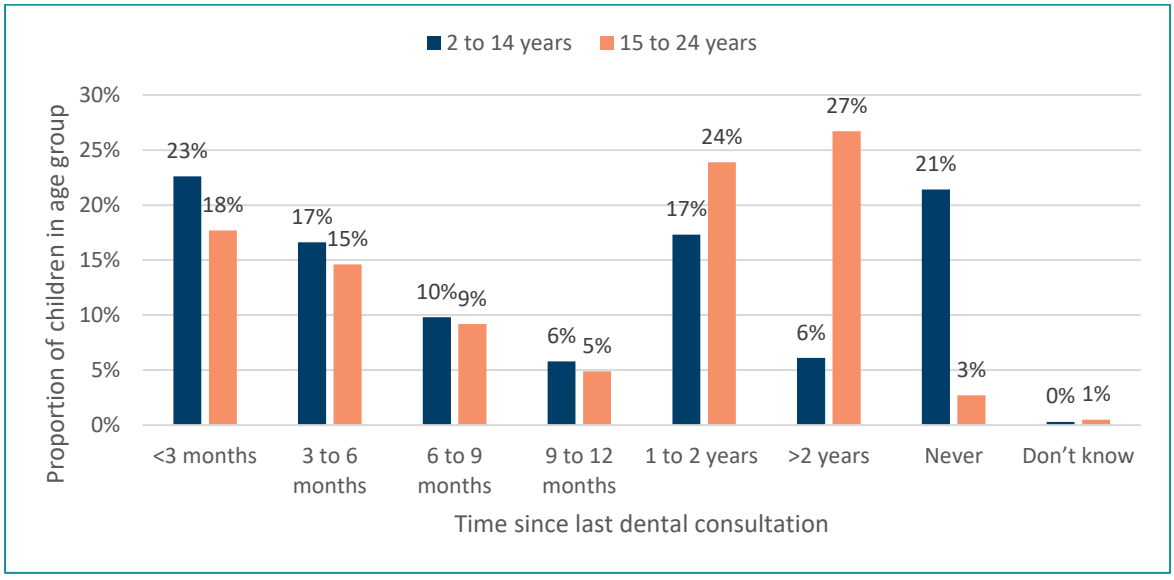

Figure 36. Time since last consultations with a dentist or dental professional in Australia by age group, 2014-15
Source: AIHW 2021

In 2018-19 Brisbane South PHN had the lowest rate of hospitalisations due to dental conditions of all Queensland PHNs for children aged zero to nine years (419 hospitalisations per 100,000 persons age-standardised) and second lowest for young people aged 10 to 19 years (981 hospitalisations per 100,000 persons age-standardised) (Table 47) (Queensland Health 2020).

Table 47. Hospitalisations (age-standardised rate per 100,000 persons) due to dental conditions in children and young people, 2018-19

PHN	0-9 years (ASR per 100,000 persons)	10-19 years (ASR per 100,000 persons)
Brisbane South	419	981
Brisbane North	720	1,279
Central Qld, Wide Bay, Sunshine Coast	751	1,073
Darling Downs and West Moreton	745	1,305
Gold Coast	792	824
Northern Queensland	612	1,219
Western Queensland	1,845	1,010

Source: Queensland Health 2020.

Domestic and family violence services

While domestic and family violence service utilisation data was not available at PHN-level, national data provides an indication of what may be occurring within Brisbane south.

In 2017-18, female clients sought specialist homelessness services associated with family or domestic violence at a rate of 75.9 per 100,000 persons by comparison to 22.1 per 100,000 persons among males. This is an increase of 20.5 per 100,000 persons (37%) among females and 6.4 per 100,00 persons (41%) among males on rates recorded in 2011-12. Figure 37 depicts the age distribution of clients seeking specialist homelessness services in Australia as a result of family or domestic violence. This data shows that the majority of adult clients accessing homelessness services as a result of family or domestic violence were aged 25 to 44 years, with many likely being accompanied by children aged 0 – 9 years given the high proportion of this age group also reported (AIHW 2019e).

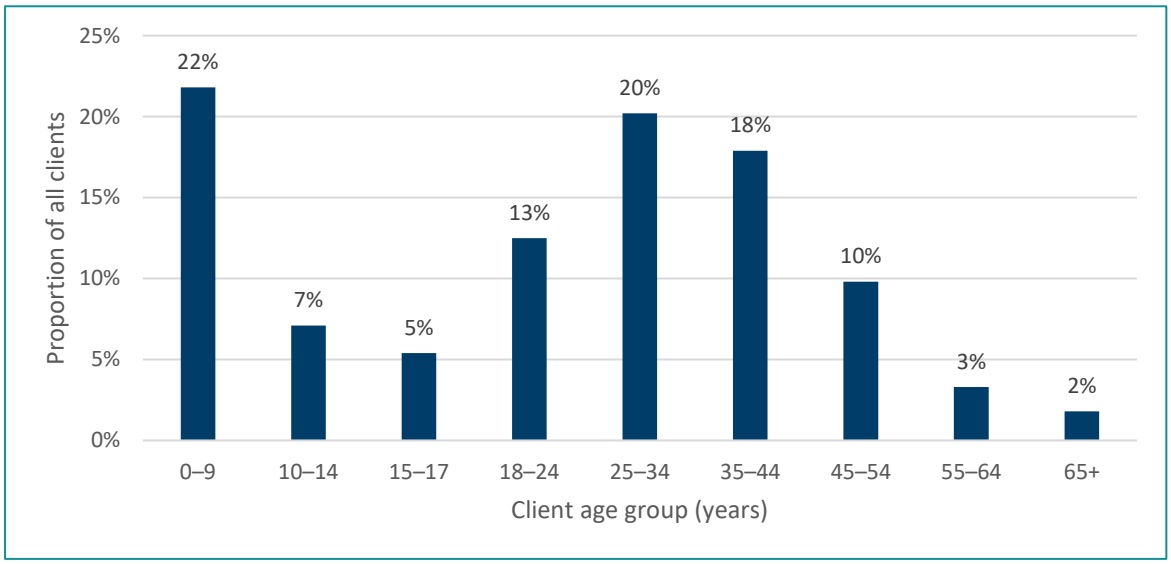

Figure 37. Proportion of clients seeking specialist homelessness services as a result of family or domestic violence by age group, 2017-18.

Source: AIHW 2019e

2.3.1.2 *Tertiary healthcare*

Potentially preventable hospitalisations

In 2018-19, Brisbane south's ASR per 100,000 of potentially preventable hospitalisations (PPHs) among children and youth were 1,798 and 1,468 respectively, higher than national rates but lower than state rates. Within the region, Logan LGA contributed the greatest number of PPHs and had the highest rates among both age demographics. Rates were consistently higher among children aged 0 to 14 years than youth aged 15 to 24 years (Table 48) (PHIDU 2021).

Table 48. Admissions for potentially preventable hospitalisations among children and youth, 2018-19

Region	0 to 14 years (children)		15 to 24 years (youth)	
	Number	ASR per 100,000	Number	ASR per 100,000
Australia	76,084	1,612	37,012	1,140
Queensland	18,638	1,918	10,201	1,548
Brisbane South PHN	4,186	1,798	2,395	1,468
Brisbane (C) - part b	1,578	1,320	945	953
Logan (C)	1,995	2,616	963	2,086
Redland (C)	515	1,807	392	1,971
Scenic Rim (R) – part a	40	1,517	24	1,427

Source: PHIDU 2021

Lower urgency care

In 2018-19, the utilisation rates of emergency departments by children and youth for lower urgency care in Brisbane south were 140 and 85 presentations per 100,000 persons ASR respectively, lower than national rates of 181 and 144 presentations per 100,000 persons ASR.

Within the region, Brisbane Inner had the highest rates across both age demographics (205 and 104 presentations per 100,000 persons ASR) followed by Holland Park – Yeronga (192 presentations per 100,000 persons ASR), Mt Gravatt (181 presentations per 100,000 persons ASR) and Brisbane Inner – East (175 presentations per 100,000 persons ASR) for children aged 0 to 14 years, and Capalaba (104 presentations per 100,000 persons ASR), Springwood – Kingston (98 presentations per 100,000 persons ASR) and Cleveland – Stradbroke (95 presentations per 100,000 persons ASR) for youth aged 15 to 24 years (Table 49) (AIHW 2020j).

Table 49. Use of emergency departments by children and youth for lower urgency care in Brisbane south by SA3, 2018-19

Region	Age group	
	0 to 14 years (children) (ASR per 100,000)	15 to 24 years (youth) (ASR per 100,000)
Australia	**181**	**144**
Brisbane South PHN	**140**	**85**
Beaudesert	26	31
Beenleigh	115	87
Brisbane Inner	205	104
Brisbane Inner - East	175	92
Browns Plains	118	77
Capalaba	170	104
Carindale	128	82
Centenary	106	52
Cleveland - Stradbroke	108	95
Forest Lake - Oxley	138	68
Holland Park - Yeronga	192	90
Jimboomba	98	62
Loganlea - Carbrook	122	87
Mt Gravatt	181	74
Nathan	168	89
Rocklea - Acacia Ridge	142	71
Sherwood - Indooroopilly	113	33
Springwood - Kingston	131	98
Sunnybank	157	71
Wynnum - Manly	133	90

Source: AIHW 2020j.

Alcohol and Other Drug treatment episodes

As shown in Figure 38, alcohol and other drug treatment episodes for children and youth in the 10 to 19 years and 20 to 29 years age brackets were predominantly for their own drug use (AIHW 2020o).

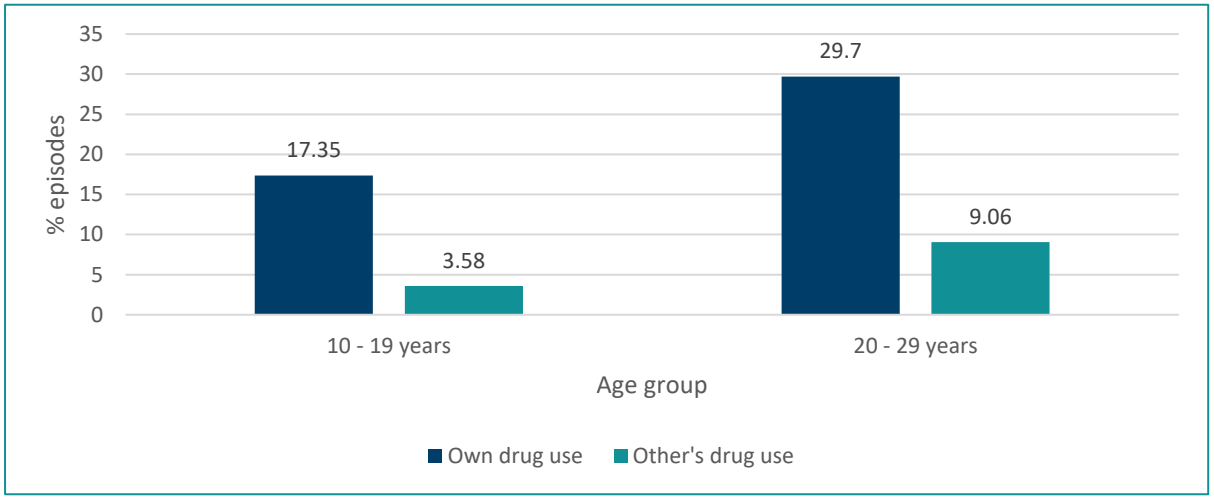

Figure 38. Alcohol and other drug episodes by client type and age group in Brisbane south, 2018-19 (%)
Source: AIHW 2020o

Emergency department presentations

Among children and youth aged 0 to 24 years, Brisbane south had higher rates of emergency department presentations than state levels but lower than national levels in 2018-19. The largest proportion of emergency department presentations were seen at hospitals in Brisbane - part b (children: 40,877; youth: 22,767), while the highest age-standardised rates per 100,000 persons were recorded in Redland (children: 38,802 presentations per 100,000 persons; youth: 33,400 presentations per 100,000 persons) (Table 50) (PHIDU 2021).

Numbers and age-standardised rates of emergency department presentations were higher among males for both 0 to 14 years and 15 to 24 years groups in Brisbane south, as was consistent with state and national trends. The highest age-standardised rate of emergency department presentations across all data was males aged 0 to 14 years in Redland (42,080 ASR per 100,000 persons) (Table 50) (PHIDU 2021).

Table 50. Emergency department presentations by gender and age group, 2018-19

Region	Males		Females		Persons	
	Number	ASR per 100,000	Number	ASR per 100,000	Number	ASR per 100,000
0 to 14 years (children)						
Australia	929,840	38,345	740,881	32,265	1,670,721	35,388
Queensland	176,708	35,344	142,576	30,029	319,284	32,756
Brisbane South PHN	45,135	37,845	36,034	31,706	81,168	34,850
Brisbane (C) - part b	22,919	37,415	17,959	30,844	40,877	34,211
Logan (C)	15,401	39,654	12,576	33,736	27,977	36,755
Redland (C)	6,290	42,080	4,907	35,267	27,977	38,802
Scenic Rim (R) – part a	274	19,978	235	17,986	11,197	19,011
15 to 24 years (youth)						
Australia	460,150	27,632	541,039	34,231	1,001,189	30,846
Queensland	90,509	27,033	112,224	34,560	202,733	30,744
Brisbane South PHN	20,744	25,033	25,143	31,363	45,887	28,148
Brisbane (C) - part b	10,227	20,783	12,540	25,259	22,767	23,031
Logan (C)	7,045	29,696	3,991	39,927	16,036	34,682
Redland (C)	3,041	29,307	3,615	37,824	6,656	33,400
Scenic Rim (R) – part a	179	20,646	194	23,400	373	21,999

Source: PHIDU 2021

2.3.1.3 Mental healthcare

Intentional self-harm hospitalisations

In 2019-20, Brisbane south had a significantly higher rate per 100,000 persons of intentional self-harm hospitalisations (217 hospitalisations per 100,000 persons) than national levels (136 hospitalisations per 100,000 persons). The highest rates in the region were recorded in Beenleigh (400 hospitalisations per 100,000 persons), Springwood – Kingston (362 hospitalisations per 100,000 persons) and Nathan (303 hospitalisations per 100,000 persons), while Springwood – Kingston and Browns Plains had the greatest number of hospitalisations (106 and 90 hospitalisations per 100,000 persons respectively) (Table 51) (AIHW 2021).

Table 51. Intentional self-harm hospitalisations among 0 to 24-year-olds in Brisbane south by SA3, 2019-20

Region	Age 0 to 24 years	
	Number	Rate per 100,000
Beaudesert	13	271
Beenleigh	63	400
Brisbane Inner[#]	25	230
Brisbane Inner - East	33	240
Browns Plains	90	264
Capalaba	29	117
Carindale	38	217
Centenary	15	133
Cleveland - Stradbroke	30	107
Forest Lake - Oxley	67	240
Holland Park - Yeronga	62	264
Jimboomba	45	206
Loganlea - Carbrook	52	230
Mt Gravatt	43	161
Nathan	42	303
Rocklea - Acacia Ridge	35	152
Sherwood – Indooroopilly[#]	13	160
Springwood - Kingston	106	362
Sunnybank	17	96
Wynnum - Manly	44	185
Brisbane South PHN	**862**	**217**
Australia	**10,887**	**136**

[#] Absolute values attributed to Brisbane Inner and Sherwood – Indooroopilly scaled to the proportion of the SA3 located within Brisbane South PHN's remit: 54% and 35% respectively.

Source: AIHW 2021.

Emergency department mental health care

While rates of mental health-related emergency department presentations among children and young people were not available at PHN-level, state and national records show that in 2019-20 individuals aged 18 to 24 years had the highest rates of mental health-related emergency department presentations (Queensland: 209.3 per 10,000 persons, Australia: 228.8 per 10,000 persons). Comparing state and national rates, Queensland had slightly higher rates among 12 to 17-year-olds but lower rates across all other age groups (0 to 4 years, 5 to 11 years and 18 to 24 years). Between 2014-15 and 2019-20, children aged 0 to 4 years had the highest average annual change (%) at both state (21.8%) and national (44.1%) levels (Table 52) (AIHW 2021).

Table 52. Rate of mental health-related emergency department presentations among children and young people in public hospitals, by age group, 2014-15 to 2019-20

Region	Age group	Rate per 10,000 persons			Average annual change (%) 2015-16 to 2019-20
		2015-16	2019–20	Rate change	
Queensland	0–4 years	4.6	10.1	5.5	21.8
Queensland	5–11 years	14.7	18	3.3	5.1
Queensland	12–17 years	131.3	147.7	16.4	3
Queensland	18–24 years	195	209.3	14.3	1.8
Australia	0–4 years	6.4	27.7	21.3	44.1
Australia	5–11 years	17.9	24.3	6.4	8
Australia	12–17 years	140.1	141.2	1.1	0.2
Australia	18–24 years	217.2	228.8	11.6	1.3

Source: AIHW 2021.

In 2019-20, 18 to 24-year-olds had the highest number of mental health-related emergency department presentations in public hospitals (2604), more than twice that of the next highest group (12 – 17-year-olds: 1161). Between 2014-15 and 2019-20, the number of presentations among zero to four-year-olds declined by 27%, contrasting the trends seen at state and national level (Table 52) (AIHW 2021).

Within Brisbane south, Forest Lake – Oxley (345) and Holland Park – Yeronga (338) had the highest number of mental health-related emergency department presentations in public hospitals among individuals aged zero to 24 years. These regions also had the highest absolute and percentage change in presentations between 2014-15 and 2019-20 (Forest Lake – Oxley: 83, 32%; Holland Park – Yeronga: 49, 17%) (Table 53) (AIHW 2021).

Table 53. Mental health-related emergency department presentations in public hospitals among children and young people in Brisbane South by SA3 and age group, 2014-15 to 2019-20

Region	Age group	2014–15	2019–20	Change (#)	Change (%)
Brisbane South PHN	0–4 years	64	47	-17	-27%
	5–11 years	164	171	7	4%
	12–17 years	1282	1161	-121	-9%
	18–24 years	2538	2604	66	3%
	0 – 24 years (total)	4048	3983	-65	-2%
Brisbane LGA					
Brisbane Inner[#]	0 - 24 years	179	201	22	11%
Brisbane Inner - East	0 - 24 years	116	137	21	12%
Carindale	0 - 24 years	145	137	-8	-6%
Centenary	0 - 24 years	82	87	5	6%
Forest Lake - Oxley	0 - 24 years	262	345	83	32%
Holland Park - Yeronga	0 - 24 years	289	338	49	17%
Mt Gravatt	0 - 24 years	221	238	17	8%
Nathan	0 - 24 years	122	123	1	1%
Rocklea - Acacia Ridge	0 - 24 years	219	182	-37	-17%
Sherwood – Indooroopilly[#]	0 - 24 years	44	49	5	12%
Sunnybank	0 - 24 years	127	110	-17	-13%
Wynnum - Manly	0 - 24 years	212	202	-10	-5%
Logan LGA					
Beenleigh	0 - 24 years	220	153	-67	-30%
Browns Plains	0 - 24 years	319	274	-45	-14%
Jimboomba	0 - 24 years	129	120	-9	-7%
Loganlea - Carbrook	0 - 24 years	208	194	-14	-7%
Springwood - Kingston	0 - 24 years	341	308	-33	-10%
Redland LGA					
Capalaba	0 - 24 years	258	237	-21	-8%
Cleveland - Stradbroke	0 - 24 years	277	254	-23	-8%
Scenic Rim LGA					
Beaudesert	0 - 24 years	42	30	-12	-29%

[#] Absolute values attributed to Brisbane Inner and Sherwood – Indooroopilly scaled to the proportion of the SA3 located within Brisbane South PHN's remit: 54% and 35% respectively.
Source: AIHW 2021.

Community and residential mental health care

In 2019-20 in Queensland, community mental health care contacts were highest among 12 to 17-year-olds at a rate of 822 per 1,000 persons. This rate of contacts was considerably higher than other age groups, and the national rate for 12 to 17-year-olds (674 contacts per 1,000 persons). In the same time period, residential mental health care episodes were most prevalent among 18 to 24-year-olds at a rate of 6.8 per 1,000 persons, slightly higher than the national rate of 6.3 episodes per 1,000 persons (Table 54) (AIHW 2021).

Table 54. Community and residential mental health care contacts/episodes by age group, 2019-20

Region	Age group	Community mental health care contacts		Residential mental health care episodes	
		Number	Rate per 1,000 persons	Number	Rate per 1,000 persons
Queensland	Less than 11 years	100,472	111	0	0
	12 to 17 years	320,977	822	53	1.4
	18 to 24 years	291,977	619	320	6.8
Australia	Less than 11 years	318,523	73	0	0
	12 to 17 years	1,218,314	674	155	0.9
	18 to 24 years	1,287,394	546	1,477	6.3

Source: AIHW 2021.

Mental health-related prescriptions

In Brisbane south in 2019-20, there were almost 28,000 patients aged between zero and 24 years accessing mental health-related prescriptions at an average rate of 7.4 prescriptions per patient. The majority of patients accessing mental health-related prescriptions were aged between 18 and 24 years (15,150 individuals), while patients aged 12 to 17 years had the highest rate of prescriptions per patient at 8.1 (Table 55) (AIHW 2021).

Within the region in the same time-period, Browns Plains, Cleveland – Stradbroke, Springwood – Kingston and Capalaba were identified as regions with the greatest number of patients and dispensations for mental health-related prescriptions. Dispensations among patients aged 0 to 17 years exhibited the highest levels of growth between 2015-16 and 2019-20 (Table 56) (AIHW 2021).

Table 55. Patients and mental health-related prescriptions dispensed (subsidised and under co-payment) in Brisbane south by age group, 2019-20

Age group	Patients	Prescriptions	Prescriptions per patient
0 to 4 years	141	327	2.3
5 to 11 years	5,163	38,925	7.5
12 to 17 years	7,493	60,536	8.1
18 to 24 years	15,150	107,139	7.1
0 to 24 years (total)	27,947	206,927	7.4

Source: AIHW 2021.

Table 56. Top 3 SA3s with the greatest number of patients and mental health-related prescriptions dispensed (subsidised and under co-payment) in Brisbane south by age group, 2019-20

Metric	Rank	Age 0 to 17 years			Age 18 to 24 years		
		Region	Number	Change (%) 2015-16 to 2019-20	Region	Number	Change (%) 2015-16 to 2019-20
Patients	1	Browns Plains	1,294	32%	Browns Plains	1,278	15%
	2	Cleveland - Stradbroke	1,103	36%	Cleveland - Stradbroke	1,263	25%
	3	Springwood - Kingston	1,099	40%	Capalaba	1,173	16%
Dispensations	1	Browns Plains	10,288	41%	Cleveland - Stradbroke	8,612	35%
	2	Springwood - Kingston	8,609	49%	Capalaba	8,435	37%
	3	Cleveland - Stradbroke	8,453	45%	Browns Plains	8,045	30%

Source: AIHW 2021.

Domestic and family violence services

Looking specifically at rates of hospitalisation for domestic and family violence assaults among children and youth (0 to 24 years), 2016 – 17 data indicates that almost all hospitalisations for females and males aged 0 to 14 years were perpetrated by a family member (6 and 7 per 100,000 persons respectively). Amongst 15 to 24-year-olds, these rates almost doubled to 12 per 100,000 persons for females and 15 per 100,000 persons for males. The highest rate of hospitalisations for domestic or family violence among 0 to 24-year-olds were among females and perpetrated by a spouse or domestic partner at a rate of 42 per 100,000 persons (Table 57) (AIHW 2019e).

Among adults, females aged 25 to 34 years and 35 to 44 years had the highest rate of hospitalisations for domestic and family violence assaults at rates of 67 and 60 per 100,000 persons respectively, and these were perpetrated by a spouse or domestic partner (Table 57) (AIHW 2019e).

Across all age demographics, males and females had similar rates of hospitalisations for domestic and family violence assaults perpetrated by a family member, but females have significantly higher rates of those perpetrated by a spouse or domestic partner (Table 57) (AIHW 2019e).

Table 57. Rates of hospitalisations for family or domestic violence assaults in Australia, by relationship to perpetrator, age and sex, 2016-17

Age group	Females (hospitalisations per 100,000 persons)		Males (hospitalisations per 100,000 persons)	
	Spouse or domestic partner	Family member	Spouse or domestic partner	Family member
0-14 years	n.p	n.p	n.p	n.p
15-24 years	42	12	n.p	15
25-34 years	67	13	10	14
35-44 years	60	15	11	13
45-54 years	31	11	n.p	12
55-64 years	n.p	n.p	n.p	n.p
65+ years	n.p	n.p	n.p	n.p

Source: AIHW 2019e

Key themes raised by community and sector representatives during local consultation regarding child, youth and family service utilisation included:

- Stigma surrounding mental health and accessing services among youth.
- The lack of service awareness and literacy among youth.
- Witnessing a downward trend in Children's Health Service utilisation, especially in early intervention clinician activity with completed occasions of service decreasing by 34% between 2015/16 and 2018/19.
- The lack of awareness of the importance of health checks for otherwise healthy children
- Sub-optimal Children's Health Service reach in 2019: 60% of children aged 0 to 1 year, 5% of children aged 1 to 4 years and 0.5% of children aged 5 to 8 years. It was suggested that this may be due to transition issues between post-natal care and child health support after the first year of age.
- Continually high demand for after-hours psychiatry appointments in young people and families.

2.3.2 Service experience

Antenatal care

Antenatal care in Australia is typically led by obstetricians. As medical specialists, obstetricians may charge their clients out-of-pocket costs (or "gap fees") to attend appointments.

As a whole of region, a lower proportion of patients (39.6%) were charged out-of-pocket costs across Brisbane South PHN compared to the national benchmark (44.2%) (Table 58). Despite this, there is notable variation in these metrics within the PHN. It can be seen from Table 58 that some SA3s within the Brisbane LGA demonstrate notably higher proportions of patients being charged out-of-pocket costs, such as Brisbane Inner (70.0%), Brisbane Inner – East (73.6%), and Carindale (70.3%). Contrastingly, a relatively low proportion of patients residing within the Logan and Scenic Rim LGAs were charged out-of-pocket obstetric costs.

When examining the median out-of-pocket cost, several SA3s within the Brisbane LGA demonstrated that patients were charged a gap fee more than $100. These SA3s also corresponded with SA3s with a higher relative socioeconomic advantage, such as Brisbane Inner ($116 gap fee per service), Holland Park – Yeronga ($115 gap fee per service), and Carindale ($112 gap fee per service). Out-of-pocket costs were lowest in the Beaudesert SA3.

Table 58. Out-of-pocket expenditure for obstetric medical specialist services, 2016-17

	Per cent of patients with obstetric costs (%)	Median out of pocket cost ($)
Australia	44.2	$78
Brisbane South PHN	39.6	$87
Brisbane LGA		
Brisbane Inner	70.0	$116
Brisbane Inner - East	73.6	$108
Carindale	70.3	$112
Centenary	61.0	$99
Forest Lake - Oxley	24.9	$96
Holland Park - Yeronga	57.9	$115
Mt Gravatt	48.0	$104
Nathan	52.4	$109
Rocklea - Acacia Ridge	41.8	$92
Sherwood - Indooroopilly	69.4	$71
Sunnybank	38.6	$83
Wynnum - Manly	58.5	$76
Logan LGA		
Beenleigh	13.8	$67
Browns Plains	12.3	$76
Jimboomba	22.2	$42
Loganlea - Carbrook	21.6	$51
Springwood - Kingston	20.2	$79
Redland LGA		
Capalaba	46.6	$83
Cleveland - Stradbroke	45.8	$71
Scenic Rim LGA		
Beaudesert	26.3	$30

Source: AIHW 2018c

Children and young people

Local consultation and engagement activities have noted the following emergent trends for service experience for children and young people's health and wellbeing in the region:

- health system integration and access
- a fragmented system of care that can be difficult to access, coordinate, and navigate
- low availability of services in regional, rural and remote areas
- lack of information sharing between services and health professionals
- developmental screening and early intervention
- a lack of timely, locally available and affordable medical and allied health support for children with developmental needs
- increasing need for early intervention and prevention programs
- mental health services:

- long wait times for public child psychology services and severe and complex mental health services
- limited psychological support options for 12 to 25 year-olds, including limited funding for clinical care management
- headspace capacity constraints limiting their ability to respond to increased demand
- gaps in services for school-aged children to receive mental health referrals
- limited service availability for children and young people with behavioural difficulties
- the traditional welfare approach of acute and crisis responses encouraging dependency
- limited resources for infant mental health, and managing complex care arrangements
- consumers struggling with the transition from youth to adult mental health services.
- primary care services:
- the lack of confidential testing, access and safe spaces for sexually transmitted infection screening for young people
- domestic and family violence services:
- the lack of capacity to support demand for crisis and ongoing domestic and family violence services in the Redland LGA
- limited resources to respond to domestic and family violence in a timely and coordinated way
- the lack of shared-care options for antenatal care and support for new mothers
- an increased need for safe social spaces for adolescents
- the need for enhanced early intervention and prevention programs for domestic and family violence
- the need for enhanced early intervention and prevention programs for obesity

2.3.3 Service mapping

2.3.3.1 Antenatal Care

Table 59 shows the hospitals in the Brisbane south region that provide birthing facilities.

Table 59. Birthing hospitals in Brisbane south region

Public	Private
• Beaudesert Hospital • Logan Hospital • Mater Public Hospital • Redland Hospital	• Greenslopes Private Hospital • Mater Mothers' Private Hospital, Brisbane • Mater Mothers' Private Hospital, Redland • Sunnybank Private Hospital

Source: Brisbane South PHN 2020

Public antenatal care is provided within the public birthing hospitals. Antenatal shared care arrangements are in place with several GPs across the Brisbane South PHN region. Shared care arrangements are in place with both Metro South Health and Mater Health Services.

Private obstetric services are typically located within or close by birthing hospitals. As such, private obstetric services tend to be clustered within the Brisbane LGA, with a limited number of services available in the Redland, Logan, and Scenic Rim LGAs.

2.3.3.2 Children's Health Service

The Child Health Service (CHS) provides universal, multidisciplinary primary community healthcare services for children aged zero to eight years who reside in the catchment area for the Child and Youth Community Health Service (CYCHS). The service seeks to achieve positive early childhood health and development outcomes through monitoring growth and development, and addressing concerns about individual children's developing using an early intervention, relationship-based framework to reduce and minimise the impact of risk factors before problems become entrenched, and strengthens parents' capacity to support their children's ongoing developmental needs.

The CHS accepts health professional referrals and self-referrals, and includes a tiered system of universal, targeted and extended care services. Code universal service elements include monitoring health and wellbeing (growth and nutrition), child development and surveillance, health promotion and education, and early identification of family need or risk and the appropriate response to an identified need or risk.

Universal interventions include:

- Early feeding and support drop-in clinics
- Home visiting
- Key age child health checks
- Parenting groups, including Triple P

Targeted interventions include:

- Extended home visiting
- Additional clinic consultations
- Individual structured interventions with EICs
- Targeted groups (e.g. Circle of Security, Postnatal Wellbeing)
- Infant feeding and parenting support program
- Multidisciplinary and/or multiagency support.
- Specific services undertaken through partnership include:
- Immunisation clinics
- School pop-up clinics for four to five-year checks
- Secondary hearing assessment clinics
- Early Years Place
- right@home program

2.3.3.3 Paediatric allied health

Based on geographic service mapping, there are numerous private allied health services available in the region, particularly within the Brisbane LGA. As noted in 2.2.4.4 Early childhood development, there is a growing perceived demand on paediatric allied health services, particularly following the establishment of the NDIS in mid-2018.

Children with developmental support needs, particularly those that are ineligible for the NDIS, are experiencing difficulties accessing timely care; with many services reporting wait lists. The differences in NDIS, MBS, and private billing have also been reported as a contributing factor; with

NDIS services outpricing MBS and private billing. This suggests that although services may appear to be available, local consultation and engagement activities have revealed that many of these services are at capacity and experiencing workforce shortfalls.

2.3.3.4 Mental health

Perinatal and infant mental health

While many pregnant and parenting women access antenatal care, which may include aspects of perinatal mental health, specialist perinatal and infant mental health services are also a key consideration for parents requiring additional supports.

The Belmont Private Hospital, located in the Brisbane LGA, is the only private hospital with dedicated services for perinatal mood disorders (Belmont Private Hospital n.d.). The hospital has a small number of mother-baby beds for inpatient care, which are the only such beds available in the region.

The Metro South Addiction and Mental Health Service provides the Perinatal Service for women aged 18+ years with a child up to one year of age, who have concerns about their mental health. This service is available to women residing in the Logan and Redland LGAs and Beaudesert. The service provides counselling, treatment and support, linkage to community and non-government services, and psychoeducation (Metro South Addiction and Mental Health Services, 2021).

Mater Mothers offer a Parenting Support Centre, which provides free early parenting support up to six months post-partum for mothers having birthed at a Mater Mother's hospital. The service has reported a high proportion of clients experiencing depression and anxiety (Mater Mothers 2016).

Primary care and community-based care

The Brisbane South PHN is home to five headspace centres, located in Capalaba (Redland LGA), Meadowbrook (Logan LGA), Woolloongabba (Brisbane LGA), Inala (Brisbane LGA), and the Beaudesert satellite centre (Scenic Rim LGA). Headspace offer a variety of mental health care services for young people aged 12-25 years experiencing mild to moderate severity mental health concerns. The Meadowbrook centre also offers the headspace Youth Early Psychosis Program, as the spoke of the Southport-Meadowbrook hub and spoke in South East Queensland. The headspace centres report a significant increase in volume, and overall complexity, of young people attending the service since the last needs assessment. Wait times for young people to attend headspace services have been impacted by the increased complexity and demand.

Numerous private allied health services offer community-based mental health supports across the region. Access to these services typically requires a referral and GP Mental Health Treatment Plan, or fully-funded out-of-pocket costs by families. Service mapping reveals that the majority of private allied mental health practitioners are clustered within and close to the Brisbane LGA.

Tertiary care

The Child and Youth Mental Health Service (CYMHS) is the major public mental health service for children and young people experiencing complex or acute mental health needs. CYMHS are delivered by Children's Health Queensland and Metro South Health, and available across the region (Table 60).

Table 60. Child and Youth Mental Health Services in Brisbane south

Community Clinics	Hospitals
• Cleveland • Beenleigh • Browns Plains • Inala • Logan Central • Mount Gravatt • Yeronga	• Greenslopes Private Hospital – Eating Disorders Team • Logan Hospital • Mater Young Adult Health Centre • Queensland Children's Hospital • Redland Hospital

Mental health services are also available through the Mater Young Adult Health Centre for young people aged 16 to 25 years. These services include the Emotional Health Unit and inpatient services.

2.3.3.5 Intensive Family Support

Intensive Family Support is a state-administered, local community provider-delivered service that works closely with families at risk of entering the statutory child protection system. Intensive Family Support provides families with multiple and complex needs with case management. Providers of Intensive Family Support in the region include Act for Kids and Relationships Australia Queensland.

2.3.4 Workforce

Through local consultation and engagement, several themes were emergent with respect to the workforce working with children, youth and families in the region.

Workforce shortage and burnout

The workforce is feeling a sense of burnout, which has been exacerbated by the COVID-19 pandemic.

Policy changes, such as the extension of the Better Access to Mental Health allied health supports from 10 to 20 sessions per person in mid-2020 has anecdotally seen mental health workers hold on to their clients for longer, which has contributed to services remaining at capacity for longer periods of time. Difficulties accessing primary and community-based care have also impacted upon the tertiary sector, with children and young people presenting with higher and more complex needs. This high volume and increasing complexity of consumers over a sustained period has in-turn placed increased strain on the workforce. At present, it was clear from engagement with service providers that there is a perceived shortage of skilled child and youth mental health practitioners, within both the primary and community care and tertiary care settings. This raises further concerns with respect to imminent implementation of the state-wide rollout of mental health professionals in schools and availability and capacity of the current workforce.

Difficulties with navigation and integration of the health system

It has been reported that there is a perceived lack of service provider awareness of available paediatric services in the region, which included difficulties accessing and navigating the NDIS and awareness of available support services.

Various barriers to interprofessional collaboration with and within the paediatric services has been noted. This includes ineffective or underutilised mechanisms to support shared care and information sharing.

2.4 Health equity

According to 2016 Census data, Loganlea - Carbrook (28%), Mount Gravatt (24%) and Browns Plains (24%) SA3s had the highest proportion of children aged under 15 years in families where the mother had low educational attainment. These results were considerably higher than that of Brisbane south as a whole (16%) which fared favourably by comparison to Queensland (18%) (Public Health Information and Development Unit 2018).

Brisbane South PHN (13%) was comparable to Queensland (14%) with regards to the proportion of families with children aged under 15 years where no parent was employed. Regions within the PHN's remit with the highest proportion of families in this situation were Springwood – Kingston SA3 (24%) and Beaudesert SA3 (24%) (Public Health Information and Development Unit 2018).

Key themes raised by community and sector representatives during local consultation regarding vulnerable child, youth and family populations included:

- difficulty engaging priority populations in the Children's Health Service
- inequities in early childhood systematically impacting vulnerable populations and in turn contributing to poor physical and mental health outcomes, and low socioeconomic status in adulthood.

2.4.1 First Nations people

Key themes raised by community and sector representatives during local consultation regarding First Nations child, youth and family health included:

- First Nations child services having limited access to comprehensive child developmental assessments such as Foetal Alcohol Spectrum Disorders and ASD diagnostics
- the lack of long-term family-inclusive therapeutic counselling and support services for First Nations youth
- the lack of culturally appropriate services within the Children's Health Service for First Nations people
- First Nations specific resources are limited, and need to be updated to reflect service changes and provide contemporary content
- an identified need for great consideration and understanding within the Children's Health Service of intergenerational trauma, historical fear of government services and misconceptions of the CHS being linked to the Department of Child Safety within First Nations communities
- limited culturally specific content and service offerings for First Nations people.

2.4.2 Multicultural communities

Key themes raised by community and sector representatives during local consultation regarding child, youth and family health of people from multicultural backgrounds included:

- the importance of engaging and educating people from multicultural backgrounds on vaccination, and continual year-on-year inoculation
- the lack of primary and secondary preventative care amongst multicultural populations, especially those with low health literacy

- the lack of chronic disease management services for people from multicultural backgrounds
- the lack of comprehensive preventative approaches and support services for Maori and Pasifika communities
- the lack of culturally appropriate services within the Children's Health Service for people from multicultural backgrounds
- lack of resources, content and service documentation available in languages other than English
- relationships between the Children's Health Service and multicultural community-specific partner agencies lack depth with little support provided to foster integrated care arrangements
- an identified need for great consideration and understanding within the Children's Health Service of cultural differences and beliefs, complex psychosocial issues, racial and social stigma and limited access to basic resources within multicultural communities
- challenges accessing interpreter services, including coordination, availability, gender barriers and technology limitations.

2.4.3 People who identify as LGBTQIA+

Limited information regarding children and young people was available for general health and wellbeing of LGBQTIA+ children and young people, however, the mental health and suicide prevention needs for LGBTQIA+ peoples is discussed further in Section 8. Mental Health and Suicide Prevention.

2.4.4 People experiencing or at risk of homelessness

In 2014-15, 51.3% of clients accessing specialist homelessness services were children and young people aged 0 to 24 years. Children aged zero to nine years made up almost half of these clients (23%), followed by 18 to 24-year-olds (14.8%), 10 to 14-year-olds (7.4%) and 15 to 17-year-olds (6.1%) (Table 61) (AIHW 2015).

Table 61. Children and young people accessing specialist homelessness services in Australia by age group, 2014-15

Age group	Number of clients	% of total clients
0 to 9 years	10,190	23.0%
10 to 14 years	3,266	7.4%
15 to 17 years	2,679	6.1%
18 to 24 years	6,562	14.8%
0 to 24 years (total)	22,697	51.3%

Source: AIHW 2015.

Micah Projects *'500 Lives 500 Homes'* campaign surveyed 364 young people in Brisbane between 2014 and 2017 in an effort to understand the health, housing and support needs of children and young people in the region experiencing or at risk of homelessness. Outcomes of this campaign showed 53% of those surveyed were female (45% male, 2% other), 22% identified as First Nations, 13% identified as lesbian, gay, bisexual or unsure, and 30% were sleeping rough. The average age of participants was 19 years, with an average time experiencing homelessness of 2.1 years (Micah Projects 2017).

In identifying health needs, it was established that serious and often co-occurring health conditions add to the daily challenges faced by young people experiencing homelessness in Brisbane. Over one-

third (35%) of those surveyed had asthma, 35% had dental problems and 10% had heart issues. In addition, 87% of participants reporting having a mental health condition, 63% reported a dual diagnosis of mental health condition and substance use, and 38% reported a tri-morbidity of mental health condition, substance use and a serious health condition.54% of participants reported having unresolved trauma, and 33% had been admitted against their will to hospital for mental health reasons (Micah Projects 2017).

A significant proportion of young *500 Lives 500 Homes* participants reported living with a disability, with 15% reporting an acquired brain injury and 33% a learning or developmental disability (Micah Projects 2017).

2.4.5 People with disability

In 2015, 7.4% of children in Australia aged 0-14 years had some level of disability, with 4% experiencing disability at a severe or profound level. From this, disability was found to be more common among boys than girls (9.4% and 5.4% respectively), with the most common types of disability being intellectual and sensory/speech. This population is an especially vulnerable population, due to the greater risk of maltreatment for children who experience intellectual disability, behavioural and mental problems, compared to their peers without a disability (AIHW 2020g).

Autism Spectrum Disorders

Autism spectrum disorder (autism) is a lifelong developmental condition that has an impact on how a person thinks, feels, experiences their environment, and interacts with others (Autism Spectrum Australia n.d.). Autism is characterised by differences in interacting and communicating with others, repetitive behaviours, and narrow interests (Raising Children Network 2021). Key strengths and interests that people with autism may possess and contribute to the broader community include a strong focus and deep interest in specific topics, logical or visual thinking, attention to detail, and being skilled with technologies (Autism Spectrum Australia n.d.). While some signs of Autism may be observable from 12-18 months of age, it may not be until recognised as such until social demands increase, such as participating in school (AIHW 2017b).

The diagnosis of Autism requires a multidisciplinary assessment of observed interactions with others and during play, interviewing parents, and a review of the child's developmental history (Raising Children Network 2021). These developmental assessments are essential to obtain an accurate diagnosis and associated estimates of the level and type of supports required. If long-term supports are needed, the child and family may be encouraged to apply for the NDIS (Raising Children Network 2020).

Nationally, 29% of NDIS participants (with an approved plan) had a primary disability of ASD, with an additional 5% of participants noting ASD as a secondary disability. This is the largest primary disability category for the NDIS. The prevalence rates for people with Autism increase from early childhood to a peak in 8-11 years of age before declining (NDIA 2019).

Locally, engagement with stakeholders has revealed notable difficulties in accessing private paediatric allied health services (for example, speech therapy) following the NDIS rollout for children who do not yet have, or are below threshold requirements, for NDIS supports. It is also reported that universal services, such as Early Childhood Early Intervention are at-capacity, and therefore are having challenges in meeting service demand. Local GPs and Child and Youth Mental Health Services have also reported a perceived increase in Autism across the region.

2.4.6 Rural and remote communities

Community and sector representatives involved in local consultations regarding children, youth and families living in rural and remote communities highlighted the lack of prenatal and perinatal health services in regional areas of Brisbane south such as the Southern Moreton Bay, Coochiemudlo, and North Stradbroke Islands.

2.5 Impact of COVID-19

2.5.1 Health status

The recently-released AIHW report on *The first year of COVID-19 in Australia: direct and indirect health effects* noted that there were noteworthy increases in psychological distress for young people than levels observed prior to the pandemic (9.7% in April 2021 compared to 8.4% in February 20017) (AIHW 2021).

Locally, community and sector representatives involved in local consultation regarding the impact of the COVID-19 pandemic on child, youth and family health status highlighted a perceived increase in mental health and domestic and family violence incidents. Moreover, it was suggested that the additional pressure being felt by families due to the pandemic was increasing the complexity and risk in domestic and family violence cases currently being observed. An increase in school refusal since the onset of the pandemic was also reported, with schools seeking further support to address the issue.

2.6 Health priorities and options

2.6.1 Priority unmet needs

Considering the comparative, felt, expressed and normative needs of the Brisbane south region, a number of children, youth and families-related priority unmet needs emerged during prioritisation. In order of priority, as determined through the prioritisation process, these needs included:

1. Priority populations experience higher levels of child, youth and family health needs, including children and families in regional areas, First Nations communities, CALD families, and LGBTQIA+ young people.
2. Maintaining the health and wellbeing of children, youth and families to enhance positive health outcomes and improve quality of life.
3. Working to address the broad range of factors that contribute to mental health challenges of young people in the Brisbane south community.

2.6.2 Current activities

Brisbane South PHN works in partnership with local communities and health system partners to provide several geographically focussed initiatives in the child, youth and family space.

2.6.2.1 Thriving and On Track – Early Childhood Developmental Screening and Allied Health Intervention

Within Brisbane south, there was a higher rate of developmentally vulnerable children compared to the national average. A large proportion of children lived in areas of comparatively higher socio-economic disadvantage, which leads to poor nutrition, lower physical exercise and immunisation coverage, and high developmental vulnerability. In response to this, the *Thriving and On Track* project was established with the aim of increasing access to developmental screening and early intervention services for children aged 2.5 to 3.5 years, in the Logan and Inala areas. The project involves collaboration involves Children's Health Queensland, Department of Education, Logan Together and The Benevolent Society with the Brisbane South PHN. Brisbane South PHN recognises

that timely access to childhood development screenings has the potential to improve health outcomes for children (Brisbane South PHN 2021).

2.6.2.2 Southern Moreton Bay Islands Community Impact Project

The *SMBI (Southern Moreton Bay Islands) Initiative* involves the Brisbane South PHN working closely with the SMBI community to improve health and wellbeing of children aged zero to eight years and maternity care. To achieve this, the delivery of a community-driven, cross-sector, place-based approach will be implemented. The delivery of care to this region is challenging, with a higher-than-average rate of developmentally vulnerable children in the area (Brisbane South PHN 2021). Four focus areas developed are:

- Health and child development, early childhood support and school readiness
- Strong and connected community
- Healthy family relationships and wellbeing programs
- Recreational activities for school-aged children.

2.6.2.3 Recognise, Respond, Refer Domestic and Family Violence

Brisbane South PHN has rolled out the Domestic and Family Violence (DFV) Local Link across the Brisbane south region to support general practices to respond to domestic and family violence. This service offers one-point of referral for patients affected by domestic and family violence, as well as advice and support to enable general practices to better identify and respond to domestic and family violence. DFV Local Link is now available to all general practices in the Brisbane south region (Redlands, Logan, Beaudesert/Jimboomba, Brisbane south areas).

2.6.2.4 Strengthening Health Responses for Children in Out of Home Care

Children and young people in care are a highly vulnerable group with increased physical, mental and social health needs and with limited access to health care services. The Strengthening Health Responses for Children in Out of Home Care build capability and capacity of the sector to better support children in alternative care arrangements to access necessary health and wellbeing assessments.

It is recommended that children in care have:

- a preliminary health check within 30 days of entering care
- a comprehensive health and developmental assessment within 3 months of entering care and annually thereafter
- a health management plan.

2.6.2.5 Birthing in Our Community

Please refer to 4.6.2.3 First Nations current activities for more information on this program.

2.6.2.6 Maternity Shared Care

Shared care is a joint arrangement to provide maternity care between a general practitioner (GP) and a specialist obstetrician or hospital-based obstetric unit. It is an option for women experiencing low-risk pregnancy. In special circumstances, a high-risk woman may be accepted into a shared care program and would require close collaboration between her GP and the hospital. Brisbane South PHN offers consumers to find a Shared Care GP through Metro South Health and Mater Mother's Hospital, as well as useful links and resources for health providers.

2.6.2.7 Post-Natal Home Visiting

The Postnatal Home Visiting Program (PNHV) is an important health promotion strategy and attempts to universally deliver support to all mothers in the BSPHN region and also strategically

seeks to provide support to those least likely to seek and utilise the services. The PNHV aims to continue to expand access to post-natal support services within the first 2 months of a child's life, by providing the general public with access to post-birth home midwifery services.

2.6.2.8 Beaudesert Place-Based Initiative

Brisbane South PHN has identified significant indicators of health and wellbeing need in Beaudesert area (BSPHN Health Needs Assessment, 2018). Further engagement with Beaudesert GPs, Scenic Rim Regional Council, and community service organisations highlighted additional challenges in meeting the mental health needs of people in Beaudesert, particularly for children and young people. A place-based approach was agreed in order to deeply understand, and adapt to, the unique challenges faced by Beaudesert people in accessing mental health supports. The project has been in place since Feb 2021 and works closely with community organisations, community groups, schools, GPs, allied health professionals and community members to address systemic barriers to achieving positive mental health and wellbeing outcomes.

2.6.3 Options for future activity

- Partner, collaborate and lead system reform, delivering measurable and meaningful health and wellbeing impact.
- Integrate and coordinate care systems within a holistic social determinants framework. This may include partnering with system partners such as Education, Local Council, and health partners to support early screening and intervention.
- Support community-led action that delivers sustainable change in health and wellbeing. This may include partnering with local communities of highest need and system partners (such as Education, Local Council, and health partners) to support community-driven change.
- Improve the health and wellbeing outcomes of our community, with a focus on addressing health inequities and inequalities. This will be achieved through a focus on priority populations through the coproduction of services to meet local needs.
- Enable strong and connected primary care to create a person-centred system that improves health access, experiences and outcomes. Options for action may include primary care workforce development and education.

3. Older People

Health and service needs evolve and adapt with an individual as they progress through different stages of life. The transition into older adulthood brings complex challenges that are not experienced by most younger people. The experience of this shift is varied across populations and individuals, yet common challenges include development of geriatric syndromes (delirium, falls, frailty, and incontinence), greater susceptibility to influenza, onset of chronic conditions or increased complexity and associated disability, reduced mobility and independence (WHO 2021d), WHO Collaborating Centre for Reference and Research on Influenza 2020). Older adults are considered as a relatively vulnerable population due to these increased health risks and complexity of needs. If not addressed, this growing population within the region will experience increasing barriers to health services, difficulties accessing high-quality care, and poor health literacy resulting in poor health and wellbeing outcomes for the individual and the population as a whole.

3.1 Strategic environment

3.1.1 National

The *Final Report of the Royal Commission into Aged Care Quality and Safety (Care, Dignity and Respect)* was tabled in Parliament on the 1st of March 2021. The report outlines a clearly articulated purpose which is "To deliver an entitlement to high quality care and support for older people, and to ensure that they receive it. The care and support must be safe and timely and must assist older people to live an active, self-determined and meaningful life in a safe and caring environment that allows for dignified living in old age."
Care, Dignity and Respect outlines 148 wide-ranging recommendations, many of which are either directly or indirectly relevant to the work of Brisbane South PHN. Relevant recommendations in the report include:

- An integrated system for the long-term support and care of older people and their ongoing community engagement.
- Up to date and readily accessible information about care options and services, and care finders to support older people to navigate the aged care system.
- A new aged care program that is responsive to individual circumstances and provides an intuitive care structure, including social supports, respite care, assistive technology and home modification, care at home and residential care. In particular, the new program will provide greater access to care at home, including clearing the home care waiting list.
- A more restorative and preventative approach to care, with increased access to allied health care in both home and residential aged care.
- An Aboriginal and Torres Strait Islander aged care pathway to provide culturally safe and flexible aged care to meet the needs of Aboriginal and Torres Strait Islander people wherever they live.
- Improved access to health care for older people, including a new primary care model, access to multidisciplinary outreach services and a Senior Dental Benefits Scheme.
- Equity of access to services for older people with disability and measures to ensure younger people do not enter or remain in residential aged care.

The Australian Government, with the support of all state and territory governments, has recognised the emerging issue of the abuse of older Australians, and the importance of developing a national strategy to address it. The *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023* (2019) highlights the need to focus on the specific needs of aging Aboriginal and Torres Strait Islander, and culturally and linguistically diverse (CALD) populations. There are five key objectives in the plan:

- Empowering all older Australians to live with their preferred level of autonomy and have a say in decisions that affect their day-to-day life.
- Promoting positive views of ageing in the community.
- Ensuring there's somewhere to turn if an older person needs help to prevent abuse and neglect.
- Developing a nationally consistent approach to identifying and responding to abuse and neglect of older Australians
- Building on our understanding of abuse of older Australians and its effects.

Towards the end of life, older people are likely to require palliative care at some point within their health care journey. It should also be acknowledged that palliative care is not just for older people, it is needed across the life course and at different stages of an illness trajectory (as discussed in 1.2.5.6 Palliative Care). The greatest level of detail has been incorporated into this section, as it is statistically more likely that a higher proportion of older people require palliative care when compared to younger people.

The *National Palliative Care Strategy* (2018) outlines the need to keep the person (both family and carers) at the centre of care and providing a number of key initiatives to meet the needs of the individual, family and carer. Services responses that the *National Palliative Care Strategy* advocates for are:

- Specialist palliative care
- Social, spiritual, cultural, community relationships and organisations
- Community, disability, aged and social services
- Grief and bereavement support
- General Practice and primary care
- Other specialists medical, nursing and allied health care.

3.1.2 State

Queensland Health's *Healthy Ageing: A strategy for older Queenslanders* (2019) aims to 'improve health services for older Queenslanders and keep them well for longer' through achieving a vision of 'good health and wellbeing that matter to older people'. Three key priorities, all of which are relevant to the work of Brisbane South PHN, are a focus within the strategy, including:

- *Staying in good health for longer* — build older persons' capacities to stay independent, well and active in their communities.
- *Person-centred care for older Queenslanders* — adopt holistic person-centred care for older people in hospitals and other care settings.
- *Integrating health and other support services* — adopt integrated models of care to deliver more acute and sub-acute health services in the home and community.

Although there isn't a current Palliative and End-of-Life Care Strategy for Queensland, The Queensland Department of Health has started a consultation and engagement process with Hospital and Health Services, non-government organisations, clinicians, the palliative care sector and

consumers to support the development of a new Palliative and End-of-Life Care Strategy. The Strategy will be pivotal in guiding directions and outcomes for palliative care in Queensland.

The *Queensland Law Reform Commission's report: A legal framework for voluntary assisted dying* recommended a voluntary assisted dying scheme be established to provided additional end of life choice (Queensland Law Reform Commission 2021). Voluntary assisted dying provides dying individuals choice as the timing and circumstances of their death (Queensland Health 2021). A draft bill was introduced to the Queensland Parliament in May 2021, and was passed in September 2021. The scheme will commence on 1 January 2023, following a 15-month implementation period (Queensland Health 2021).

3.1.3 Regional

Brisbane South PHN and Metro South Health are committed to *Brisbane South Older People's Health and Wellness Strategy 2019-2024* (2019) which has a shared 'whole-of-system' vision of 'older people in the Brisbane south region experience a greater quality of life through safe connected and coordinated person centred health care in an age friendly community'. The strategy proposes that the vision will be achieved via the successful delivery of four key priorities:

- Facilitate connected person-centred care
- Enable evidence-based, safe and quality care
- Improve health outcomes for vulnerable communities, and
- Build an aged friendly community.

Additionally, Brisbane South PHN and Metro South Health are also committed to the development of 'a capable, motivated and supported workforce that provides high quality and integrated care for all older people in the Brisbane south region. The *Brisbane South Aged Care Workforce Strategy 2020-2024* (2020) states a number of key priority areas for implementation, including:

- Increasing the capacity and capability of primary care.
- Improving the interface between care setting
- Upskilling residential aged care facility (RACF) and in-home care workforce.
- Attracting and rewarding General Practitioners (GPs).
- Improving gerontic content in clinical training pathways.
- Attracting skilled clinicians in geriatric medicine in both the hospital and community settings.

3.1.4 Sector

In lieu of having a Queensland Palliative and End-of-Life Care Strategy, Palliative Care Queensland released *2021 Palliative Care in Queensland Priorities* (2021), pointing to six key priorities that should be implemented to improve care for people towards the end of life, including:

- Fund and support palliative care to improve sector effectiveness and quality
- Redesign services to ensure equitable and holistic access along the entire palliative care journey
- Work with the community (through the philosophy of public health palliative care) to increase awareness, engagement and partnerships
- Build capacity in the palliative care health workforce to ensure competency, capability and appropriate staffing
- Advance and showcase research, innovation and sector improvements in palliative care

- Promote the role of palliative care in emerging issues, including disaster planning and the deliberation on Voluntary Assisted Dying (VAD) in Queensland

3.2 Health status

3.2.1 Demographic

In 2016, 13% of Brisbane south's population were aged 65 years or older ('older people'), slightly lower than Queensland's 15%. Scenic Rim and Redland LGAs had the highest proportion of older people within the region with 20% and 17% respectively. The greatest number of older people were located in Brisbane LGA, approximately 74,241 persons when scaled to the area located in the PHN region (54%) (Table 62). At a sub-regional level, the Cleveland - Stradbroke SA3 had the largest population of older people, with 16,100 individuals making up 20% of the total SA3 population (QGSO 2018).

Like many areas in Australia, the number of older persons residing in Brisbane south is expected to grow considerably in the coming years. By 2041, it is estimated that 305,528 older persons (more than two times that of the 2016 population) will live in the region, making up 19% of the total population. This is an increase of approximately 6,506 older people per year. Scenic Rim and Redland LGAs are expected to exhibit the highest rates of growth, 29% and 28% respectively. Jimboomba is projected to experience 52% compound annual growth of older people by 2041, almost 2 times higher than the next fastest growing area, Beaudesert (29%) (QGSO 2018).

Table 62. Older adults (65+ years) in Brisbane South PHN region, 2016 and 2041

		Number of older adults, 2016	Proportion of total population, 2016	Projected number of older adults, 2041	Proportion of projected total population, 2041	Growth rate (persons aged 65+ per year)
Queensland		713,653	15%	1,504,173	21%	31,621
Brisbane South PHN[a]		142,890	13%	305,528	19%	6,506
LGA	**Brisbane [b]**	144,028	12%	263,015	17%	4,759
	Logan	36,219	12%	102,303	18%	2,643
	Redland	26,171	17%	54,506	28%	1,133
	Scenic Rim [b]	8,013	20%	19,680	29%	467

a PHN population estimates scaled to include 54% of Brisbane LGA and 34% of Scenic Rim LGA.
b 54% of Brisbane LGA and 34% of Scenic Rim LGA reside within the Brisbane South PHN region. Populations scaled for PHN region but not LGA.

Source: QGSO 2018

3.2.1 Behaviours

Table 63 demonstrates that at a whole of region level, a lower proportion of older persons are consuming alcohol and risky levels compared to the wider Queensland population, yet a slightly higher proportion are daily smokers. Over half (52%) of older persons in Brisbane south engaged in insufficient physical activity levels based on the Department of Health's guidelines (Queensland Health 2020).

Table 63. Health behaviours in older adults, 2019-20

Indicator	Brisbane South PHN		Queensland	
	65-74 years	75+ years	65-74 years	75+ years
Alcohol consumption (Risky lifetime)	15.6%	9.5%	18.9%	10.7%
Current daily smoker	6.9%	4.1%	6.6%	3.0%
Insufficient physical activity	51.8%	-	49.2%	-

Source: Queensland Health 2021

Health Outcomes

Findings from Metro South Health's *What Matters to Bill and Betty - Frail Older Persons Project* (2020) indicate that 49% of Australians aged 65 to 74 years have more than five long-term health conditions, increasing to 70% for people aged 85 years and older.

Self-rated health

In the Brisbane south region, 80.1% of older persons aged 65-74 years self-assessed their health status as excellent, very good, or good; whereas this declined to 73.5% of older adults aged 75+ years (Queensland health 2021).

Frailty and Falls

Frailty is defined as the presence of a multi-system impairment and vulnerability, which can result in decreased resilience to stressor events (Zhang, et al., 2020). As a result of this, frail older adults are at an increased risk of a range of negative health outcomes, such as falls, fractures, disability, dementia, which can further lead to a general poor quality of life, increased costs and use of health resources, and increased rate of hospitalisation (Kojima, et al., 2019).

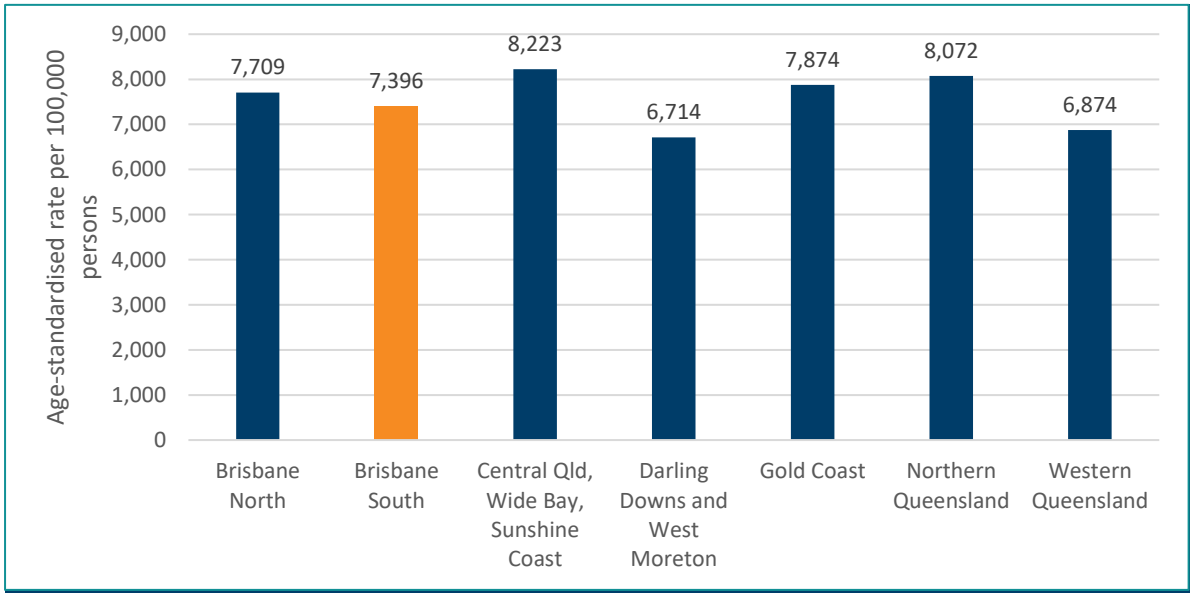

Figure 39. Hospitalisations due to falls in persons aged 65+ years (age-standardised rate per 100,000 persons), 2018-19
Source: Queensland Health 2020

The Brisbane South PHN region demonstrated the third lowest rate of falls across Queensland PHNs (Figure 39).

Dementia and Alzheimer's disease

Dementia refers to a group of symptoms that are caused by disorders that affect the brain and a persons' thinking, behaviour, and abilities to perform everyday tasks. Dementia can occur in younger ages, however, is most common in people aged 65+ years (Dementia Australia 2020). Alzheimer's disease, a condition that causes damage to the brain and impairs memory, thinking, and behaviour, is the most common form of dementia (Dementia Australia 2020). As shown in Figure 40, health care expenditure associated with dementia increases with age to a peak in 75-79 years; with the majority of expenditure noted in people aged 65+ years.

Modelling by Alzheimer's Australia showed Metro South Health region, which largely aligns with the Brisbane South PHN region, has projected the highest dementia prevalence in Queensland between 2011 and 2050 (Stalker & Parkinson, 2018). This is validated with several Brisbane south locations reporting higher rates of overnight hospitalisation for dementia than other regions.

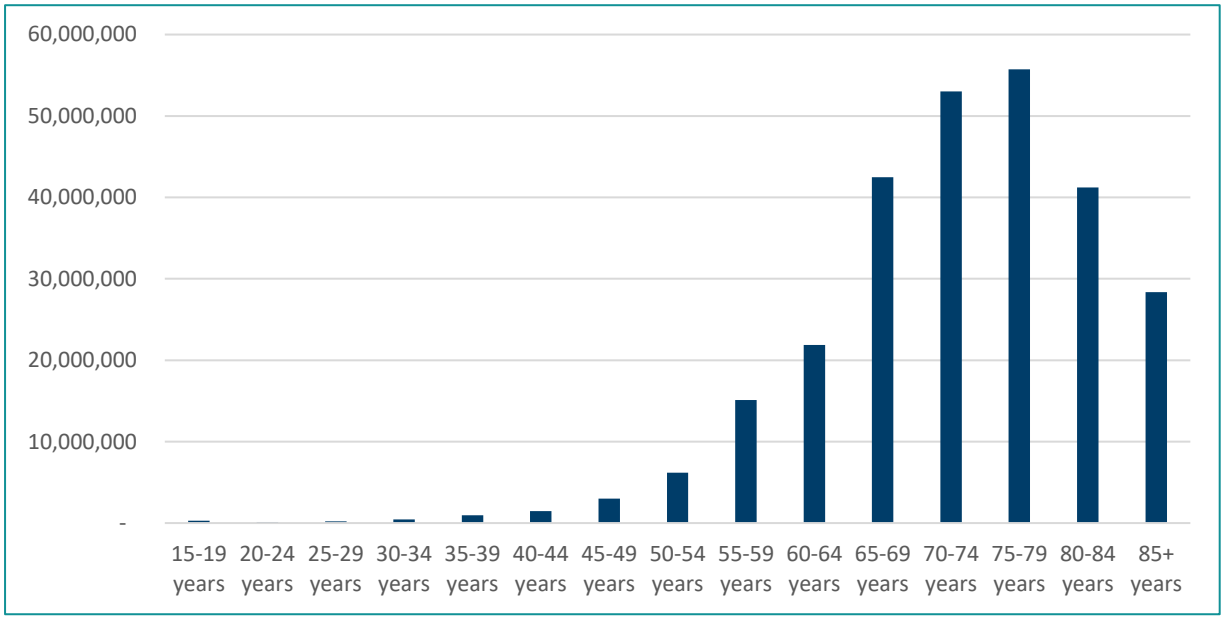

Figure 40. Total healthcare expenditure on Dementia in Australia, by age group, 2018-19
Source: AIHW 2021

Brisbane South PHN's rate of mortality for dementia and Alzheimer's disease was elevated above state and national levels (both 41 ASR per 100,000 persons) at 44 ASR per 100,000 persons. Centenary, Rocklea - Acacia Ridge and Beaudesert had the highest rates of mortality for dementia and Alzheimer's disease within the region (103, 78 and 65 ASR per 100,000 persons respectively) (AIHW 2021).

Parkinson's Disease

Parkinson's disease is a progressive neurological condition that can affect anyone, and is the second-most common neurological condition in Australia. Recent research suggests that more than 100,000 Australians are living with the condition. Three main symptoms are tremors, slowness of movement and rigidity. No cure for Parkinson's currently exists, however treatments that aimed at symptom management allow Parkinson's patients to live a productive and fulfilling life (Parkinson's Australia, 2021).

Figure 41 demonstrates that health expenditure related to Parkinson's disease increase with age, particularly from 75 years onwards. The greatest proportion of expenditure is in public hospital settings, with a notably smaller proportionate cost incurred in the primary care setting (Figure 42).

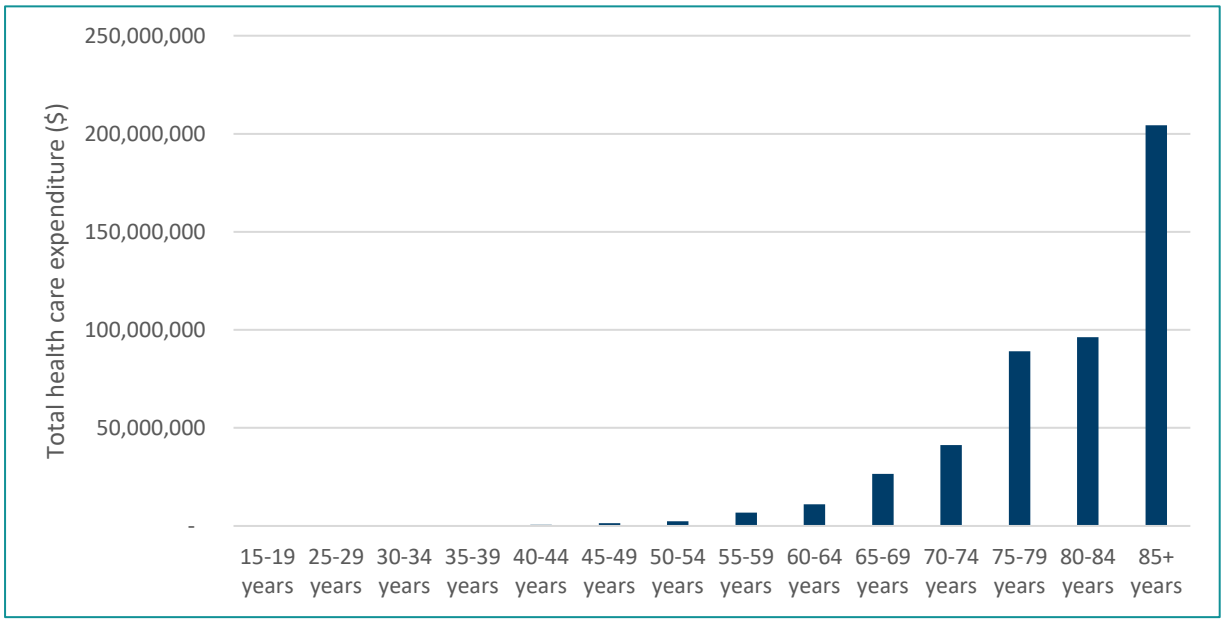

Figure 41. Total healthcare expenditure on Parkinson's disease in Australia, by age group, 2018-19

Source: AIHW 2021

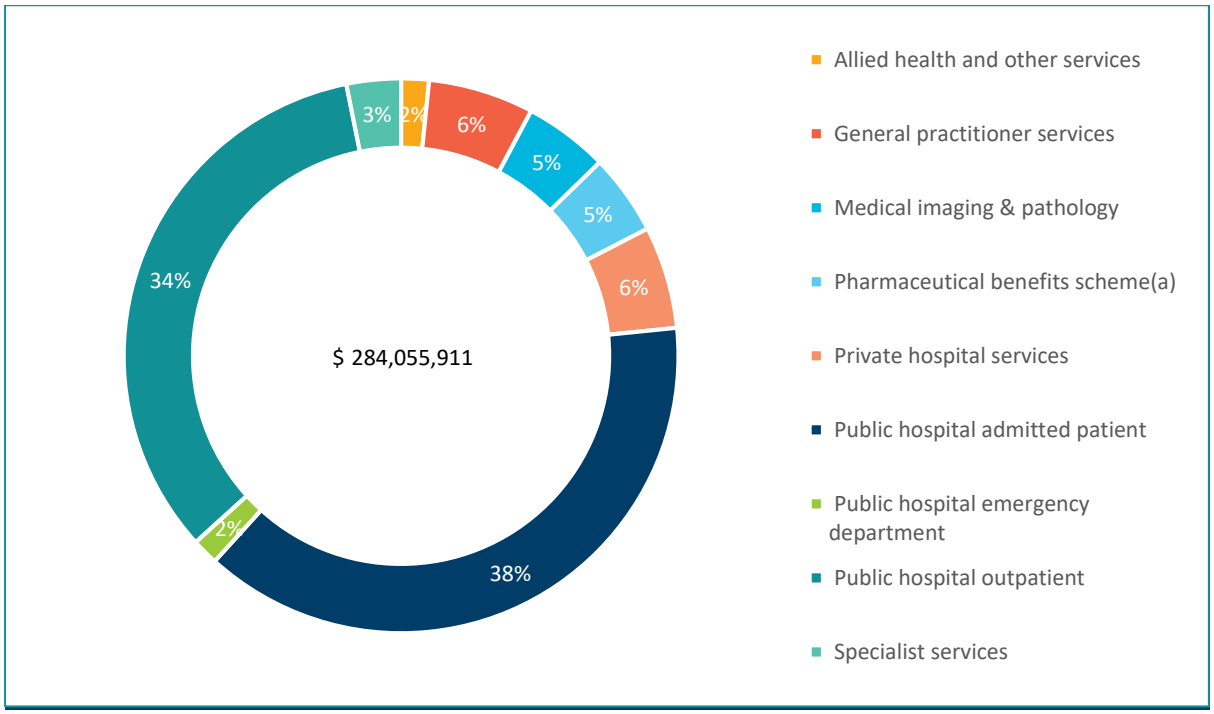

Figure 42. Healthcare expenditure attributable to Parkinson's disease in Australia, by service type, 2018-19

Source: AIHW 2021

Mental Health

While the prevalence of mental health concerns tended to decline in older persons, there were particular sub-groups at higher risk of experiencing mental ill health including older adults in hospital and supported accommodation, people living with dementia, and older carers (AIHW 2018f).

End-of-life and Palliative Care

Six in ten palliative care hospitalisations ended with the patient's death, compared to 4 in 10 for other end-of-life care (AIHW 2021). Half of palliative care (54%) and one-third of other end-of-life care hospitalisations (34%) recorded cancer as the principal diagnosis (AIHW 2021).

Key themes raised by community and sector representatives during local consultation regarding older persons health outcomes included:

- the lack of health literacy regarding the self-administration of insulin.
- the lack of death literacy in the community.
- older people's oral health suffering due to the high out-of-pocket costs associated with care.
- a perceived increase in loneliness and social isolation in older persons.

3.3 Health system

3.3.1 Service utilisation

As the population ages, many health conditions and associated disabilities become more common. Even when the majority of older people consider themselves to be in good health and manage to live independently, health service use increases with age (AIHW 2018g).

3.3.1.1 General practice

As is to be expected, the utilisation rates of GP services across Brisbane south were substantially higher amongst older people. While 2018-19 general population rates of services per 100 people ranged from 432 in Sherwood-Indooroopilly to 817 in Beenleigh, in the over 65s rates ranged from 987 in Sherwood - Indooroopilly to 1,689 in Jimboomba (AIHW 2020i). Figure 43 depicts these rates across the region, with a general trend depicting higher service utilisation, and therefore higher need, in disadvantaged areas (AIHW 2020i).

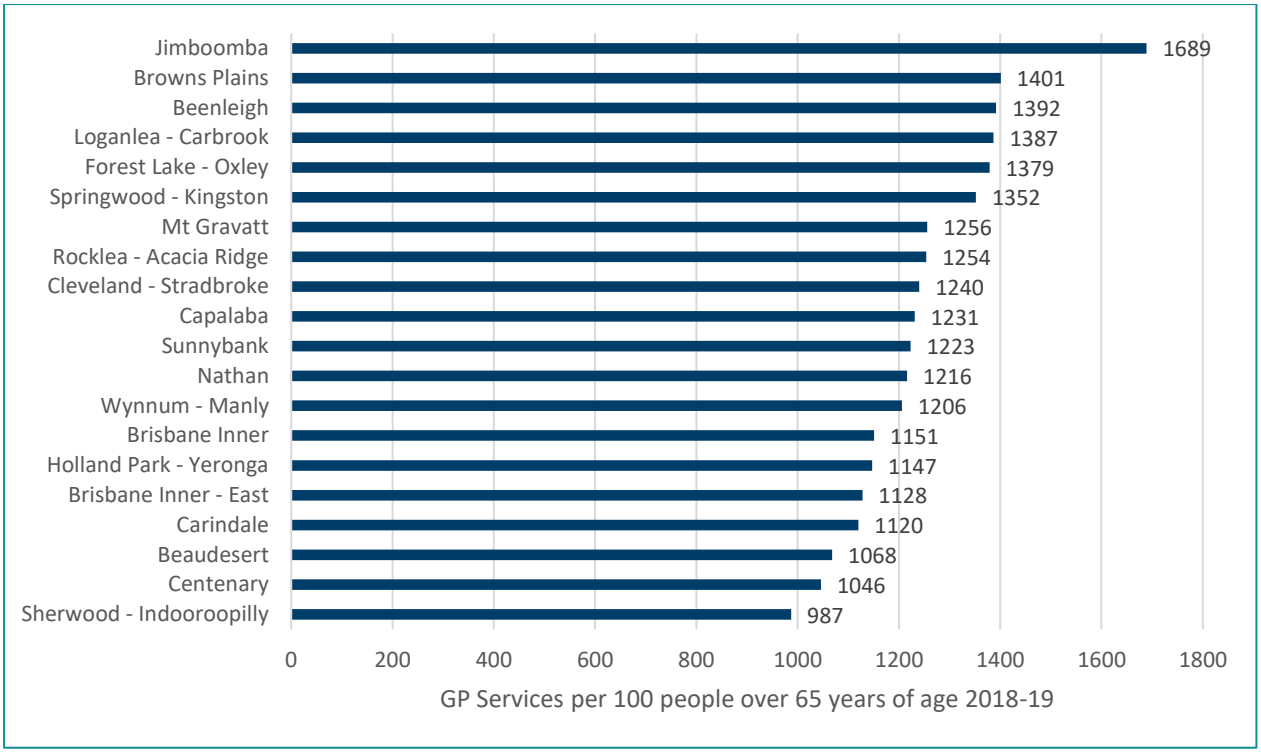

Figure 43. General practice services per 100 persons aged 65 years and over, 2018-19

Source: AIHW 2020i

3.3.1.2 General practice services and aged care residents

The Australian Medical Association estimated there were 27,569 potentially avoidable hospital admissions of aged care residents in the year proceeding 30 June 2021. These admissions are estimated to account for 159,693 bed days at a cost of AUD$312 million. Acknowledging that improved access to GP services in aged care is not only cost-effective but also contributes to a higher quality of care, the 2021-2022 federal budget included a package of incentives for GPs to engage more proactively with people living in residential care (Burke 2021).

On average, residential aged care patients in Brisbane south attended 18.7 GP appointments per year in 2018-19, on par with other Metropolitan PHNs (19.1) across the country and slightly higher than national rates (17.8). GP attendance amongst patients in residential aged care was higher in Brisbane south than in Brisbane North (18.4) but lower than Gold Coast (22.2) (AIHW 2020i).

3.3.1.3 Hospitalisations

Brisbane south had the same rate of overnight hospitalisations for dementia as national levels (both 6 ASR per 10,000 persons). Rocklea – Acacia Ridge (10 ASR per 10,000 persons), Centenary (7 ASR per 10,000 persons), and Loganlea – Carbrook (7 ASR per 10,000 persons) had the highest rates within the region (AIHW 2018f).

3.3.1.4 Aged care

Despite the fact that the vast majority of care and support for older people is provided by relatives and friends, it has been estimated that 80% of older Australians will access some form of government funded aged care service in their lifetime (AIHW 2018h).

The ABS *Disability, Ageing and Carers, Australia: Summary of Findings* report (2019) indicated in 2019 most older Australians lived in households (93.5%), with only 4.6% living in cared

accommodation. Of those older Australians living at home, 1.3 million needed some assistance with everyday activities.

There are a range of aged care supports and services available across the Brisbane south region, from residential care to respite and home care flexible to consumer's needs (AIHW 2021). Aged care service data is provided at Aged Care Planning Region (ACPR) level, of which Brisbane South and Logan River Valley ACPR's reside within the Brisbane South PHN region (Figure 44) (Department of Health 2019i).

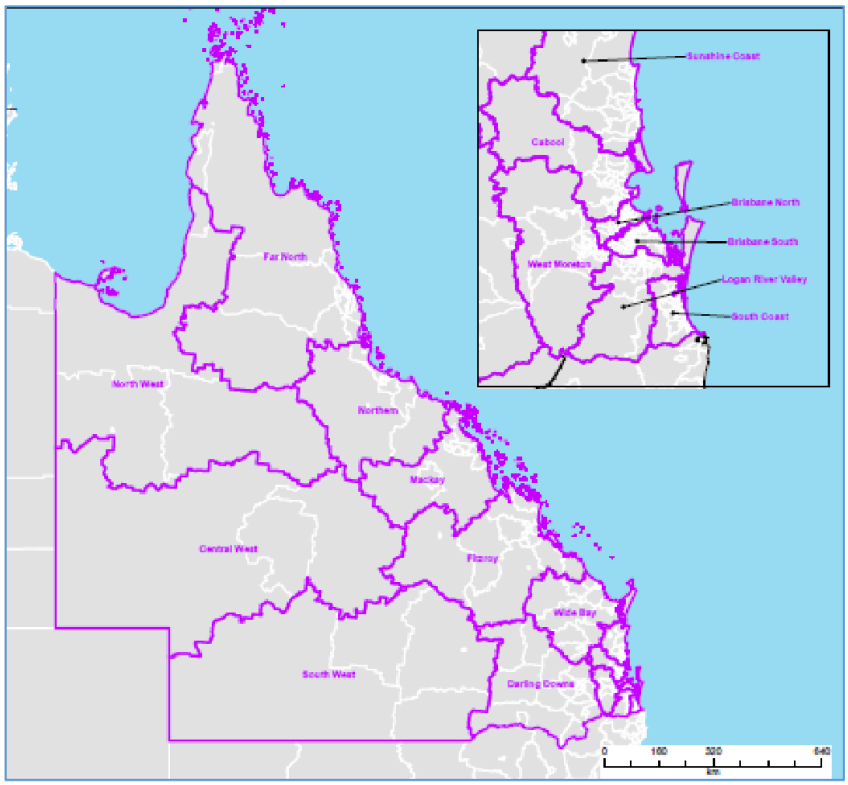

Figure 44. Aged Care Planning Regions in Queensland and South East Queensland

Source: Department of Health 2018

Assessment services

Aged care assessments determine whether an older person is eligible or not for government-subsidised aged care. Assessors visit the person's home or hospital to understand the person's care needs, decide the types of services the person may be eligible for and create a needs-based support plan of care. Comprehensive assessments for people with complex needs are carried out by teams of medical nursing and allied health professionals, called Aged Care Assessment Teams (ACAT), while assessments for lower entry programmes such as the Commonwealth Home Support Program are conducted by Regional Assessment Services (RAS).

Residential aged care

Residential care can be provided on a permanent or respite basis, and provides care and support to older Australians who can no longer live at home due to their ongoing need for help with everyday tasks and/or health care. Residential care services include help with day-to-day tasks such as laundry, personal care and clinical care, amongst others. 24-hour care is also provided to people who need almost complete assistance with most activities of daily living (AIHW 2021).

Residential aged care accounted for the bulk of Australia's aged care expenditure in 2018-19 (66%) despite the fact that the majority of older people would prefer to remain at home with support and Home Care Packages which enable them to maintain their independent living (Department of Health 2018a).

In June 2020, there were 7,964 people living in residential care in Brisbane south. In line with national trends, the vast majority of them (97%) were permanent residents, with similar proportions across the region's two ACPRs (Table 64). Rates of residential aged care residents per 1,000 older persons were higher in Brisbane South ACPR (53) than Logan River Valley ACPR (46) (AIHW 2021).

Table 64. Residential aged care users in Brisbane south, 2020

Region (PHN/ACPR)	Respite	Permanent	Total
Brisbane South PHN	251	7,713	7,964
Brisbane South (ACPR)	185	5,734	5,919
Logan River Valley (ACPR)	66	1,979	2,045

Source: AIHW 2021

Residential aged care is often the final place of residence for older people before death. The Royal Commission into Aged Care Quality and Safety *Final Report* (2021) found that the quality of palliative and end-of-life care expected within residential facilities is often lacking in Australia.

While PHN-level data regarding wait times for aged care services weren't available, records indicate that 42% of older people in Queensland entered residential care within 3 months of their ACAT approval with a median time elapsed of 167 days in 2018-19. The median time elapsed between ACAT approval and entry into residential care at both state and national levels more than quadrupled between 2009 and 2019, with older Queenslanders having to wait longer than their interstate counterparts (Figure 45) (Productivity Commission 2020). Metro South Health's *What Matters to Bill and Betty - Frail Older Persons Project* (2020) report found the most commonly recorded Diagnosis-Related Group (DRG) for occupied beds in acute settings amongst older people was 'Z64 - *Other factors influencing health status'.* This DRG is commonly used for patients waiting for nursing home placements and/or complex social admissions, indicating extended wait times for transfers resulting in inefficient use of acute hospital resources.

The Royal Commission into Aged Care Quality and Safety *'Final Report'* (2021) linked long wait times for accessing services to increased risks of declining function, preventable hospitalisations, carer burnout, premature entry to residential aged care, and death.

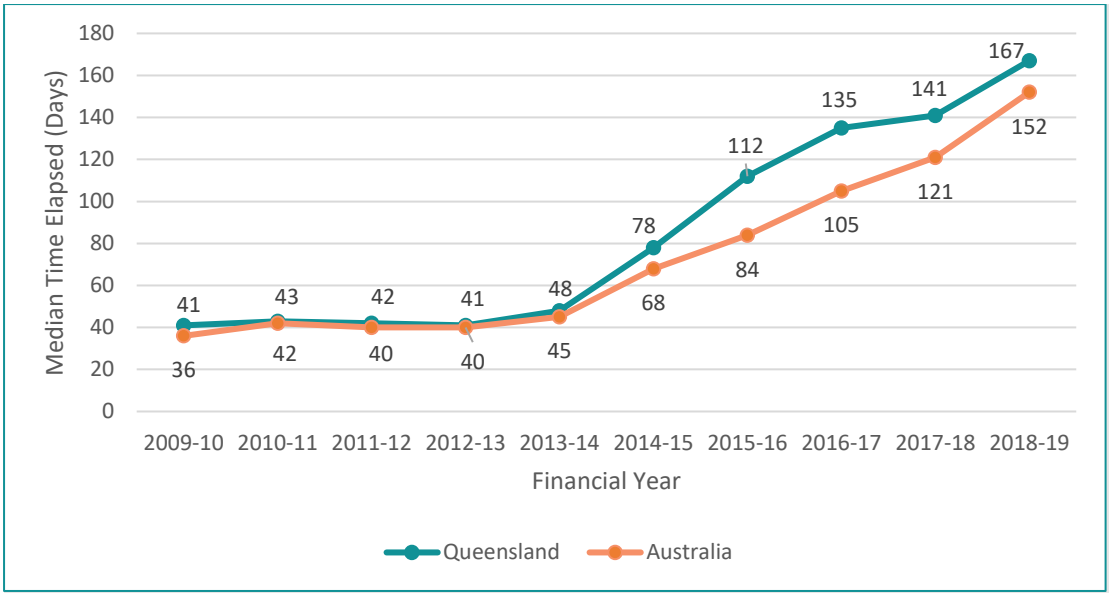

Figure 45. Median time elapsed between ACAT approval and entry into residential aged care services, 2009-19
Source: Productivity Commission 2020

Respite care

Respite care provides short-term support and care services with the primary objective of giving people supported at home and their carers a break from their usual arrangements. Respite care includes a range of services which are flexible to consumers' needs from in-home day and overnight respite to residential respite which provides short-term care in Australian Government subsidised aged care homes on either planned or emergency bases (AIHW 2021).

The Commonwealth Home Support Program

The Commonwealth Home Support Program (CHSP) provides a broad range of entry-level services focused on supporting older people to maintain their health, independence and safety living at home and in the community. It is the most commonly used service by older Australians and includes community and home support such as domestic assistance and meals, care relationships and support such as respite care, and assistance with care and housing for those experiencing or at risk of homelessness (Department of Health 2020b).

Home Care Packages

Home Care Packages often contain many of the same services available from the CHSP but are provided as a more structured and comprehensive service package aiming at supporting people with more complex care needs to live independently in their own homes. Services are tailored to individuals and might include personal care such as bathing, support services such as cleaning and clinical care such as that provided by nurses and allied health professionals. Home Care Packages come in four levels and can provide assistance for basic and low care needs (Home Care Levels 1 and 2), intermediate needs (Home Care Level 3) and high care needs (Home Care Level 4) (AIHW 2021). Although more than two-thirds of people using aged care services in Australia do so from home (Royal Commission into Aged Care Quality and Safety 2021) and access to Home Care Packages continues to increase (19% increase from December 2019 to December 2020), there are still large numbers of people without access to a Home Care Package at their approved level (Department of Health 2021c).

In 2020, there were 5,307 Home Care Package recipients across the Brisbane South PHN region. Level 2 was the most common package (36%), followed by Level 4 (30%), Level 3 (24%) and Level 1

(11%). This was consistent across both Brisbane South and Logan River Valley ACPRs (Table 65) (AIHW 2021). Brisbane South ACPR had higher rates of Home Care Package users, 35 per 1,000 older persons, while Logan River Valley had 30 per 1,000 older persons (AIHW 2021). This may indicate low levels of service literacy and/or access issues in the Logan River Valley region given the known elevated levels of need in this area.

Table 65. People using Home Care Packages in Brisbane south, 2020

Region (PHN/ACPR)	Level 1	Level 2	Level 3	Level 4	Total
Brisbane South PHN	577	1,882	1,256	1,592	5,307
Brisbane South (ACPR)	426	1,410	953	1,201	3,990
Logan River Valley (ACPR)	151	472	303	391	1,317

Source: AIHW 2021

National records indicate the median time elapsed for Home Care Packages in 2018-19 at both state and national levels ranged from 7 months for a Level 1 package to almost 3 years (35 months) for a Level 4 package (Table 65) (Productivity Commission 2020).

Other aged care services

When mainstream residential or home care services are unable to cater for the specific needs of an individual, flexible care options such as transition care or short-term restorative care are also available. Transition Care assists older people in regaining physical and psychosocial functioning following an episode of inpatient hospital care to help maximise independence and avoid premature entry to residential aged care. Short-term restorative care (STRC) is similar to transition care, but is provided to people who have had a setback or decline in function without having been in hospital.

Palliative care

Palliative care is an approach that improves the quality of life of people facing the challenges associated with life-threatening illness. Palliative care is discussed broadly in 1.2.5.6 Palliative care and End of life care.

Palliative care hospitalisations

People aged 75 years and over accounted for just over half of all palliative and end-of-life care patients (54%), with the average patient age at admission being 74 years by comparison to 56 years for hospitalisations for all reasons. One in 10 palliative care and other end-of-life care hospitalisations were for patients aged under 55 years (AIHW 2021).

Palliative care in general practice

Findings of the *Better Evaluation and Care of Health (BEACH)* survey showed there were no significant differences in GP palliative care-related encounter rates between males and females, and approximately 9 in 10 encounters were with people aged 65 years and over. 4.8% of encounters were with patients under 55 years of age (Britt et al 2016).

Palliative care in residential aged care facilities
There is limited data available to estimate the needs and provision rates of palliative care in residential aged care settings. In 2019-20, 1.3% of people living in residential aged care in Australia (3,178) had an Aged Care Funding Instrument appraisal indicating the need for palliative care. Despite this, it is generally accepted that the number of claims involving palliative care is inherently lower than the total number of residents requiring this type of care due to various factors including funding arrangements (AIHW 2021).

3.3.1.5 Elder abuse services

In 2017-18, 3,006 calls were made to elder abuse telephone helplines in Queensland, equating to 27% of national total. 84% of these cases were directly attributable to family and domestic violence, with the most common form of abuse, of which each case can have multiple, being financial (65%) followed by emotional (54%), neglect (14%), physical (12%) and sexual (1%) (AIHW 2019e).

Key themes raised by community and sector representatives during local consultation regarding older people's service utilisation included:

- a general lack of service literacy among both providers and consumers regarding the availability of services and supports in the healthcare and community service systems, especially with regards to palliative care options
- the lack of funding and service availability for those under 65 years of age that require nursing care, especially domiciliary nursing
- a desire among the families of older people for more nurse-led respite care
- witnessing an increase in the demand for Advanced Care Planning in the community
- high rates of emergency department presentations and admissions (62%), especially in Redland and Logan LGAs
- high rates of day surgery admissions, separations and occupied bed days, as well as relatively long lengths of stay among older people
- increasing demand in the community for core palliative care medications to be stocked and sold at pharmacies, with only 20% of pharmacies having signed a Letter of Intent to do so.

3.3.1 Service experience

The ABS *Disability, Ageing and Carers, Australia: Summary of Findings* (2019) report indicated that of the 1.3 million older Australians living at home who needed assistance with everyday activities, only two-thirds (65.9%) had their needs fully met (down from 69.2% in 2015). Almost one-third (31%) reported their needs were partly met, while 3.1% reported their needs were not met at all. Older people were most satisfied with the level to which their 'assistance with reading and writing tasks' and 'meal preparation' needs were met, but least satisfied with the level to which their 'assistance with property maintenance' and 'household chores' needs were met (ABS 2019).

Key themes raised by community and sector representatives during local consultation regarding older people's service experiences included:

- consumers' care being managed clinically by one provider and funded by another, leading to a disjointed, confusing and stressful service experience
- the need for further oversight within RACFs to better support and improve clinical outcomes
- extended wait times for MyAgedCare assessment in general practice settings
- the lack of falls prevention support
- the lack of care coordination and support to navigate the healthcare system

- the inaccessibility of funding for palliative care services
- a lack of affordable and timely diagnostic and specialist services
- fears relating to end-of-life medications and the relatively poor availability of nurses to administer them
- the lack of support available to enable older people to spend their end-of-life at home, increasing familial burden and concern among consumers
- an increasing number of older people being unable to die in their chosen place due to a lack of funding or resources
- the Palliative Care Outcomes Collaborative (PCOC) tool inadequately representing the care clients require or receive
- the mental health and psychosocial support needs of older people not being met by home care services
- the importance of recognising that people aging in residential aged care and in-place at home have different needs
- witnessing a significant proportion of older people not accessing services due to cost and/or transport difficulties
- long wait times in emergency departments, with approximately 49% of older people's presentations meeting Queensland Health emergency department criteria for admission or discharge within 4 hours
- consumer experiences of ageism
- the lack of digital health literacy amongst older people.

3.3.1 Service mapping

3.3.3.1 Aged care

As of September 2021, there were three RAS organisations with 14 supporting sub-contractors in the Brisbane South ACPR while Logan River Valley had only two RAS organisations with two supporting sub-contractors (Department of Health 2021d).

Across the Brisbane South PHN region in 2020 there were 96 residential care services, 106 home care service providers and 124 home support services. The geographic distribution of providers was equitable to the geographic distribution of older people throughout the region with Brisbane South ACPR accounting for 71% of providers and 72% of older people while Logan River Valley ACPR accounted for 29% of providers and 28% of older people (Table 66) (AIHW 2021).

Table 66. Aged care service distribution in Brisbane south

	Region (PHN/ACPR)		
	Brisbane South PHN	Brisbane South ACPR	Logan River Valley ACPR
Population of older people			
Number	157,073	112,697	44,376
Proportion [(a)]	100%	72%	28%
Residential care			
Number	96	72	24
Proportion [(a)]	100%	75%	25%
Home care			
Number	106	80	26
Proportion [(a)]	100%	75%	25%
Home support			
Number	124	80	44
Proportion [(a)]	100%	65%	35%
Total aged care services			
Number	326	232	71
Proportion [(a)]	100%	71%	29%

(a) Proportion of Brisbane South PHN availability

Source: AIHW 2021

Residential places

As of June 30, 2020, there were 9,168 residential aged care places within the 93 residential aged care facilities (RACFs) in the Brisbane South PHN region. These were made up of 6,735 (73%) in Brisbane South ACPR and 2,433 (27%) in Logan River Valley ACPR. There were 84.3 residential care places per 1,000 persons aged 70 years and over in Brisbane South ACPR with an occupancy rate of 87.9% while Logan River Valley ACPR had 69.9 residential care places per 1,000 persons aged 70 years and an occupancy rate of 81.0% (Table 67) (AIHW 2021).

Table 67. Residential aged care facilities and places in Brisbane south, 2020

Region (PHN/ACPR)	Residential aged care facilities	Residential places	Average number of places per facility	Residential places per 1,000 population aged 70+ years
Brisbane South PHN	93	8,944	96	82.5
Brisbane South (ACPR)	71	6,659	94	84.3
Logan River Valley (ACPR)	22	2,285	104	69.9

Source: Department of Health 2020

The rate of residential aged care places within the PHN region increased from 81.9 (per 1,000 persons aged 70 years and over) in 2017 to 82.5 in 2020, indicating the increase in growth of aged care places is slightly greater than growth in the population of people aged 70 and over. This trend is

similar to that seen at state levels but in contrast to national trends where rates of residential aged care places have been declining (77.2 in 2017 to 74.8 in 2020) (Figure 46) (AIHW 2021).

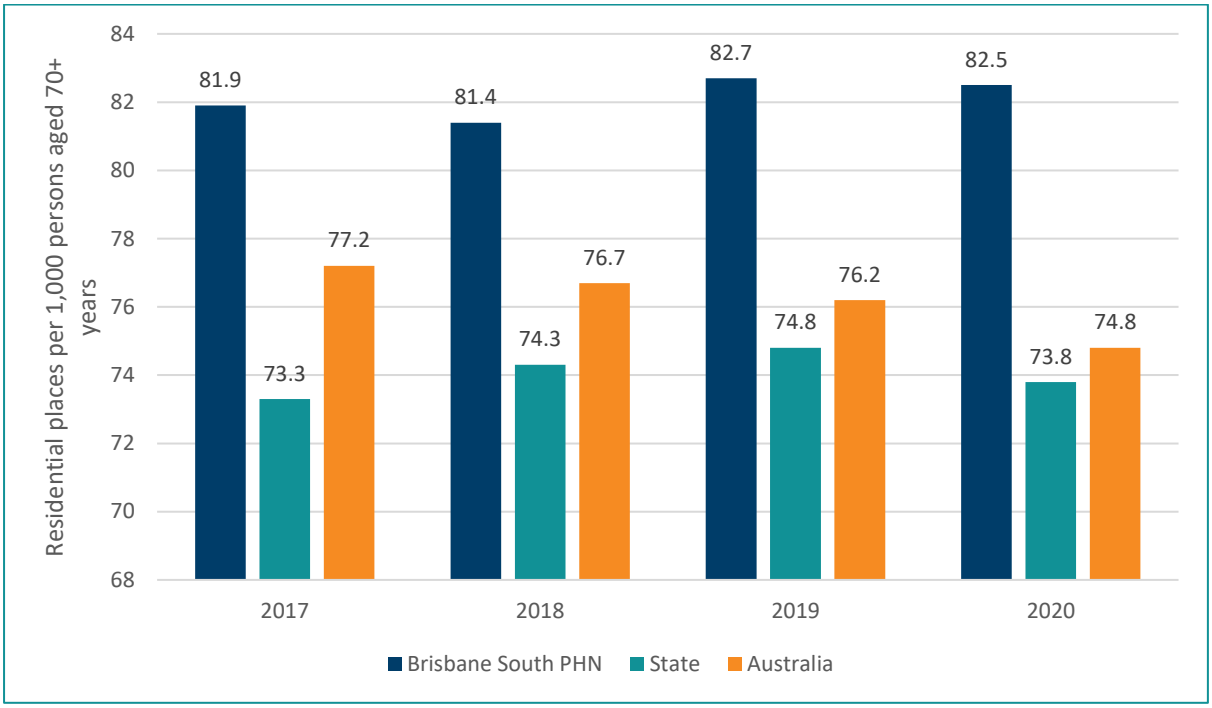

Figure 46. Places in residential care per 1,000 people aged 70 years and older, 2017-2020

Source: AIHW 2021

In 2020, there were on average 96 residential places per aged care facility in Brisbane south, suggesting the average facility is relatively large. Within the region, facilities in the Logan River Valley ACPR had an average of 106 residential places per facility while facilities in Brisbane South ACPR had an average of 94 places (Table 67) (AIHW 2021).

The Royal Commission into Aged Care Quality and Safety *Final Report* (2021) commented that on average RACFs with fewer than 30 beds usually delivered better quality of care.
Key themes raised by community and sector representatives during local consultation regarding older persons service mapping included:

- a lack of hospital and/or respite care options outside of hospital settings
- a lack of public dental services available to older people
- funding for NGOs not being equitably distributed.

3.3.1 Workforce

The *Brisbane South Aged Care Workforce Strategy 2020-2024* documented a number of key workforce issues to be addressed in the aged care sector:

- Increasing demand for aged care services in the Brisbane south region will require continued growth in the size and scale of the aged care workforce. The rate of growth of the aged care workforce observed at a national level is not increasing at a sufficient level to demand projections for the next few decades.
- Most of the demand for aged care services is for in-home care, as people are supported to stay in their own home for longer. When people do enter residential aged care, they tend to be older and have more complex care needs often requiring specialised support.

- Along with an increase in demand for aged care services, Brisbane south region will experience a rise in demand for end-of-life services across the broad aged care sector. High quality end-of-life services in primary care and well-defined pathways and protocols for coordination and integration of care between community and hospital settings are critical to ensure older adults are dying well.
- Several areas in the region will experience particularly high demand for aged care services, including the Statistical Area Level 3s (SA3) of Cleveland-Stradbroke, Capalaba, Mount Gravatt, Springwood/Kingston and Wynnum/Manly.
- The aged care workforce can be broadly defined based on all touchpoints an older person and their carers and families have, ranging from service navigation, assessment, primary care, acute care, in-home and residential aged care, community support and palliative care.
- There is a growing reliance on the vocationally trained personal care workforce, with an associated decrease in the representation of medical, nursing and allied health professionals working directly in aged care.
- Challenges exist with attracting and retaining competent and passionate staff in aged care services, particularly limited by remuneration rates, working hours and shifts, career progression and industry perceptions. Less than a quarter of GPs located in Brisbane south work directly in RACFs. While the number has increased in recent years, industry surveys indicate that many GPs are considering ceasing visiting their patients residing in RACFs in the next few years.
- Many consumers and carers report feeling overwhelmed by the service system, not being listened to by their care providers, and experiencing ageism in their experiences of the aged care and health care systems. In particular, the social, cultural and spiritual needs of Aboriginal and Torres Strait Islander older people, older people from culturally and linguistically diverse (CALD) backgrounds, and older people from LGBTIQ+ communities are not being met.
- A fragmented approach to delivering services across the primary health care, aged care and acute care settings can prevent older people from receiving the right care, in the right place, at the right time.
- There is limited awareness and uptake of new models of multidisciplinary, coordinated care for older people, and new ways of working that incorporate technology. Standard care models are often driven by a medical diagnosis, which limits the opportunity for health maintenance, early intervention and focusing on the broader health and social needs of an older person.

Key themes raised by other community and sector representatives during local consultation regarding the workforce involved in caring for older people included:

- a lack of understanding and expertise regarding dementia, particularly among RACF staff
- the tertiary healthcare system monopolising the recruitment of registered nurses, resulting in community facilities and services being understaffed and/or lacking experience in their workforce.

From a palliative care perspective, across Australia in 2018:

- 271 palliative care physicians and 3,528 palliative care nurses were employed, equating to 1.0 and 12.2 full-time equivalent FTE per 100,000 persons respectively.
- Between 2013 and 2018, there was a 48% increase in the number of employed palliative care physicians and an 8.1% increase in the number of employed palliative care nurses across the country (AIHW 2021).
- 1 in 130 employed medical specialists were palliative medicine physicians and 1 in 95 employed nurses were palliative care nurses (AIHW 2021).
- Nearly three quarters (70%) of employed palliative medicine physicians worked in a hospital setting, compared to 52% of employed palliative care nurses (AIHW 2021).

- Approximately 63% of employed palliative medicine physicians were female, almost twice the proportion of all employed medical specialists (33%) (AIHW 2021).

3.4 Health equity

Community and sector representatives involved in local consultation highlighted the lack of accessible health services for older people in the Brisbane south region, especially in rural and remote areas.

3.4.1 First Nations people

Community and sector representatives involved in local consultation highlighted the lack of access to culturally appropriate aged care services for First Nations people in the region. Further detail is discussed in Section 4. First Nations.

3.4.1 People from multicultural backgrounds

Many older people from multicultural backgrounds face barriers in accessing and engaging with services and are less likely to use them. These barriers include a lack of awareness and knowledge of available services, an inability to navigate system complexities, language barriers, and a lack of culturally and linguistically appropriate aged care providers (Department of Health 2019j).

Across Brisbane south, 21% of residential care and home care package users were born in a non-English speaking country. Brisbane South ACPR had a higher proportion of culturally and linguistically diverse aged care service users than Logan River Valley (Table 68 and Table 69) (AIHW 2021).

Table 68. Users of aged care services in Brisbane south, 2020, by country of birth

Region (PHN/ACPR)	Country of birth							
	Australia		Non-English-speaking country		Other main English-speaking country		Not stated	
	no.	%	no.	%	no.	%	no.	%
Brisbane South PHN	8,562	64	2,802	21	1,840	14	206	2
Brisbane South (ACPR)	6,393	64	2,229	22	1,272	13	154	2
Logan River Valley (ACPR)	2,169	65	573	17	568	17	52	2

Source: AIHW 2021

Table 69. Users of aged care services in Brisbane South, 2020, by language spoken

Region (PHN/ACPR)	English		Other languages		Not stated/ inadequately described	
	no.	%	no.	%	no.	%
Brisbane South PHN	11,872	89	1,338	10	200	1
Brisbane South (ACPR)	8,776	87	1,119	11	153	2
Logan River Valley (ACPR)	3,096	92	219	7	47	1

Source: AIHW 2021

Key themes raised by community and sector representatives during local consultation regarding older people from CALD backgrounds included:

- challenges regarding the perception of mental health within CALD communities including recognising it as a spiritual issue or not recognising it at all
- the lack of access to culturally appropriate aged care services
- challenges providing accessible health information and education
- the importance of engaging trusted community advocates
- additional challenges in navigating the aged care system
- increased reliance on families caring for their elders
- challenges accessing interpreter services, especially in Logan LGA.

3.4.1 LGBTQIA+ community members

Over the past years, there has been an increasing recognition for the need for more inclusive aged care services, particularly to meet the needs of LGBTQIA+ older persons. This is reflected in the *Aged Care Diversity Framework* (Department of Health 2017a).

LGBTIQ+ Health Australia (2021) has undertaken significant work to describe the needs and experiences of LGBTQIA+ elders, including denial of gender identity and systemic discrimination. Older lesbian women and gay men may fear ostracism from other residents and diminished care from staff. Respect was noted as the most common concern for transgender and gender diverse older people, at both an individual health care worker level (such as the use of correct name, salutation, and pronouns), and at a wider organisational policy and procedure level (LGBTIQ+ Health Australia 2020).

3.4.1 People experiencing or at risk of homelessness

One in six homeless Australians on the night of 2016 census were aged 55 or older, equating to around 18,600 people. This is a growing issue for older Australians, likely continuing to increase due to the nationally ageing population and declining rates of home ownership among the population. There is a concern regarding the increasing number of older people who are homeless, or at risk of becoming homeless in Queensland, specifically older women. Older women are becoming homeless, or at risk of becoming homeless, as a result of a number of factors including domestic violence, relationship breakdown, financial difficulty and limited superannuation. It has been shown that homelessness or insecure housing, specifically in older people, can take a toll on the individual's health and emotional wellbeing. Participants of The Ageing on the Edge—The Older Persons Homelessness Persons Prevention Project described their current housing as compromising their health, safety and wellbeing (AIHW 2018i; Fiedler and Faulkner 2020).

3.4.1 People with a disability

Brisbane south had slightly elevated levels of people aged 65 years or older with a profound or severe disability who lived in the community (15%) by comparison to the Australian population (14%). Within the region, Browns Plains (19%), Forest Lake – Oxley (19%), Beenleigh (17%), Jimboomba (17%), and Loganlea – Carbrook (17%) had the highest proportions of people in this demographic (Public Health Information Unit 2021).

Key themes raised by community and sector representatives during local consultation regarding older people with a disability included:

- the complexity of the NDIS system and obtaining Specialist Disability Accommodation (SDA) for older people, especially those with psychosocial disability, posing accessibility challenges
- difficulty identifying GPs that specialise in disability
- the lack of care coordination and service navigation support for adults with disability
- the lack of communication and understanding of consumer's needs
- older people receiving NDIS support not having consistent/regular staff
- the lack of understanding and expertise amongst the aged care workforce with regards to psychological services, especially regarding intellectual disability
- the need for workforce training (especially amongst GPs) regarding disability with key focus areas to include communication, gap payments, providing information in an appropriate manner, and building trust and rapport.

3.4.1 Rural and remote communities

It has been noted earlier that Cleveland – Stradbroke SA3 had the highest number of older persons within the region. Of particular consideration within this population group are those older persons residing on the Southern Moreton Bay Islands and North Stradbroke Island. The population on these Islands had a considerably higher median age compared to the wider Cleveland – Stradbroke SA3 population, Queensland and national median ages (Figure 47) and higher proportions of peoples aged 65+ years (Figure 48).

These figures indicate an increasing need to optimise transportation and health service availability to an ageing population in these remote areas.

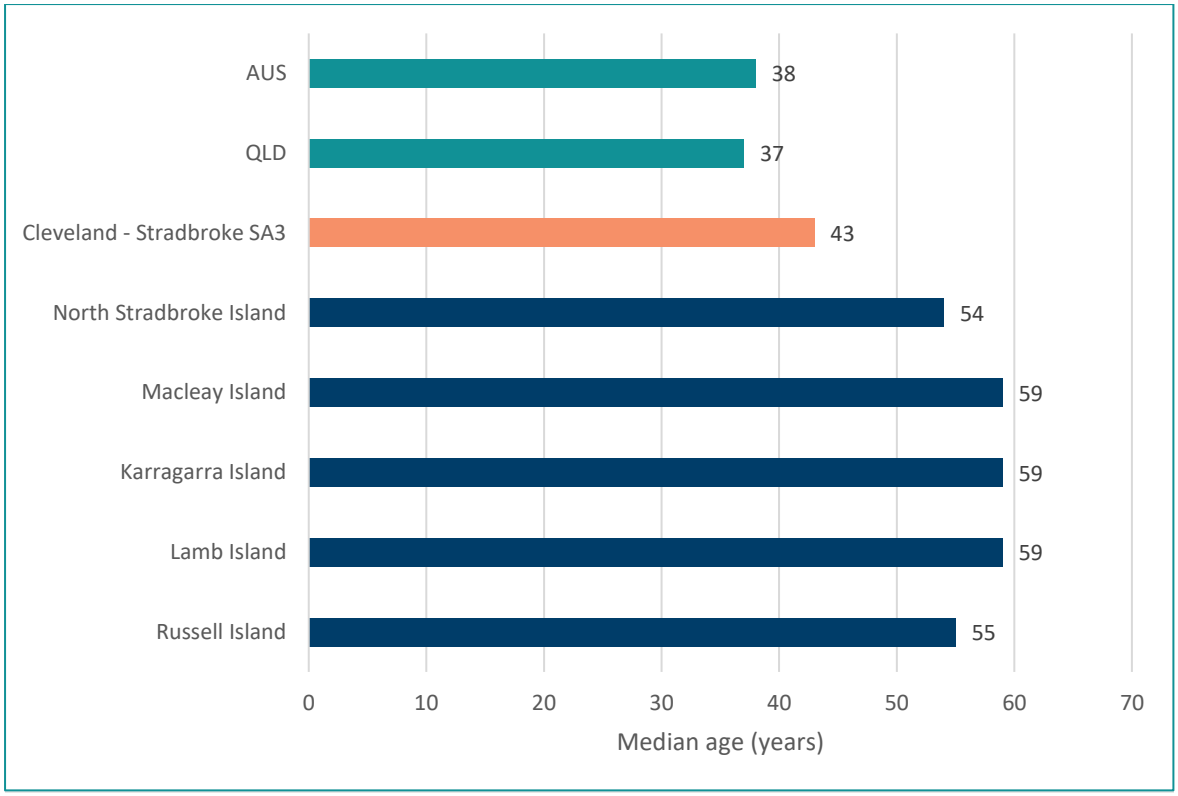

Figure 47. Median age comparison of Southern Moreton Bay Islands residents, 2016

Source: ABS 2016

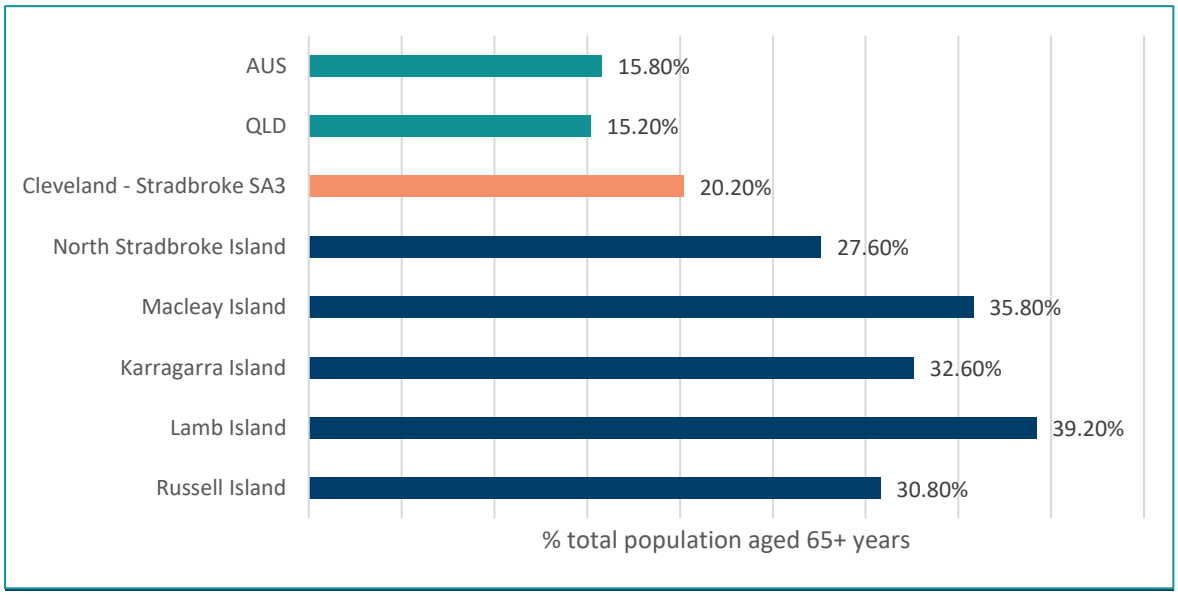

Figure 48. Proportion of older persons residing on Southern Moreton Bay Islands residents, 2016

Source: ABS 2016

Beaudesert SA3 also had an elevated median age (43 years) and higher proportion of older persons aged 65+ years (19.8%) (ABS 2016).

3.5 Impact of COVID-19

3.5.1 Health status

Community and sector representatives involved in local consultations highlighted that COVID-19 pandemic-related lockdowns and restrictions have increased social isolation and negatively impacted the mental health of older people in the Brisbane south community.

3.5.1 Health system

Key themes raised by community and sector representatives during local consultation regarding the impact of the COVID-19 pandemic on older people in the health system included:

- increased fear of hospital settings amongst older people and their families, compounded by COVID-19 restrictions and limited visitation opportunities
- the lack of COVID-19 vaccinations in the aged care sector, and the complex and disjointed nature of the health system acting as a barrier to vaccine roll-out
- witnessing an increase in demand for palliative care services in the community
- challenges within RACFs regarding enforcing visitation rules, obtaining PPE and the transfer of residents between hospitals and facilities increasing the risk of exposure
- visitation restrictions negatively impacting the mental health of people in aged care facilities, resulting in an escalation of negative behaviour.

3.6 Health priorities and options

3.6.1 Priority unmet needs

Considering the comparative, felt, expressed and normative needs of the Brisbane south region, several older people-related priority unmet needs emerged during prioritisation. In order of priority, as determined through the prioritisation process, these needs included:

1. Developing and supporting a skilled and capable workforce as an important enabler of the aged and health care service systems.
2. Continued need for empathetic and high-quality end-of-life planning and palliative care to support the aging population in Brisbane south to age with dignity.
3. Maintaining the health and wellbeing of older people in protecting against negative health outcomes and improving quality of life.

3.6.1 Current activities

3.6.2.1 Aged Care Navigators

Brisbane South PHN is working closely with community organisations to deliver different types of services and activities across the region to help older people learn more about government-supported aged care programs and how to access them. In collaboration with several local services, Brisbane South PHN delivered a number of activities and services including seminars, phone support and group and individual sessions to almost 7000 older people in the region. The outcomes from the program will be evaluated in order to inform future policy considerations and guide implementation of long-term models of aged care support.

3.6.2.2 Greater Choices for at Home Palliative Care

Brisbane South PHN has continued local consultation, since the 2018 Needs Assessment findings, that has reinforced the need to improve access to quality palliative care services, with a focus on at-home service availability. The At Home Palliative Care project aims to improve the provision of

palliative care and end-of-life services for residents in the Brisbane South PHN region, with a focus on greater choice in quality, culturally appropriate, at-home services as outlined in the PHN Greater Choice for At Home Palliative Care Project Activity Summary. Brisbane South PHN seeks to achieve this by improving the at-home care options and integration of care between different care providers within and across sectors relevant to the provision of palliative care services.

3.6.1 Options for future activity

- Partner, collaborate and lead system reform, delivering measurable and meaningful health and wellbeing impact. This may include ongoing formalised partnerships with health and aged care system partners.
- Integrate and coordinate care systems within a holistic social determinants framework. This may include an enhanced focus on reducing barriers to accessing and navigating the health and aged care sectors.
- Support community-led action that delivers sustainable change in health and wellbeing. This may be achieved through the coproduction of services with local communities of need.
- Improve the health and wellbeing outcomes of our community, with a focus on addressing health inequities and inequalities. This may include a focus on priority populations of need and tailored services and capability building of mainstream services.
- Enable strong and connected primary care to create a person-centred system that improves health access, experiences and outcomes. Options to action this may include an increased focus on the uptake of digital health technologies as an enabler for person-centred care, workforce development and education, and inclusive service design models.

4. First Nations Peoples

Australia's First Nations peoples hold the longest continuous cultures globally, having a deep richness of traditions, customs, practice, and culture to share and be valued across the country.

The land, sea and waters of the Brisbane south region are the traditional countries of the **Yuggera** (Ugarapul, Jagera); **Turrbal**; **Quandamooka** / Minjerribah / Moongumpin (Nunukal, Ngughi and Gorenpul) and **Yugambeh** (**Mununjahlii**, Gugingin, Bollogin, Wangerriburra, Minjungbal, Birinburra, Migunberri and Kombumerri) First Nations (and sub-clans). The Brisbane south region is also home to many transient populations of First Nations peoples, people from locations all over Queensland making the region home as they connect with family and friends.

For the First Nations people in Brisbane south, and Australia, colonial history and policy, and its consequential impacts have been devastating on the social and emotional wellbeing of First Nations peoples. These effects of colonisation, forced dispossession, systemic racism, violence, and intergenerational trauma continue to be felt by First Nations peoples. At its heart, reconciliation is a critical underpinning in driving change in the relationships between First Nations and non-First Nations Australians, for the betterment of all Australians (Reconciliation Australia 2020).

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right.

Article 24.1, United Nations General Assembly, Statement of the Rights of Indigenous Peoples.

Reconciliation Australia's five dimensions of Reconciliation are the guiding principles of Brisbane South PHN's Reconciliation Action Plan. They provide the lens through which we commission our programs and initiatives. The first dimension of Reconciliation is **Race Relations.** The vision is for all Australians to understand and value Aboriginal and Torres Strait Islander and non-Indigenous cultures, rights and experiences, which results in stronger relationships based on trust and respect and that is free of racism. Whilst the reasons for the gaps in health outcomes for First Nations peoples are complex and multifactorial, we cannot discuss improving health care measures and health literacy for First Nations peoples without first acknowledging the continuing impact of colonisation, interpersonal and institutional racism, and the resulting health and social impacts of poverty, trauma, addiction, housing shortages, poorer education outcomes, unemployment, and the lack of social supports that impact our people to this day.

In a 2019 survey into cultural safety in healthcare from the AIHW, over one-third of surveyed First Nation participants reported that they had not sought necessary health care due to previously experiencing racism or cultural discrimination in a health care setting.

In short: racism still exists in our health care services today and it is harming First Nations patients. Until all Australians understand and value Aboriginal and Torres Strait Islander cultures, rights, and experiences, we are poorer for it as a nation.

Part of the work we do to dismantle institutionalised racism is the proactive cultivation of strong working relationships with Aboriginal and Torres Strait Islander Community Controlled Health Organisations. These organisations support the needs of their communities through asset-based, holistic and decolonising approaches. Their approaches privilege Aboriginal and Torres Strait Islander ways of knowing, being and doing, and build on the positive characteristics and resources of the community.

The second dimension of Reconciliation is **Equity and Equality** – that Aboriginal and Torres Strait Islander peoples participate equally in a range of life opportunities and the unique rights of Aboriginal and Torres Strait Islander peoples are recognised and upheld.

Brisbane South PHN recognises the importance of self-determination to advance equitable care, and improve health outcomes. Without self-determination – the right to determine one's own social, cultural, and economic development – it's not possible for First Australians to fully overcome the legacy of colonisation and dispossession that impacts health outcomes today.

The third dimension of reconciliation is **Institutional Integrity**. It is the vision that our political, business and community institutions actively support all dimensions of reconciliation. Brisbane South PHN are proud to be preparing our third Reconciliation Action Plan which identifies the next three years of progressive action towards reconciliation efforts within our organisation.

The fourth dimension of reconciliation is **Unity**. The vision is that Aboriginal and Torres Strait Islander histories, cultures and rights are a valued and recognised part of a shared national identity and, as a result, there is national unity. This is achieved through the fifth and final dimension of **Historical Acceptance** – whereby we fully acknowledge our past through education and understanding.

4.1 Strategic environment

4.1.1 National

The *National Agreement on Closing the Gap 2019-29* recognises that whole-of-population (mainstream) approaches have failed to deliver equitable outcomes for First Nations peoples. This Agreement states that focusing investment, wherever possible, through well-governed and accountable community-controlled services is fundamental to reducing the gap in life expectancy that persists between First Nations and the wider Australian populations.

The *National Strategic Framework for Aboriginal and Torres Strait Islander People's Social and Emotional Wellbeing 2017-2023* describes the necessity for health to be viewed holistically, encompassing physical, spiritual, and mental health, connection to land, and connection to kin. This Framework highlights the crucial underpinnings of self-determination and culturally valid understandings informing the development and delivery of health care services.

The *Indigenous Australians' Health Programme* provides funding to First Nations health services to coordinate health care for Aboriginal and Torres Strait Islander people. Through doing so, the Indigenous Australians' Health Programme aims to provide improved access to high-quality and culturally-safe primary health care services, resulting in improving overall health and wellbeing and reducing hospital admissions (Australian Government 2021).

The national-level agreements and programs are monitored and reported against the *Aboriginal and Torres Strait Islander Health Performance Framework.* This Framework monitors a series of

indicators related to health status, social determinants of health, and health system performance, with a specific focus on First Nations peoples and services.

4.1.2 State

The *Queensland Department of Health Strategic Plan 2021-2025* identifies an ongoing commitment to working with First Nations Peoples; highlighting the need to drive health access and equity through the health reform agenda.

The *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026* recognises the significant importance of developing and supporting a First Nations workforce to enhance the cultural capability and safety of health care services provided throughout the state. This Strategic Framework identifies a number of priorities for action, including:

- Increasing the numbers of First Nations peoples entering and remaining within the health workforce
- Culturally-tailored and appropriate recruitment and retention processes
- Development and sustainment of partnerships to enhance professional development on ongoing learning opportunities
- Provision of leadership and planning development opportunities.

4.1.3 Regional

The *Metro South Health Strategic Plan 2021-2025*, similarly to the Queensland Department of Health Strategic Plan 2021-2025 identifies the need to specifically focus on providing equitable access to high quality health care, with an emphasis on reducing the gap in rates of potentially preventable hospitalisations related to diabetes. Further, the Metro South Health Equity and Access Unit is a dedicated business unit that works to ensure that Metro South Health offer equitable, accessible, and culturally-appropriate services through a focus on several communities including First Nations peoples.

4.1.4 Sector

The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national leadership body for Aboriginal Community Controlled Health Organisations across Australia. NACCHO provide guidance and advice to the Australian Government, and advocates for community-developed solutions that will improve the health and wellbeing of First Nations peoples (NACCHO 2021).

The Queensland Aboriginal and Islander Health Council (QUAIHC) is Queensland's peak body for Aboriginal and Torres Strait Islander Community Controlled Health Organisations. QUAIHC's strategic priorities include enhancing the delivery of comprehensive primary health care for First Nations people and building the capability of mainstream service providers to provide culturally appropriate and safe health care (QUAIHC 2016).

4.2 Health status

4.2.1 Demography

The Australian Bureau of Statics 2016 Census indicated that approximately 23,100 people in Brisbane south (approximately 2% of the total population) identified as either Aboriginal, Torres Strait Islander, or Aboriginal and Torres Strait Islander. This represents a relative lower proportion of First Nations people in the region compared to the state-wide proportion of 4%. Despite this, Brisbane South PHN had the largest urban First Nations population among Australia's metropolitan PHNs, and the tenth largest among all PHNs nationally (Table 70) (ABS 2016).

Table 70. First Nations population across PHNs, 2016

Rank	PHN	Classification	Number of First Nations persons	Proportion of total First Nations persons in Australia
1	Northern Queensland	Regional	68,071	11%
2	Hunter New England and Central Coast	Regional	64,942	10%
3	Northern Territory	Regional	57,525	9%
4	Country WA	Regional	43,914	7%
5	Western NSW	Regional	31,104	5%
6	Central Queensland, Wide Bay, Sunshine Coast	Regional	29,539	5%
7	North Coast NSW	Regional	24,996	4%
8	Darling Downs and West Moreton	Regional	24,544	4%
9	Tasmania	Regional	23,330	4%
10	**Brisbane South**	**Metropolitan**	**23,122**	**2%**

Source: ABS 2016

4.2.1.1 Children and young people

In 2016, Brisbane south's First Nations population was relatively young, with children and adolescents (inclusive of those aged 0 - 24 years) comprising 56% of the First Nations population (PHIDU 2021). By comparison, 33% of Brisbane south's total population were children and young people in 2019 (ABS 2020). Brisbane south's First Nations population had a relatively high birth rate, constituting 3% of the region's total births in 2016-17, which would be a contributing factor in the high proportion of children and young people observed in the First Nations population (Table 72) (ABS 2016).

Of the 15,800 First Nations children and adolescents who called Brisbane south home, almost half (45%) resided in Logan Indigenous Area (IARE). A further 38% resided in Brisbane City (part b) IARE, 14% in Redland IARE and 3% in Beaudesert - Boonah (part a) (PHIDU 2021).

4.2.1.2 Older people

Brisbane south's First Nations communities had a notably lower proportion of older people (aged 55 years and over) than the total population. Approximately 9% of First Nations people in the region were aged 55 years or older in 2016 (PHIDU 2021), by comparison to 24% of the total population in 2019 (ABS 2020). Gender distribution of older First Nations people was approximately 45% males and 55% females (Table 71) (PHIDU 2021).

Redland IARE had the highest proportion of older First Nations peoples, making up 12% of the First Nations population in that region; while Logan IARE had the lowest proportion at 8% (Table 71) (PHIDU 2021).

Table 71. Geographical distribution of First Nations people, by age group

Age group	Proportion of First Nations people				
	Brisbane South PHN	IARE/s with highest proportion of First Nations people in Brisbane south	IARE proportion of First Nations people	Queensland	Australia
0 - 4 years	12%	Logan	14%	12%	12%
5 - 9 years	12%	Beaudesert - Boonah (part a)	16%	12%	12%
10 - 24 years	32%	Logan	33%	31%	30%
25 - 54 years	35%	Brisbane City (part b)	39%	34%	35%
55+ years	9%	Redland	12%	10%	11%
Proportion of total population	2%	Logan	4%	5%	3%

Source: PHIDU 2021

4.2.2 Community strengths

Brisbane South PHN held a First Nations Forum to engage with key system and sector partners to discuss the health and system needs for First Nations peoples in the region.
Key strengths that were identified within the Brisbane south region included:

- the First Nations-specific models of care that are in place across the region
- the cohesiveness and collective drive of community organisations which lead to positive outcomes during the COVID-19 pandemic in 2020 and early 2021
- First Nations outreach services supporting social connectedness, people's sense of belonging, culture, spirituality and ancestry
- culture as a protective factor at the centre of healing.

4.2.3 Behaviours

First Nations people experience health inequity for a variety of reasons. It is acknowledged that First Nations people are best placed to define what their health needs are and what solutions are most appropriate in meeting these needs (Queensland Health 2020).

The inequality experienced by First Nations people across Australia is equally evidenced in the Brisbane south region and Queensland. When considering the behavioural factors impacting the health needs of First Nations people in these two regions, most outcomes were poor compared with State or National data (Table 72).

First Nations persons in Queensland were much more likely to smoke daily (45%), exceed single occasion risk for alcohol consumption (59%) (Queensland Health 2016), use illicit drugs (25%) and be obese (40%) (AIHW 2020p) than their non-First Nations peers. Similar to the broader population, adult males (35%) in First Nations communities were significantly more likely to report using illicit drugs in the previous 12 months than adult females (16%) (Table 72) (AIHW 2020q).

Within Brisbane south, 39% First Nations mothers across all age categories smoked during pregnancy by comparison to 12% of pregnant mothers 29 years and under, and 5% aged 30 years and over in the general population (Department of Health 2017b). 60% of First Nations children aged 0 to 14 years in Queensland live in households with a daily smoker (AIHW 2020q). In addition, only 1 in 2 (52%) First Nations mothers reported attending at least one antenatal visit in their first trimester by comparison to 71% in all pregnant mothers (Table 72) (AIHW 2018d).

Positively, the proportion of First Nations mothers who smoked during pregnancy in Brisbane south (39%) was lower than both Queensland (47%) and Australian (43%) rates (PHIDU 2021), and First Nations children within the region had high rates of full immunisation at 5 years of age (96%) (Table 72).

Table 72. Health behaviours in First Nations peoples, Brisbane South PHN and Queensland

Indicator	Proportion of population (%)	Benchmark
Brisbane South PHN		
First Nations mothers who smoked during pregnancy (%)	39%	QLD: 47% AUS: 43%
First Nations mothers aged 29 years or under who smoked during pregnancy (%)	39%	Non-First Nations BSPHN: 12%
First Nations mothers aged 30 years or older who smoked during pregnancy (%)	39%	Non-First Nations BSPHN: 5%
First Nations children who were fully immunised at 5 years of age (%)	96%	Queensland: 97% Australia: 97%
First Nations mothers with at least one antenatal visit in the first trimester (%)	52%	Australia: 54%
First Nations adults aged 18-64 years performing insufficient physical activity (%)	62%	Non-First Nations BSPHN: 41%
Queensland		
First Nations persons who smoked daily (%)	45%	Non-First Nations QLD: 11%
First Nations children aged 0 - 14 years living in households with a daily smoker (%)	60%	-
First Nations persons who report using illicit substances in the past 12 months (%)	25%	Australia: 27% Non-First Nations QLD: 16%
First Nations males who report using illicit substances in the past 12 months (%)	35%	Females: 16%
First Nations persons exceeding single occasion risk for alcohol consumption (%)	59%	Non-First Nations QLD: 46%
First Nations persons who were obese (%)	40%	Non-First Nations QLD: 25%
First Nations children aged 5 - 17 years who were obese (%)	13%	-

Source: PHIDU 2021

4.2.4 Outcomes

The gap in health outcomes between First Nations and non-First Nations Australians is considerable and has been identified by United Nations committees as a human rights concern. The Australian Government acknowledged this inequity and recognises 'closing the gap' as a priority (Calma 2017).

4.2.4.1 Self-reported health status

Comparing the self-assessed health status of First Nations people residing in Queensland, it is reasonable to assume First Nations persons living in Brisbane south perceive their health similarly or

slightly better than others across the country (Figure 49). At a national level, 65% of First Nations persons with no long-term health conditions reported their health as 'excellent/very good'. Self-reported health status of 'excellent/very good' decreased with the addition of long-term health conditions, with only 30% First Nations people with 3 or more conditions rating their health this way. Almost two fifths of First Nations people with three or more long-term health conditions rated their health status as 'poor' (Figure 50) (AIHW 2017c).

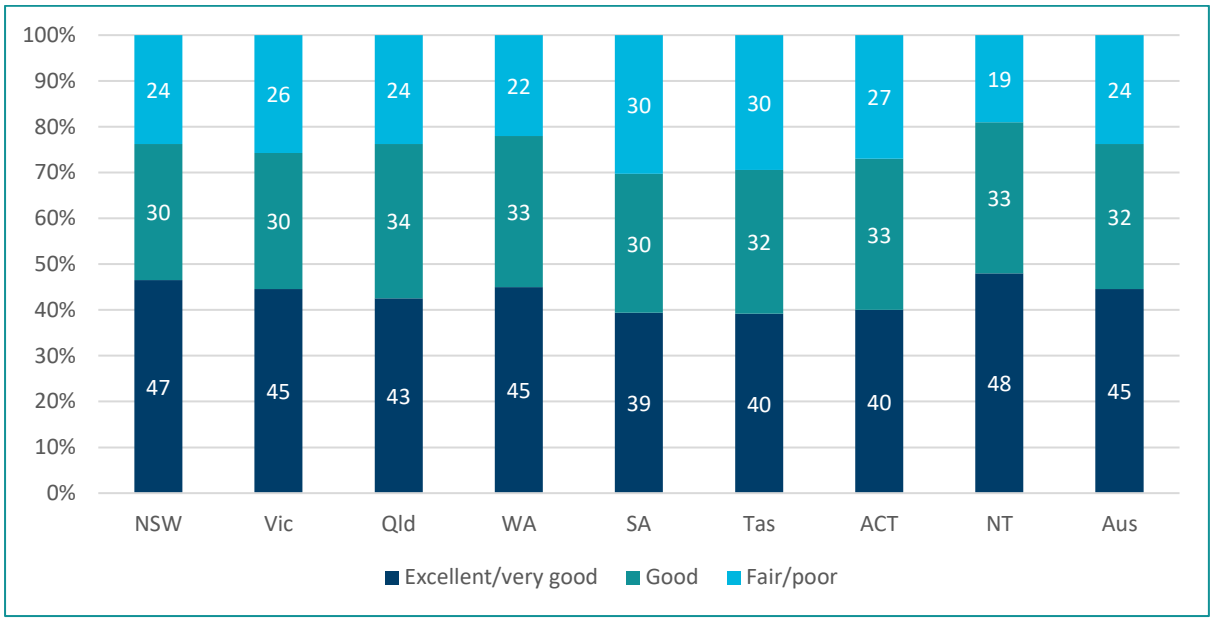

Figure 49. Self-assessed health status, Indigenous Australians aged 15 and over, by jurisdiction, 2018-19
Source: Table D1.17.8 AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018-19

Figure 50. Self-assessed health status of Indigenous Australians aged 15 and over, by number of long-term health conditions, 2018-19
Source: Table D1.17.8 AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018-19

4.2.4.2 Hospital admissions

While hospital admissions among First Nations people in Brisbane south were lower than state and national levels in most categories, admission for mental health-related conditions, chronic asthma and iron deficiency anaemia were elevated. In particular, Brisbane City (part b) IARE had very high ASRs of admission for mental health related conditions per 100,000 persons (3,645, BSPHN: 2,824, QLD: 2,528) while Logan IARE had high rates of admission for chronic asthma (281, BSPHN: 320, QLD: 281) and iron deficiency anaemia (260, BSPHN: 216, QLD: 200) (Table 73) (PHIDU 2021).

Table 73. Hospital admissions for First Nations persons in Brisbane south region

Indicator	Result				
	Brisbane South PHN	IARE/s with most unfavourable result in the BSPHN region	IARE result	Queensland	Australia
Admissions for mental health related conditions(b)	2,824	Brisbane City (part b)	3,645	2,528	2,627
Admissions for dialysis for kidney disease(b)	11,339	Logan	15,509	21,065	27,142
Admissions for chronic angina(b)	156	Brisbane City (part b)	197	217	178
Admissions for chronic asthma(b)	320	Brisbane City (part b)	381	281	244
Admissions for chronic congestive heart failure(b)	188	Redland	230	242	248
Admissions for COPD(b)	446	Beaudesert - Boonah (part a)	527	518	583
Admissions for chronic diabetes complications(b)	318	Logan	388	469	421
Admissions for iron deficiency anaemia(b)	216	Logan	260	200	189
Admissions for other chronic conditions(b)	118	Logan	183	184	199
Admissions for all chronic conditions(b)	1,765	Logan	1,940	2,114	2,062

a. Among persons aged 0 to 74 years
b. ASR per 100,000 persons
Source: PHIDU 2021.

4.2.4.3 Burden of disease and injury

Mental and substance use disorders were the leading broad cause of health loss among First Nations Australians, attributed 21% of total loss, followed by injuries (13%), cardiovascular disease (11%) and cancers (10%). Injuries, cardiovascular disease and cancers were also the top 3 contributors to premature death burden, attributed 22%, 19% and 18% of total burden respectively. Mental and substance use disorders contributed the majority of disability burden (41%) (AIHW 2011).

While chronic kidney disease was not in the top conditions contributing to burden of disease, First Nations Australians experienced 7.3 times higher disease burden from the condition compared with non-First Nations Australians. Chronic kidney disease was 2.1 times more prevalent among First Nations people than non-First Nations people, and First Nations persons were 5 times more likely to be hospitalised for the condition, excluding for dialysis (Table 74) (AIHW 2018b).

First Nations persons in Queensland experienced 2.7 times higher fatal burden of disease (years of life lost) and 1.4 times higher non-fatal burden of disease (years lived with disability) attributed to musculoskeletal conditions compared to non-First Nations Australians (AIHW 2011).

Table 74. Burden of disease and injury in First Nations persons in Queensland

Contributing factor/disease	Burden (%)
Broad causes of health loss	
Mental and substance use disorders	21%
Injuries	13%
Cardiovascular disease	11%
Cancers	10%
Musculoskeletal conditions	7%
Premature death burden	
Injuries	22%
Cardiovascular disease	19%
Cancers	18%
Disability burden	
Mental and substance use disorders	41%
Musculoskeletal	14%
Respiratory conditions	11%

Source: AIHW 2011

4.2.4.4 Deaths

The all-cause death rate (age-standardised rate, ASR) of First Nations Australians was 54% higher than non-First Nations Australians in 2014 (Queensland Health 2016), with the death rate attributed to chronic diseases 2.5 times higher in First Nations persons than non-First Nations persons (AIHW 2019a). Coronary heart disease, diabetes and chronic lower respiratory disease were the leading

causes of death amongst First Nations persons, all of which were experienced at rates higher compared to non-First Nations peoples; 1.5 times, 5.2 times and 2.9 times respectively (Table 75) (Queensland Health 2016). Additionally, First Nations peoples were 3.7 more likely to die from chronic kidney disease than their non-First Nations counterparts (AIHW 2018b).

Table 75. Causes of death of First Nations persons in Queensland

Cause of death	Benchmark (Non-First Nations Australians)
All cause	1.54 times higher than non-First Nations ASR
All chronic diseases	2.5 times higher than non-First Nations ASR
Top 5 causes of death	
Coronary heart disease	1.5 times higher than non-First Nations ASR
Diabetes	5.2 times higher than non-First Nations ASR
Chronic lower respiratory disease	2.9 times higher than non-First Nations ASR
Lung cancer	1.7 times higher than non-First Nations ASR
Self-harm and suicide	1.6 times higher than non-First Nations ASR

Source: *Queensland Health 2016, AIHW 2019a*

Infant mortality

The rate of infant mortality is high within First Nations populations. While data wasn't available at PHN level, it is known that the rate of infant mortality among First Nations people is higher in Queensland (7 per 1,000 live births) than Australia (6 per 1,000 live births). This makes Queensland's First Nations infant mortality rate almost double that of non-Indigenous Queenslanders (4 per 1,000 live births) (AIHW 2017c).

Median age at death

As part of the Australian Government's '*Closing the Gap'* campaign, a target has been set to 'Close the life expectancy gap within a generation (by 2031)'. In 2015-17, life expectancy at birth was 71.6 years for First Nations males and 75.6 years for First Nations females. These figures are 8.6 and 7.6 years lower respectively than for non-First Nations Australians. While a 10% improvement in First Nations age-standardised mortality rates were witnessed between 2006 to 2018, the target to 'close the gap' is not on track (Australian Government 2020).

First Nations males in Brisbane south had a median age of 56 years at death, by comparison to 59 in Queensland. Logan IARE had a very low median age at death for First Nations males at 53 years (Table 76) (PHIDU 2021).

Table 76. Median age of death among First Nations people in Brisbane south

Indicator	Result				
	Brisbane South PHN	IARE/s with most unfavourable results in the BSPHN region	IARE result	Queensland	Australia
Median age of death (males)(years)	56	Logan	53	59	56
Median age of death (females)(years)	67	Logan	65	63	62
Median age of death (all)(years)	61	Logan	59	61	59

Source: *PHIDU 2021*

Avoidable deaths

Brisbane south had favourable results compared to Queensland and Australia with regards to avoidable deaths from circulatory system diseases (BSPHN: 45 ASR per 100,000 persons, QLD: 54 ASR per 100,000 persons, AUS: 61 ASR per 100,000 persons), avoidable deaths from respiratory system diseases (BSPHN: 14 ASR per 100,000 persons, QLD: 17 ASR per 100,000 persons, AUS: 18 ASR per 100,000 persons) and median age at death for First Nations females (BSPHN: 67 years, QLD: 63 years, AUS: 62 years) (Table 77).

While the Brisbane south region as a whole exhibited on-par rates of avoidable deaths from falls, fire, burns, suicide and self-inflicted injuries, the Logan IARE had a high rate of avoidable deaths in this category, 32 ASR per 100,00 persons (BSPHN: 27 ASR per 100,000 persons, QLD: 26 ASR per 100,000 persons, AUS: 25 ASR per 100,000 persons). The same can be said for avoidable deaths from other external causes in the Brisbane City (part b) IARE with 33 ASR per 100,000 persons (BSPHN: 27 ASR per 100,000 persons, QLD: 26 ASR per 100,000 persons, AUS: 35 ASR per 100,000 persons) (Table 77) (PHIDU 2021).

Table 77. First Nations health indicators in the Brisbane south region

Indicator	Result				
	Brisbane South PHN	IARE/s with most unfavourable results in the BSPHN region	IARE result	Queensland	Australia
Avoidable deaths from cancer(a)(b)	17	Logan	19	18	16
Avoidable deaths from diabetes(a)(b)	16	Logan	20	24	24
Avoidable deaths from circulatory system disease(a)(b)	45	Brisbane City (part b)	51	54	61
Avoidable deaths from respiratory system diseases(a)(b)	14	Logan	15	17	18
Avoidable deaths from falls, fires, burns, suicide and self-inflicted injuries(a)(b)	27	Logan	32	26	25
Avoidable deaths from other external causes(a)(b)	27	Brisbane City (part b)	33	26	35

a. Among persons aged 0 to 74 years
b. ASR per 100,000 persons
Source: *PHIDU 2021.*

4.2.4.5 Social and emotional wellbeing

As the leading cause of broad-cause health loss, disability burden and death amongst First Nations persons in Australia, mental and substance use disorders, including self-harm and suicide, contribute significantly to First Nations health need and are a high priority (AIHW 2011, Queensland Health 2016).

The *'Fifth National Mental Health and Suicide Prevention Plan Performance Indicators'* (2018) highlight a notably higher proportion of First Nations people living in Queensland (31.4%, age-standardised proportion) experienced high or very high levels of psychological distress compared to non-First Nations people (11.9%). A higher proportion of First Nations people (4.9%) also accessed public mental health care services compared to non-First Nations people (1.9%). The proportion of First Nations people (9.8%) accessing MBS and DVA clinical mental health services was relatively equal to the proportion of non-First Nations people (9.9%) accessing these services. Additionally, while the proportion of adults (aged 18+ years) living with mental health concerns who experienced discrimination was relatively high (28.3%), this was notably higher for First Nations adults (44.5%) *(National Mental Health Commission 2018)*.

Children and young people

In Queensland, anxiety and depression contributed 11% of the burden of disease and injury of First Nations children aged 0 - 14 years, and 29% for First Nations young people aged 15 - 29 years. Suicide and self-harm were the second highest contributor towards burden of disease and injury amongst First Nations young people aged 15 - 29 years (8%), followed by Schizophrenia (7%). First Nations young people aged 15 - 29 years had significantly higher burden of disease and injury associated with suicide and self-inflicted injuries compared to their non-First Nations counterparts (3%) (Queensland Health 2017).

In Brisbane south, mental disorders were the leading contributor to the burden of disease among First Nations peoples aged 15-29 years (56.7%); a higher proportion when compared to non-First Nations people (51.6%) (Queensland Health 2017).

Key themes raised by community and sector representatives during local consultation regarding First Nations people's health outcomes included:

- a perceived increase in health and mental health issues, especially related to drug and alcohol misuse
- high levels of unmet need relating to people's social and emotional wellbeing
- anger management, relationship issues, family violence, stress and rehabilitation impacting people's social and emotional wellbeing
- significant need regarding inadequate housing and overcrowding
- the lack of skills, training and trust in the justice system and law enforcement in identifying and managing domestic and family violence
- the inaccessibility of affordable fresh food, as a risk factor for chronic disease
- a perceived increase in youth pregnancy, adolescent substance misuse, school dropouts, and child-to-parent violence
- issues with maternity care including low birth weights, smoking and drug use during pregnancy and antenatal appointment attendance
- ever increasing demand for services as the First Nations population in South East Queensland continues to grow
- education across all levels (early childhood, primary and high school and tertiary) being an ongoing issue
- elder abuse
- the highly complex unmet needs of incarcerated First Nations women and the significant stigma associated with accessing health services in prison settings
- a perceived increase in the occurrence of attention deficit hyperactivity disorder (ADHD)
- significant unmet need in relation to ear-nose-throat, dental decay and cataracts
- mental health challenges and suicidality amongst First Nations youth aged 12 - 29 years
- experiences of trauma and impacts on wellbeing of the high rates of children in the care of Child Safety.

4.3 Health system

Primary healthcare services are central in providing clinical, social and emotional support to community members in Australia. It is known that primary health care services are underutilised by First Nations people, especially First Nations men (Canuto et al 2018).

First Nations Australians may access mainstream or Indigenous-specific primary health care services (ISPHCS), which offer prevention, diagnosis and treatment of ill health in a range of settings. These initiatives are available in the public health system funded by various government bodies, including Brisbane South PHN, and in the private sector (AIHW 2018c).

4.3.1 Service utilisation

4.3.1.1 Primary health care

Preferred providers of healthcare

First Nations Queenslanders most commonly sought health care or advice from their doctor/GP (46%) or First Nations medical services and/or community clinics (40%). Comparing these to national rates, First Nations Australians sought out their doctor/GP more and Aboriginal medical services and/or community clinics (34.1%) less than First Nations Queenslanders, but these remain the two leading health care provider types (Table 78) (AIHW 2020r).

Table 78. Sources of health care First Nations Australians usually go to for health problems or advice, 2018-19

Type of health care	Queensland (%)	Australia (%)
Doctor/GP	46.0	54.0
First Nations medical service and/or community clinic	40.0	34.1
Hospital	6.3	3.5
Other health care providers incl. traditional healer	0.5	0.6
No regular source of health care	7.6	7.7

Source: *AIHW 2020r.*

Preventative health

Approximately 10,500 First Nations people in Brisbane south underwent a First Nations-specific health check in 2019-20, comprising 34% of the total First Nations population. This rate was down from 2018-19 when 37% of the First Nations population received a health check, but was on-par with the Queensland rate of 35% in 2019-20 which also declined from 2018-19 (37%). Brisbane south's rates were favourable by comparison to national rates, where 29% and 28% of First Nations Australians underwent a health check in 2018-19 and 2019-20 (AIHW 2021).

Additionally, the rate of First Nations-specific health check patients who received follow-up services in Brisbane south during 2018-19 was high (63%) by comparison to Queensland (53%) and Australia (47%) (AIHW 2021).

Prior to 2019-20, face-to-face was the only method of delivery for First Nations-specific health checks in Brisbane south, Queensland, and Australia. However, with the onset of the COVID-19 pandemic, primary care telehealth was introduced. Face-to-face delivery was still the preferred and most common method of conducting health check appointments, with only 3-4% of health checks conducted via telehealth (AIHW 2021).

While participation in BreastScreen and the National Bowel Cancer Screening Program (NBCSP) is low among all Australians, this is particularly so amongst First Nations people. In 2018-19, 37% of First Nations women aged 50 to 74 years participated in BreastScreen by comparison to 53% in the general population. Similarly, 24% of First Nations Australians aged 50 to 74 years participated in the NBCSP by comparison to 40% in the general population. Of those who participated in the NBCSP, First Nations Australians were more likely to return a positive test result (11%) by comparison to non-First Nations participants (8%). Despite these higher rates, First Nations Australians were also less likely to be assessed (as is recommended) following a positive screen by comparison to non-First

Nations Australians, with 43% of First Nations people not obtaining follow-up assessment by comparison to 29% of the general population (AIHW 2018j).

Chronic disease management

In 2018, 65% of regular clients at Queensland First Nations primary health care organisations with type 2 diabetes had a general practice management plan (GPMP), while 62% had a team care arrangement in place. These numbers were relatively stable across both males and females, and were significantly higher than national rates (56% and 54% respectively). By comparison to all other states and territories, Queensland had the highest rates of GPMP and team care arrangement utilisation for First Nations people with type 2 diabetes who were regular clients of a First Nations primary health care organisation (AIHW 2017c).

Antenatal care

In 2016-18, 50% of First Nations women who gave birth in Brisbane south did not attend antenatal care within the first 10 weeks of their pregnancy. While it is acknowledged that this rate is unfavourable, it is lower than state (66%) and national (55%) rates. IARE's within the region with the lowest rates of antenatal care attendance within the first 10 weeks of pregnancy included Redland (60%) and Beaudesert - Boonah (part a) (58%) (PHIDU 2021).

Access to services

In 2018-19, 11% of First Nations Queenslanders identified themselves as having not gone to the doctor when they needed to in the previous 12 months. The leading reasons provided by respondents as to why they didn't visit the doctor when they needed to include personal reasons, logistical reasons, and the cultural appropriateness of the service. 4.4% of First Nations people said cost was a contributing factor as to why they didn't visit the doctor when they needed to (Table 79) (AIHW 2020r).

Table 79. Reasons for First Nations Australians not accessing health services when needed (%), 2018-2019

	Queensland	Australia
Whether needed to visit doctor in last 12 months, but didn't		
Yes	10.9	12.5
No	89.1	87.5
Reasons why didn't visit the doctor when needed to(b)		
Cost (%)	4.4‡	7.4
Logistical reasons		
Waiting time too long or not available at time required (%)	10.0†	15.7
Transport/distance (%)	15.6†	13.8
[service] Not available in area (%)	2.8†	2.2†
Sub-total	*23.6*	*28.9*
Cultural appropriateness of service		
Discrimination/ not culturally appropriate/ language problems (%)	0.0	1.4†
Dislikes service/professional, embarrassed, afraid (%)	12.8†	11.4
Felt it would be inadequate (%)	9.2†	9.5
Does not trust doctor (%)	2.8‡	4.1
Sub-total	*22.8†*	*21.5*
Personal reasons		
Too busy (including work, personal or family responsibilities) (%)	31.2	32.8
Decided not to seek care (%)	26.8†	27.9
Sub-total	*55.2*	*57.6*
Other	13.6†	11.2
Total who needed to visit doctor, but didn't	**25,039**	**102,033**

† Estimate has a relative standard error between 25% and 50% and should be used with caution.
‡ Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.
(a) Persons aged 2 and over.
(b) More than 1 response allowed, sum of components may exceed total.
(c) Other health professionals include: nurse, sister, and Aboriginal (and Torres Strait Islander) Health Worker.
(d) Persons aged 18 and over, present at interview and responding for self.
(e) Excludes 'not asked'.
(f) Includes persons who reported they needed to go to a dentist (persons aged 2 and over), doctor, other health professional, hospital or counsellor (persons aged 18 and over) in the last 12 months, but did not go.
Notes
1. Percentages calculated within columns. Cells in this table have been randomly adjusted to avoid the release of confidential data and discrepancies may occur between sums of the component items and totals.
2. Data excludes 'not stated' responses.
Source: AIHW 2020r.

11% of First Nations Queenslanders also identified themselves as having had prescriptions that didn't get filled in the last 12 months, accounting for approximately 13,000 respondents. The leading reason why First Nations people did not go to get their prescriptions filled was cost, with 35% of people stating this reason, followed by deciding they didn't need it (32%) and other reasons (32%) (Table 80) (AIHW 2020r).

Table 80. Reasons for First Nations Australians not filling prescription medicines, 2018-19

	Queensland	Australia
Whether had prescriptions that didn't get filled in last 12 months		
Yes (%)	10.5	13.9
No (%)	89.1	86.0
Total	**120,825**	**433,596**
Reason(s) did not go to get prescription filled in last 12 months(a)		
Cost (%)	34.6	35.7
Decided didn't need it (%)	31.5	29.7
Didn't want to (%)	7.9‡	15.0
Too busy (%)	11.0‡	10.6
Other(b) (%)	31.5	22.1
Total who did not get prescription filled in last 12 months	**12,716**	**60,212**

† Estimate has a relative standard error between 25% and 50% and should be used with caution.
‡ Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.
(a) Components may not add to total as this is a multiple response item.
(b) Includes 'Transport issues', 'Lost the prescription' and 'Other'.
Note: Percentages calculated within columns. Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.
Source: AIHW 2020r

4.3.1.2 Tertiary health care

Emergency department presentations

Brisbane south had a higher ASR of resuscitations and emergency presentations per 100,000 First Nations people (10,100) than Queensland (7,639) and Australia (7,982), with Logan IARE recording particularly high rates (13,735). Redland IARE also had high rates of urgent presentations (23,517). Brisbane south had comparatively low rates of non-urgent presentations for First Nations people (2,076) compared with state and national levels (2,260 and 6,645 respectively) (Table 81) (PHIDU 2021). These low rates of non-urgent presentations may indicate the primary health system is adequately meeting the needs of First Nations people in the region, but could also be representative of First Nations people being hesitant to access care until their condition deteriorates to an acute level.

Table 81. Emergency presentations for First Nations persons in the Brisbane south region

Indicator	Result				
	Brisbane South PHN	IARE/s with most unfavourable result in the BSPHN region	IARE result	Queensland	Australia
Resuscitations and emergency presentations(b)	10,100	Logan	13,735	7,639	7,982
Urgent presentations(b)	21,766	Redland	23,517	20,412	21,645
Semi-urgent presentations(b)	13,338	Brisbane City (part b)	16,511	15,892	25,838
Non-urgent presentations(b)	2,076	Brisbane City (part b)	3,084	2,260	6,645
Presentations for mental and behavioural disorders(b)	3,176	Brisbane City (part b)	4,076	2,720	3,637

Source: *PHIDU 2021*

Closed treatment episodes

In 2017-18, 16% of closed treatment episodes were attributed to people who identified as being of First Nations origin in 2017-18, an increase from 10% in 2016-17 (AIHW 2019c).

4.3.1.3 Aged care

Of the 13,410 individuals residing in a residential aged care facility in the Brisbane south region at June 2020, only 175 identified themselves as being a First Nations person (1.3%). Looking at the aged care planning regions (ACPRs) within Brisbane south, 0.9% of residents in Brisbane South ACPR were First Nations by comparison to 3.5% in Logan River Valley ACPR (AIHW 2021).

Key themes raised by community and sector representatives during local consultation regarding First Nations people's service utilisation included:

- First Nations population growth outpacing service growth leading to long wait times for general practice, allied health and specialist appointments
- increased demand for youth mental health services, particularly in the Bayside region
- high demand for First Nations mental health and alcohol and other drug treatment services, resulting in long waitlists
- the lack of accessible services to meet the need of First Nations people in aged care, disability services and access pathways to the NDIS
- transportation issues for in-hospital dialysis acting as a barrier to access
- witnessing an increase in demand for homelessness services in the Logan, Beaudesert and Redland region
- failure to attend healthcare appointments being an ongoing issue
- fear, a lack of understanding in some communities and a lack of internet access limiting the utilisation of telehealth services
- witnessing an increase in 'Did not attend' (DNAs) general practice telehealth appointments
- the ongoing effects of the Stolen Generation, including a distrust in medical services, acting as a barrier to access

- hesitancy to obtain support and speak up about domestic and family violence due to fear of Child Safety notifications
- Insufficient liaison officers to assist First Nations people navigate hospital-based services
- First Nations people experiencing homelessness have complex case management needs.

4.3.2 Service experience

4.3.2.1 Cultural appropriateness

Reasons related to the cultural appropriateness of health services were not among the leading reasons why First Nations Australians did not access health services when they needed to, but it was mentioned by 22% of people as a contributing factor in their decision. In Queensland, this figure was slightly higher at 23% of respondents. It is heartening to see that in Queensland 0% of First Nations respondents listed 'Discrimination/not culturally appropriate/language problems' as their reason for not accessing health services when they needed to (AIHW 2020s).

4.3.2.2 Patient experience

The self-reported patient experiences of First Nations Queenslanders indicate that the majority of interactions between First Nations patients and clinicians in Queensland were respectful, patient-focussed and appropriate. Queensland respondents had an overwhelmingly positive response across all patient experience domains, with 76% rating the overall quality of the healthcare they'd received in the last 12 months as 'excellent/very good' and a further 16% rating it as 'good' (Table 82) (AIHW 2020k).

Table 82. Patient experience of First Nations persons aged 15 and over, 2018-19

	Queensland	Australia
How often doctor(s)/GP(s) listened		
Always/usually	87.6	88.8
Sometimes/rarely/never	12.5	11.4
How often doctor(s)/GP(s) explained things in a way that could be understood		
Always/usually	87.1	87.9
Sometimes/rarely/never	11.7	12.1
How often doctor(s)/GP(s) showed respect for what was said		
Always/usually	90.8	91.0
Sometimes/rarely/never	9.2	9.0
How often doctor(s)/GP(s) spent enough time with patient		
Always/usually	89.8	87.5
Sometimes/rarely/never	9.9	12.5
Overall rating of health care received in last 12 months		
Excellent/very good	75.9	74.9
Good	15.7	16.2
Fair/poor	8.7	9.1

Source: *AIHW 2020k.*

4.3.2.3 Wait times

Across the nation, 3.4% of First Nations Australians waited more than 365 days for elective surgery in 2019-20 compared to 2.8% for non-First Nations Australians. Queensland rates are highly favourable by comparison to national rates, with 1.9% of First Nations Queenslanders having waited more than 365 days for elective surgery in 2019-20 by comparison to 2.0% for their non-First Nations counterparts (AIHW 2021).

4.3.2.4 Stakeholder views

Key themes raised by community and sector representatives during local consultation regarding First Nations people's service experience included:

- poor surgical pathways for Aboriginal and Torres Strait Islander people
- the lack of partnership and coordination between the health and justice sectors, especially regarding the health of incarcerated First Nations women
- First Nations-specific mental health services only having capacity to cater a small proportion of people who need support
- the lack of connection between health services and cultural community services
- the lack of Elder support provision, especially for those with limited natural psychosocial support
- inadequate and inequitable access to mental health care for First Nations people
- the lack of culturally safe care negatively impacting access to services and health outcomes
- poor service delivery standards and responsiveness, including when attending the emergency department
- lack of consideration and acceptance given to alternative treatments including cultural healing and traditional medicine
- First Nations people not feeling culturally safe to access mainstream general practices
- First Nations people not feeling safe in First Nations medical services due to a lack of privacy and feelings of shame.

4.3.3 Service mapping

There are 7 First Nations health clinics operating in the Brisbane south region located at Capalaba, Dunwich, Wynnum, Woolloongabba, Browns Plains, Loganlea and Logan Central. These clinics are run by Yulu-Burri-Ba and Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited (ATSICHS), and are considered by the Institute of Urban Indigenous Health (IUIH) as being part of their network (Institute of Urban and Indigenous Health 2020, Brisbane South PHN 2021).

Stakeholder views provided the following insights:

- limited access to child psychiatry and psychological services
- limited chronic pain management referral pathways and program
- the lack of dental care as part of the primary health care model
- the lack of First Nations community-led and run aged care services
- the lack of publicly funded First Nations-specific paediatric assessment and therapy services
- the lack of services and facilities for people, particularly children, experiencing domestic and family violence in the Logan area
- the lack of culturally safe NDIS services
- the lack of services which can provide intergenerational trauma support
- the lack of culturally appropriate prenatal and birthing services.

4.3.4 Workforce

4.3.4.1 Broad health services workforce

In 2016, there were 172 First Nations workers employed within the Queensland health workforce per 10,000 First Nations people in the Queensland population. This is a 101% increase in the representation of First Nations persons in the Queensland health workforce since 2006. Queensland's level of representation is on par with national representation. Despite the positive change between 2006 and 2016, First Nations persons are still considerably under-represented in the Australian health workforce, making up only 1.4% of the people employed in this sector. This equates to approximately 11,000 First Nations persons employed within a total health workforce of approximately 785,000 (Table 83) (AIHW 2020s).

Table 83. Employed persons aged 15+ in health workforce(a), in Queensland and Australia, 2006, 2011 and 2016

	Queensland		Australia	
	Number	Rate per 10,000 persons(b)	Number	Rate per 10,000 persons(b)
2006				
First Nations	1,593	126	5,764	127
Non-First Nations	105,242	297	556,814	306
2011				
First Nations	2,418	156	8,455	155
Non-First Nations	136,521	347	682,206	344
2016				
First Nations	3,201	172	11,161	172
Non-First Nations	169,886	381	785,002	369
% change in numbers 2006 - 2016				
First Nations	+101%		+94%	
Non-First Nations	+52%		+41%	

(a) Health Occupations are based on the Australian and New Zealand Standard Classification of Occupations (ANZSCO) 2013, Version 1
(b) Rate per 10,000 is the number of employed First Nations/Non-First Nations persons in each particular occupation, divided by the total population of First Nations/Non-First Nations persons (excluding employed persons who did not state their occupation), and multiplied by 10,000. Excludes persons who did not state their First Nations status.
(c) Australia total includes other territories
Source: *AIHW 2020s*

4.3.4.2 First Nations-specific primary health care workforce

The vast majority of First Nations persons employed in the First Nations-specific primary health care workforce in Australia were nurses and midwives, making up 74% of the workforce. This was followed by medical practitioners (7%) and First Nations health practitioners (6%). First Nations persons made up 1.5% of the total number of nurses and midwives and 0.5% of the total number of medical practitioners in First Nations-specific primary health care settings in Queensland (AIHW 2020s).

Approximately half (52%) of First Nations health workers in First Nations-specific primary health care in Australia were employed full time in 2019-20, by comparison to 67% of their non-First Nations counterparts. These rates were slightly lower than national rates where 53% of First Nations health

workers were employed full time, by comparison to 63% of their non-First Nations counterparts. The proportion of First Nations health workers fulfilling unskilled and semi-skilled positions such as drivers and administrative staff were higher than their non-First Nations counterparts. By comparison, skilled and highly skilled positions such as CEOs/managers/supervisors, general practitioners, nurses/midwives and allied health/medical specialists were fulfilled by a higher proportion of non-First Nations than First Nations persons (Table 84) (AIHW 2021).

Table 84. Proportion of employed FTE staff by position type and First Nations status, 2019-20

Position type	First Nations (%)	Non-First Nations (%)	Total
CEO/manager/supervisor	5.6	6.7	12.4
Administrative and clerical staff	9	5.2	14.2
Driver/field officer	4.4	0.9	5.3
Other support staff	5.2	5	10.2
First Nations health worker/ practitioner	11.3	0.1	11.4
General practitioner	0.5	7.6	8.1
Nurse/midwife	2.1	12.5	14.6
Social and emotional wellbeing	3.2	2.8	6
Health promotion	1.2	0.4	1.7
Allied health/medical specialist	0.3	2.4	2.7
Dental care	0.8	1.4	2.2
Outreach worker	2.5	0.5	3
Substance misuse/drug and alcohol worker	1.4	0.6	2
Other health	4.4	1.9	6.3
Total	**51.9**	**48.1**	**100**

Source: *AIHW 2021.*

Community and sector representatives involved in local consultation highlighted the need for improved information, resource and training distribution amongst general practice and allied health regarding the provision of culturally appropriate health care to First Nations peoples, including embedding a foundation of cultural safety and trauma-informed care in their practice.

4.4 Health equity

According to 2016 Census, areas within Brisbane south with the highest proportion of First Nations peoples included Beaudesert (5%), Beenleigh (4%), Forest Lake - Oxley (4%), Springwood - Kingston (4%) and Browns Plains (3%). These five localities also comprise the top 5 most disadvantaged SA3s in the Brisbane south region based on the proportion of population classified in quintile 1 of the Index of Relative Socio-Economic Disadvantage (QGSO 2018).

While the proportion of First Nations people in Brisbane south who were unemployed, 16%, was high, this result is favourable by comparison to Queensland (20%). First Nations persons within Brisbane south were twice as likely to be unemployed compared to non-First Nations persons (QGSO 2018).

Employment and education status were closely correlated with self-reported health status. Almost half (46%) of employed First Nations people in Australia reported their health as ‘excellent/very good’, compared to only 40% of those who were unemployed. A third (34%) of First Nations people

not in the labour force reported their health as 'fair/poor'. First Nations peoples who completed year 12 were more likely to have reported their health as 'excellent/very good' (49%), when compared to those who completed year 9 or below (40%) (AIHW 2017c).

In Brisbane south, one in three (35%) dependent children residing in families with First Nations people were from jobless families, by comparison to 39% in Queensland. Moreover, 39% of First Nations households in Brisbane south were described as low-income households earning less than $650 per week, compared to 29% in Queensland. In this way, the proportion of children residing in jobless families in Brisbane south was favourable compared to Queensland results, but a higher proportion of households relied on low levels of income (QGSO 2018).

Over a third (39%) of First Nations peoples aged 15 years and over in Brisbane south did not go to school or finished school in year 10 or below. While this proportion is high by comparison to non-First Nations people in the Brisbane south region, it is favourable compared to state levels (44%) (QGSO 2018).

Outcomes of equity markers relating to First Nations persons in Brisbane south were favourable by comparison to Queensland and Australian results. Brisbane south had a high proportion of First Nations children aged 4 or 5 enrolled in a preschool program (51%), First Nations persons aged 15 to 24 learning or earning (71%), and lower proportions of First Nations people living in social housing (19%) and requiring extra bedrooms within their household (8%) (Table 85) (PHIDU 2021).

Table 85. Equity markers of First Nations persons in the Brisbane south region, 2017-18

Indicator	Result				
	Brisbane South PHN	IARE/s with most unfavourable result in the BSPHN region	IARE result	Queensland	Australia
First Nations children aged 4 or 5 enrolled in a preschool program (%)	51%	Beaudesert - Boonah (part a)	26%	45%	49%
First Nations persons aged 15 to 24 learning or earning (%)	71%	Logan	70%	60%	65%
First Nations people living in social housing (%)	19%	Brisbane City (part b)	20%	34%	29%
First Nations households requiring extra bedrooms (%)	8%	Logan	9%	12%	10%
First Nations persons aged 15+ years providing assistance to persons with a disability	13%	Redland	15%	12%	14%

Source: PHIDU 2021

Community and sector representatives involved in local consultation highlighted that in order to meet the needs of First Nations people in the Brisbane south region, the way in which healthcare is delivered may need to change considerably.

4.4.1 LGBTQIA+ community members

Gender diverse First Nations peoples, Brotherboys and Sistergirls, experience a number of significant intersecting points of discrimination and marginalisation in Australia. The Australian Human Rights Commission's *Resilient Individuals: Sexual Orientation, Gender Identity & Intersex Rights* report recognises the intersecting issues of racism, homophobia and transphobia faced by these communities. No information was found or received regarding intersex issues to inform the report.

Issues that were raised in consultation with participants included;

- Significant diversity among LGBTQ+ Aboriginal and Torres Strait peoples
- Racism, discrimination and isolation experiences
- Challenges in the maintenance of cultural ties and family support and recognition of diverse sexual orientation and gender identity. Difficulties surrounding gendered cultural initiation processes couldn't accommodate an individual's gender expression
- Historical underrepresentation of Aboriginal and Torres Strait Islander peoples in research on LGBTQ+ issues
- Minimal investigation into the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples, recognising the importance of connection to land, culture, spirituality, ancestry, family and community and how these affect the individual
- Disparities between provision of Aboriginal-specific services and services accommodating for broader LGBT populations and their health needs

The 2015 report also raised the issue of the absence of a national action plan to meet the needs of the ever-growing LGBTQ+ Aboriginal and Torres Strait Islander population (Australian Human Rights Commission 2015).

4.4.2 People experiencing or at risk of homelessness

Key themes raised by community and sector representatives during local consultation regarding First Nations people's health outcomes included:

- a perceived increase in the number of First Nations people experiencing insecure housing and homelessness, especially related to drug and alcohol misuse, in the Logan, Redland and Beaudesert regions
- the limited intensive, wrap-around support services available to First Nations people experiencing or at risk of homelessness.

4.4.3 People with a disability

According to 2016 Census results, one in 13 (8%) First Nations people in Brisbane south had a profound or severe disability, which is higher than both the general population rate (5%) and Queensland First Nations rate (6%) (QGSO 2018). In terms of caring roles, 13% of First Nations persons aged 15 years and over provided assistance to persons with a disability, on par with Queensland (12%) and Australian proportions (14%). IAREs in Brisbane south with the highest proportion of First Nations persons aged 15 year and over providing assistance to persons with a disability were Redland (15%) and Logan (14%) (PHIDU 2021).

Community and sector stakeholders involved in local consultation noted the inequity of disability and NDIS services for First Nations people as a concern.

4.4.4 Rural and remote communities

There is a large body of evidence to suggest that Australians living in rural, remote or very remote areas have higher rates of risky health behaviours such as smoking, decreased access to health services and generally poorer health status as opposed to people living in regional or metropolitan areas. For Indigenous Australians, the relationship of remoteness to health is particularly important, as they are more likely to live outside metropolitan areas than non-Indigenous Australians. Indigenous Australians represent 16% and 45% of all people living in Remote and Very remote areas respectively.

Aboriginal and Torres Strait Islander peoples experience significant disparities in health, such as decreased life expectancy, higher rates of chronic and preventable illnesses, poorer self-reported health, and higher likelihood hospitalisation than their non-Indigenous counterparts. Therefore, differences in health with increasing remoteness could also be explained by the poorer health of the Indigenous population living in these areas. Smoking rates and prevalence of diabetes and heart conditions are highest among Indigenous Australians who live in remote or very remote areas. In contrast, very remote areas have the lowest rates of overweight and obesity, as well as rates of high or very high psychological distress and proportion of Indigenous Australians reporting asthma (AIHW 2014).

4.5 Impact of COVID-19

4.5.1 Health status

Key themes raised by community and sector representatives during local consultation regarding the impact of the COVID-19 pandemic on First Nations people's health status included:

- First Nations people being displaced from Country due to isolation requirements and lockdowns negatively impacting their mental health
- increased occurrence of domestic and family violence
- increased occurrence of social isolation due to fear of COVID-19 infection.

4.5.2 Health system

Key themes raised by community and sector representatives during local consultation regarding the impact of the COVID-19 pandemic on First Nations people in the health system included:

- requiring continuous in-person opportunities and discussions to education the community about the COVID-19 pandemic, including the vaccine rollout

4.6 Health priorities and options

4.6.1 Priority unmet needs

Considering the comparative, felt, expressed and normative needs of the Brisbane south region, a number of First Nations-related priority unmet needs emerged during prioritisation. In order of priority, as determined through the prioritisation process, these needs included:

1. Working to address the social and emotional wellbeing challenges that First Nations people disproportionately experience.
2. First Nations people disproportionately experience chronic health conditions, including cardiovascular diseases and type 2 diabetes.

4.6.2 Current activities

4.6.2.1 Integrated Team Care

Brisbane South PHN's strategic vision for the Integrated Team Care program is to improve access to the most appropriate health services for Aboriginal and Torres Strait Islander people at the right time and in the right place. The objectives of this program are to reduce potentially preventable hospital admissions and emergency presentations, improve understanding and appropriate use of health care system and support Aboriginal and Torres Strait Islander peoples to take part in a healthy lifestyle. To achieve these objectives Brisbane South PHN funds two Integrated Team Care activities (1) care coordination and supplementary services and (2) supporting culturally competent mainstream services. The care coordination and supplementary services activity aims to contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic conditions through better access to care coordination, multidisciplinary care and support for self-management. Through collaboration with key stakeholders (IUIH, Brisbane North PHN, Metro South Health), Brisbane South PHN can ensure that planned actions to achieve the activity's outcomes are achieved. Culturally competent mainstream services activity aims to improve access to culturally appropriate mainstream primary care services (e.g. general practice, allied health, and specialists) for Aboriginal and Torres Strait Islander people.

4.6.2.2 Social and Emotional Wellbeing

Within an Aboriginal and Torres Strait Islander context, Social and Emotional Wellbeing is a complex, multidimensional concept of health that included but extends beyond conventional understandings of mental health and disorder. Mental health and wellbeing is an important component of health which is linked to social, emotional, physical, cultural and spiritual dimensions of wellbeing. Brisbane South PHN have commissioned a range of community-based activities aimed at social and emotional wellbeing of Aboriginal and Torres Strait Islander people, specifically suicide prevention, mental health and alcohol and other drugs treatment services. These activities aim to enhance access and integration of Aboriginal and Torres Strait Islander mental health services at a local level, and facilitate a joined-up approach with other closely connected services, including social and emotional wellbeing, suicide prevention and alcohol and other drug (AOD) services.

4.6.2.3 Birthing in Our Community

Birthing in Our Community (BiOC) is a partnership between the Institute of Urban Indigenous Health (IUIH), Mater Mothers' Hospital, and the Aboriginal and Torres Strait Islander Community Health Services (ATSICHS). Brisbane South PHN directly funds IUIH to deliver this project, which delivers clinical outcomes for Aboriginal and Torres Strait Islander women and babies participating in the program and continues to deliver outstanding results. BiOC integrates the midwifery services and expertise of the Mater Mothers' Hospital with the cultural knowledge and clinical expertise of IUIH and ATSICHS Brisbane, enabling a unique approach to service delivery (IUIH reference).

4.6.3 Options for future activity

- Partner, collaborate and lead system reform, delivering measurable and meaningful health and wellbeing impact. This may include working with local health system partners and Aboriginal Community Controlled Health Organisations to integrate care pathways.
- Integrate and coordinate care systems within a holistic social determinants framework.
- Support community-led action that delivers sustainable change in health and wellbeing. This may include the coproduction of service solutions that emphasise self-determination in models of care.
- Improve the health and wellbeing outcomes of our community, with a focus on addressing health inequities and inequalities. This includes gaining a deeper understanding and delivering

services that address the intersectionality of First Nations peoples with other priority populations, such as First Nations people experiencing homelessness.

- Enable strong and connected primary care to create a person-centred system that improves health access, experiences and outcomes. A focus on workforce development and education to enhance culturally responsiveness and safety of mainstream services, and enhancing the connectedness of mainstream and Aboriginal Community Controlled Health Organisations.

5. Multicultural health

In addition to being home to some of the world's oldest continuous cultures, the cultural backgrounds of the Australian population are richly diverse. Over seven million people have migrated to Australia since the mid-20th Century, with the vast majority resettling from the United Kingdom, New Zealand, China, India, and Vietnam (Australian Human Rights Commission 2021). Permanent migrants may enter the country via either the Migrant Program or Humanitarian Program (Parliament of Australia 2017). This report will employ the umbrella term "multicultural" to describe people from culturally and linguistically diverse backgrounds and people with refugee and asylum seeker backgrounds.

Australia has a long history of humanitarian resettlement, providing safety to more than 920,000 people since World War II. In 2021-22, Australia allocated 13,750 places to the Refugee and Humanitarian program demonstrating a continued commitment to protecting refugees, responding to global humanitarian need and providing specialist support to people from multicultural and refugee backgrounds (Department of Home Affairs 2021). Despite their experiences often including trauma, deprivation, loss and post-traumatic stress, people from refugee backgrounds are highly resilient survivors and are an asset to the communities in which they settle. They demonstrate profound adaptability, are ready to seize the opportunities they are given in their resettlement, and are eager to succeed and contribute to their new community (Centre for Policy Development and Open Political Economy Network 2019).

"We are no longer just refugees, we are equal and will be giving back to community." *(Pittaway 2008)*

While Australia's multicultural population is a highly diverse group, family unity and spirituality are oftentimes pillars of these communities. These pillars provide emotional support, comfort and guidance to people, giving them hope and motivation to strive for a better future for themselves and their loved ones (Busch Nsonwu et al 2013).
People from multicultural and refugee backgrounds aspire to live in a peaceful environment, wanting to belong and be good Australian citizens (State of New South Wales Department of Education 2020).

Much like Australia, Brisbane south is a highly culturally diverse region. This cultural diversity poses unique challenges to the availability and accessibility of health care services that are not otherwise present within the general population. Language barriers and the engagement of interpreter services, health system knowledge and health literacy, and the cultural appropriateness and safety of services are all factors that contribute to decreased utilisation of services by multicultural people in the region. Addressing the barriers to health care accessibility and availability within this population will result in improved health outcomes.

5.1 Strategic environment

5.1.1 National

Although no singular national strategy exists that provides Australia-wide guidance regarding multicultural health, a number of nationally focussed strategies that either span the life course or are condition-specific touch on the need for multicultural health to be prioritised and acted on.

In the *National Action Plan for the Health of Children and Young People 2020-2030* (Department of Health 2019f)**,** children and young people from culturally and linguistically diverse backgrounds (including those from refugee and asylum seeker families) are a stated priority. Further, action is called for to enhance access to cultural competence training for service providers to deliver culturally appropriate services and interventions as well as to enhance the health literacy of vulnerable multicultural children and families through culturally appropriate education and awareness campaigns, amongst other things.

In the *National Men's Health Strategy 2020-2030* (Department of Health 2019k)*,* males from culturally and linguistically diverse backgrounds (including migrants, asylum seekers and their children) are identified as a priority population. The strategy calls for the health systems to empower and support men and boys to optimise their own and each other's health and wellbeing across all stages of their lives, strengthen the capacity of the health system to provide quality care for all men and boys, and build the evidence base for improving the health and wellbeing of men and boys.

In the *National Women's Health Strategy 2020-2030* (Department of Health 2019l), multicultural women are mentioned as a priority due to experiencing language and cultural barriers in accessing services and information particularly concerning mental and sexual health. Further, the strategy focuses on improving health equity for women and girls, improving equality between women (i.e. mainstream and multicultural), a focus on prevention and early intervention for multicultural women and girls, taking a life course approach to health, and the need to build a strong and emerging evidence base.

Respect, care, dignity: a generational plan for aged care in Australia (2021) outlines a number of actions to meet the needs of culturally and linguistically diverse older Australians. These actions include the certification of aged care providers to meet the culturally and linguistically diverse needs of the community as well as a number of improvements for senior Australians from diverse backgrounds and life experiences e.g. face-to-face support to find aged care services and connect with health and local community services, increased translation and interpreting services, services that maintain connections to family and community and better information on providers that deliver culturally appropriate services.

In addition, multicultural health is embedded as a priority in a number of other condition specific national policy documents that span topics such as mental health, alcohol and other drugs, suicide prevention, and chronic conditions.

5.1.2 State

The Queensland Government's *Multicultural Queensland Charter* (2021) provides a vision of a united, harmonious and inclusive community through the embodiment of 8 key principles, including 'equitable access to the services provided or funded by the government for all people of Queensland'. Additionally, the *Queensland Multicultural Policy: Our story, our future* (2021) read alongside the *Queensland Multicultural Action Plan 2019-20 to 2021-22* (2019) sets out to achieve

culturally capable services and programs, and a productive, culturally capable and diverse workforce across Queensland. These actions look to ensure multicultural Queenslanders have equitably access to health services that meet their health and cultural needs. Of most significance, the state-wide role of PHNs is identified within the suite of strategy documents to build the cultural capability of primary care, co-design programs and services with multicultural communities and develop culturally appropriate resources, pathways and training materials.
The *Refugee Health and Wellbeing: A Policy and Action Plan for Queensland 2017-2020,* which is currently being updated, has guided the strategic direction and actions to better position the health system to respond to the health and wellbeing needs of people from refugee backgrounds. This included enhancing access to and coordination of primary care services.

5.1.3 Regional

At a Brisbane south regional level, the strategic environment indicates that both Brisbane South PHN and Metro South Health are committed to enhancing the health of multicultural members of the community. Brisbane South PHN has played a leading role in refugee health, as outlined in the *Refugee Health Connect Evaluation* (University of Queensland 2016), with community and sector representatives involved in local consultation highlighting Brisbane South PHN's desire to further support primary healthcare to better respond to the needs of culturally and linguistically diverse people in the region, especially those affected by domestic and family violence.

Within the *Metro South Health Service Plan 2017-2022* (2017), Metro South Health committed to developing and implementing service plans aimed at increasing service access and improving health outcomes for culturally and linguistically diverse populations. In parallel, Metro South Health continued to deliver services through their Refugee Health team, improving service access for multicultural people through the Health Access and Equity Unit, as well as administering the Queensland Transcultural Mental Health Centre (a state-wide health service based in the Metro South Addiction and Mental Health Service).

Similarly, in addition to delivering a number of multicultural health programs themselves, Brisbane South PHN has partnered with community members, Metro South Health and Children's Health Queensland to develop a *Pasifika and Māori Health and Wellbeing Strategic Framework and Action Plan for Brisbane South 2020-2025* (2020). The strategic framework is underpinned by shared values and articulates a shared vision to 'provide a collaborative, family-centred and culturally-responsive approach to delivering better health futures for Pasifika and Māori peoples in Brisbane south'. Within this vision, there is joint commitment to long-term wellness, maternal and child wellbeing, and mental health as key priority areas.

5.1.4 Sector

The Royal Australian College of General Practitioners (RACGP) strongly advocates that it is the right of everyone living in Australia to have access to primary health care services and that GPs are central to ensuring this occurs for multicultural Australians. When primary care works together with settlement, humanitarian, torture and trauma services, and secondary care, multicultural populations are more likely to receive care that meets their health and cultural needs (RACGP 2015).

Additionally, a number of practical sector resources and frameworks exist that are leading examples of how to improve access to health services for multicultural people and ensure their experience with the health system is meaningful and effective.

The Australian Refugee Health Practice Guide (2021) is a tool that can be used by doctors, nurses and other primary care providers to inform the health care of people from refugee backgrounds, including people seeking asylum, on arrival to Australia but also on an ongoing basis. General

practice has a key role to play in undertaking post-arrival health assessments and providing ongoing care for multicultural people. Primary care is ideally placed for managing referrals and coordinating multiple services that may be required.

From a mental health perspective, the *Embrace Framework for Mental Health in Multicultural Australia* (2021) is a free, nationally-available online resource which allows organisations and individual practitioners to evaluate and enhance their cultural responsiveness. The Project works to improve the cultural responsiveness of mainstream mental health services to meet the needs of the diverse Australian population. Services commissioned by PHNs are encouraged to begin with the 'PHN Self-Reflection Tool', allowing organisations to understand their 'current state' cultural responsiveness and plan for continuous improvement over time.

5.2 Health status

Data relating to the health status and needs of multicultural people is limited at national, state and local levels in Australia. This is due to a known gap in data collection methods relating to cultural identifiers such as a country of birth, ethnicity, language spoken, interpreter required and year of arrival. Without these variables it is challenging to identify multicultural persons and their specific needs and experiences within populations. In this way, many multicultural persons are 'statistically invisible' in available health data (Queensland Health 2013). These data capture issues are noted in the Queensland Governments' Queensland Multicultural Policy, noting a set of minimum mandatory indicators and desirable indicators. These indicators are to be applied across several Queensland Government Departments, including Queensland Health (Department of Local Government, Racing and Multicultural Affairs).

The identification of Aboriginal and Torres Strait Islander people in primary health care services and administrative health data sets has been beneficial in understanding the extent of the health inequities and monitoring of targets to 'close the gap' in life expectancy and infant and adult health outcomes. There is growing evidence in Australia that people from refugee backgrounds experience poorer health outcomes and increased barriers to accessing health care services. The identification of this groups proves challenging, yet there has been little consideration to how this could be undertaken or improved. The term 'refugee background' has no authoritative definition, and through visa status or directly enquiring, it cannot be comprehensively determined. Unlike the discernible question that can be used for Indigenous status, there is currently no straight-forward way to collect information of refugee status. There is the potential for concern regarding why information about refugee status is being asked, and whether there would be adverse consequences for the response, which could risk the accuracy and consistency of the answers. In order to reduce disparities in health outcomes and respond effectively to the needs of the refugee population, improved identification of refugee background is vital (Yellend et al 2018).

The 2021 OPTIMISE trial assessed value of practice facilitation for supporting delivery of quality health care to people from refugee backgrounds. The trial established that practice facilitation can improve quality of primary care for this population, as well as the importance of data collection on CALD communities. Delivering culturally responsive care is vital for our community, and OPTIMISE trial opened a conversation about enabling health services to be able to do this. Currently, no general practice software includes all the data fields that could determine a patient's refugee status or cultural and/or linguistic diversity ('country of birth', 'year of arrival', 'language spoken', 'need for interpreter' and 'cultural background'). Better reporting of this diversity can improve health outcomes for the CALD and refugee population; implementation of these five data fields in patient registration forms can support the delivery of culturally responsive and tailored care. Specifically, 'year of arrival' can assist in determining a patient's refugee status. This trial is of particular interest to the PHNs in Queensland and nationally, due to the central role of primary health care delivery

within designated regions. The documentation of cultural and linguistic diversity is critical for PHNs to provide health pathways to enable referrals, build communities of practice that facilitate integrated care and support quality improvement incentive programs and interventions (Kay 2021).

5.2.1 Demographic

5.2.1.1 People from culturally and linguistically diverse (CALD) backgrounds

Brisbane south is a culturally and linguistically diverse region. The region is home to a high proportion of people from multicultural backgrounds, with people born overseas making up 30% of the population by comparison to 22% across the state. Further, nearly one-third (32%) of Queensland's total population of people born overseas reside in the Brisbane south region (QGSO 2017). Approximately 19% of Brisbane south's residents were born overseas in non-English speaking background countries and 21% speak a language other than English at home. These rates are significantly higher than those exhibited across Queensland (see Figure 51) (QGSO 2017).

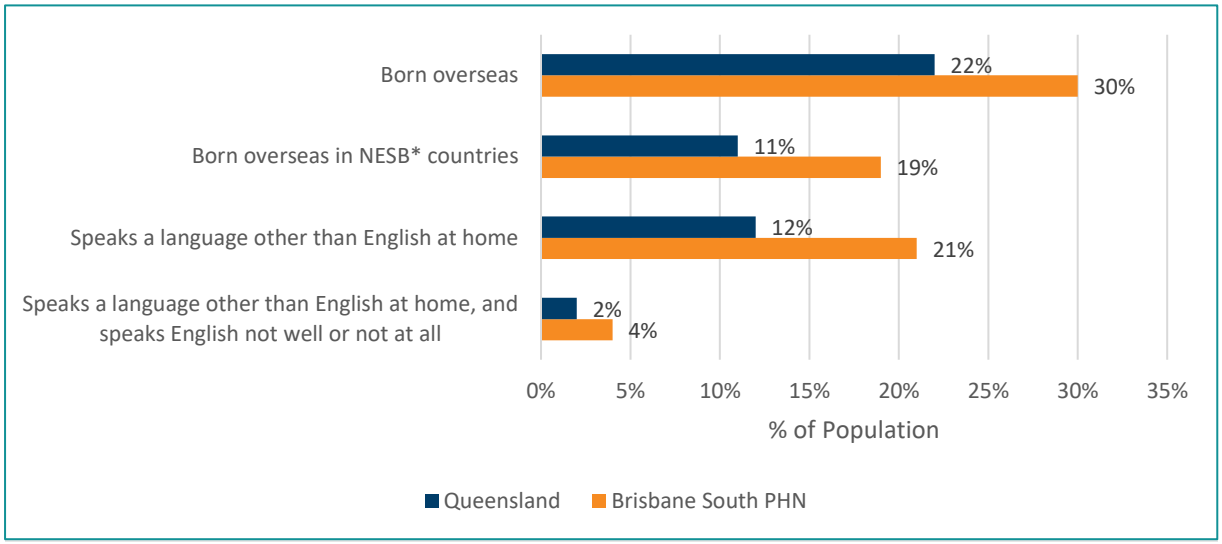

Figure 51. Cultural and Linguistic Diversity in Brisbane South PHN and Queensland, 2016
**NESB: Non-English-Speaking Background*
Source: QGSO 2017

Figure 52 and Figure 53 show the top five Non-English-speaking and English-speaking countries of birth for Brisbane south residents. The most common language other than English spoken in Brisbane south in 2016 was Mandarin, followed by Vietnamese, Cantonese, Korean, and Hindi; as shown in Figure 54.

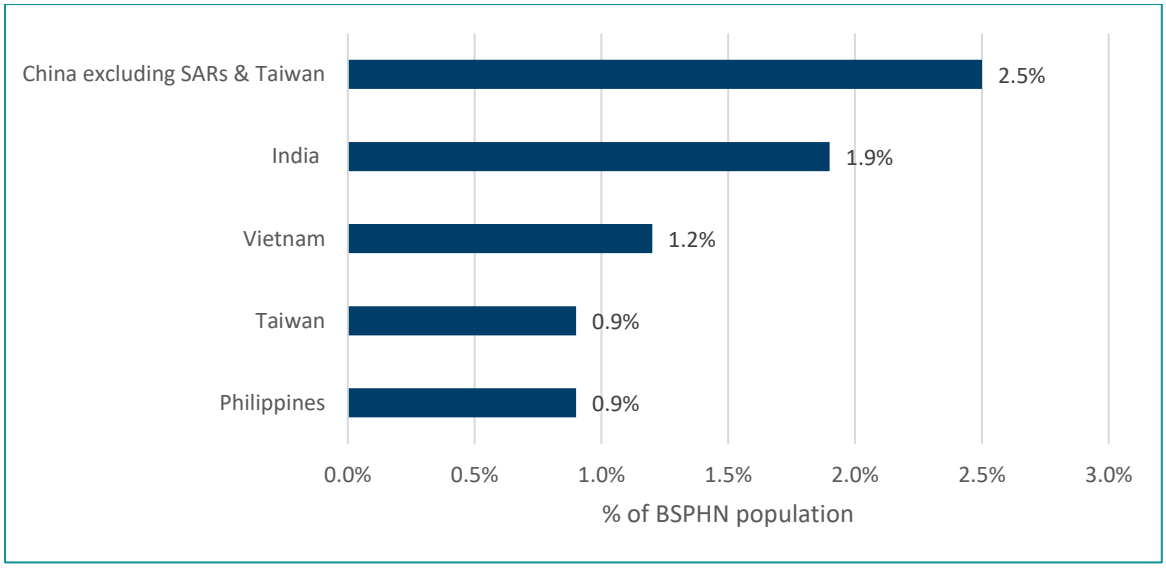

Figure 52. Top Five Non-English-Speaking Countries of Birth in Brisbane South PHN Region, 2016
Source: QGSO 2017

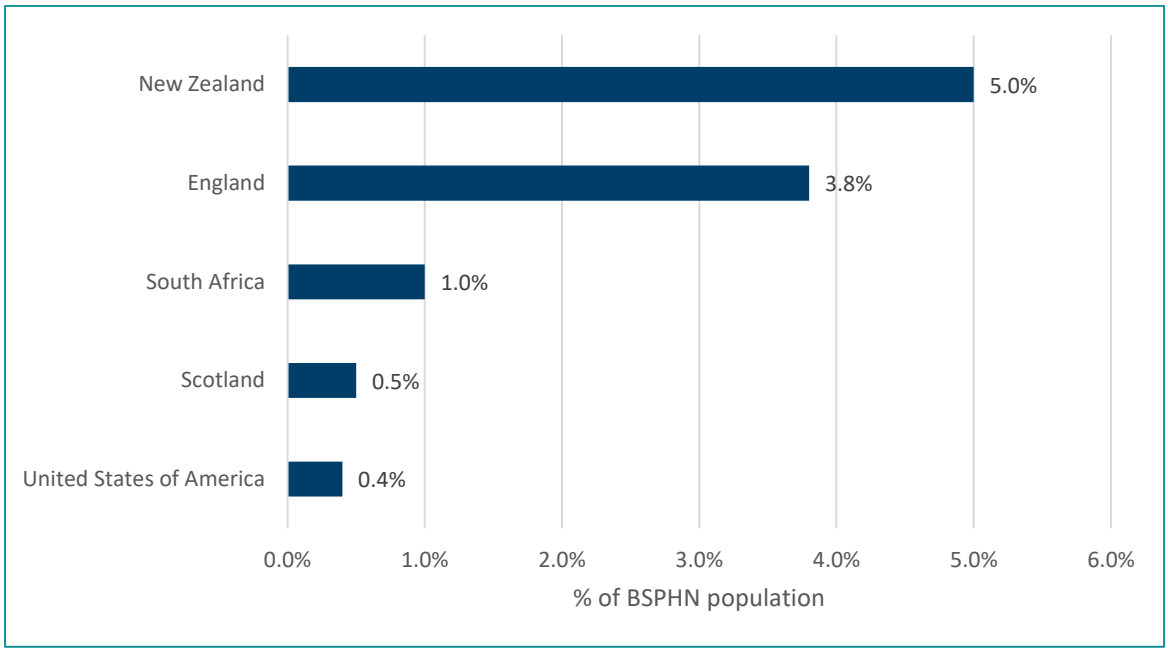

Figure 53. Top Five English-Speaking Countries of Birth in Brisbane South PHN Region, 2016
Source: QGSO 2017

The SA3s with the highest proportion of its population born in non-English-speaking countries are noted in Figure 55. These SA3s all fall within the Brisbane LGA and share at least one common border with each other from the centre of the Brisbane south region, out to the westernmost corridor of the Brisbane LGA. There are approximately 200 languages spoken in the Brisbane South PHN region with Mandarin, Vietnamese, Cantonese, Korean and Hindi constituting the top five languages other than English spoken at home (Figure 54). Sunnybank, Forest Lake-Oxley and Mt Gravatt SA3s had the highest proportions of people with low levels of proficiency in spoken English (range 8.1% to 12.6%), compared with the Brisbane south region (1.8%) and Queensland (3.8%) (Table 86).

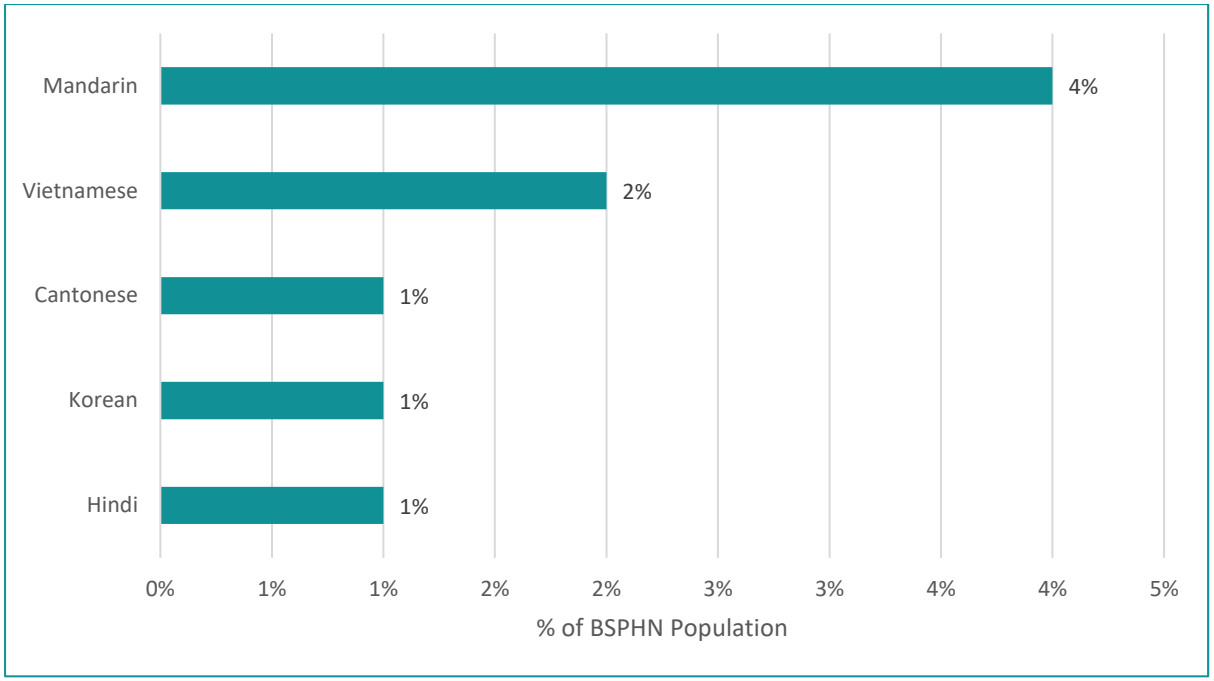

Figure 54. Top five languages other than English spoke at home in Brisbane South PHN Region, 2016
Source: QGSO 2017

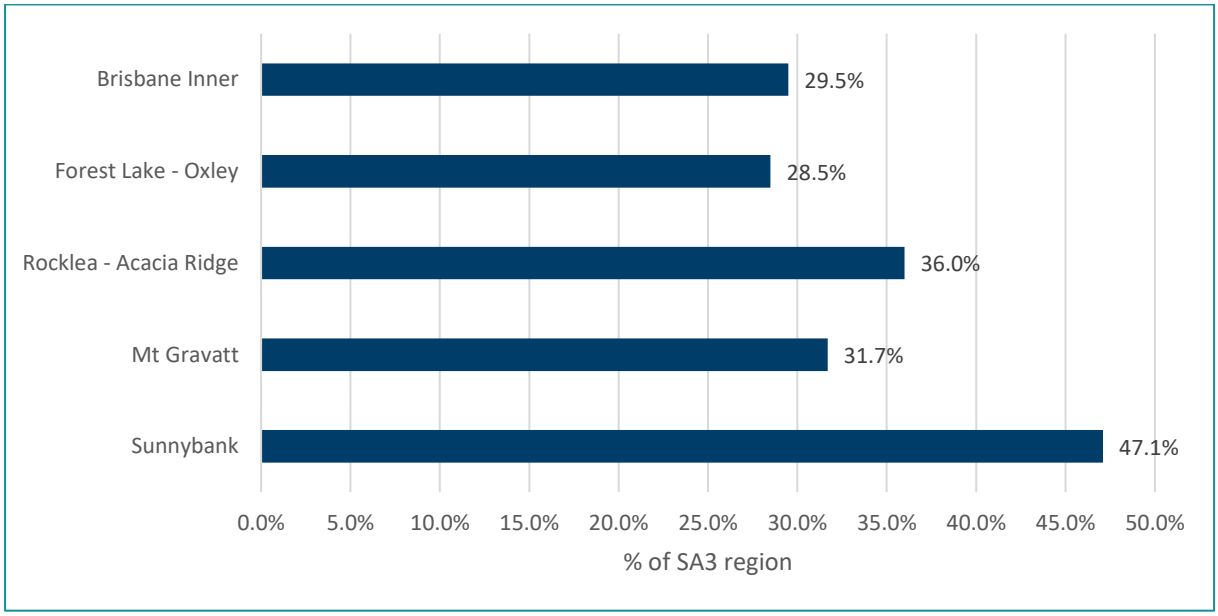

Figure 55. Brisbane South SA3s with the highest proportions of people born in non-English speaking countries, 2016
Source: QGSO 2017

Table 86. Proficiency in Spoken English of Persons by SA3, 2016

Region (State/PHN/SA3)		Speaks Other Language at Home and Speaks English Not Well or Not at All	
		Number	Proportion of Region Population (%)
Benchmark	Queensland	43,302	3.8
	Brisbane South PHN	83,675	1.8
Most Diverse	Sunnybank	6,284	12.6
	Forest Lake - Oxley	6,411	8.9
	Rocklea - Acacia Ridge	4,840	8.1
Least Diverse	Cleveland - Stradbroke	325	0.7
	Beaudesert	485	0.6
	Capalaba	29	0.2

Source: QGSO 2017

5.2.1.2 Pasifika and Māori people

Throughout this document, the term 'Pasifika and Māori' represents the peoples from New Zealand, Niue, Samoa, American Samoa, Tonga, Cook Islands, Hawaiian Islands, Rotuma, Midway Islands, Tokelau, Tuvalu, Cook Islands, French Polynesia, Easter Island (Rapa Nui), Papua New Guinea, the Indonesian provinces of Papua and West Papua, New Caledonia, Vanuatu, Fiji, Solomon Islands, Northern Marianas Islands, Guam, Wake Island, Palau, Marshall Islands, Kiribati, Nauru, and the Federated States of Micronesia (Brisbane South PHN 2021).

It is estimated that over 42,000 people from Pasifika and Māori backgrounds reside within the Brisbane south region – a population over twice the size of the First Nations population in the region. Over half (52.6%) of the Pasifika and Māori population in the PHN region live in the Logan LGA, and 39.5% live within the Brisbane LGA. Approximately one-third of the Pasifika and Māori population were born in Australia and 44% were born in New Zealand (Figure 56) (ABS 2016).

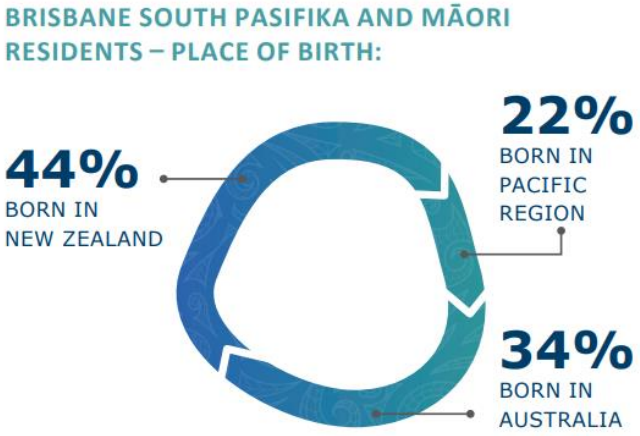

Figure 56. Brisbane South PHN Pasifika and Māori population by country of birth, 2016
Source: ABS 2016.

With many Pasifika and Māori people having migrated to Australia from or through New Zealand and potentially identifying themselves as New Zealanders in the Census, it is suspected that the true number of Pasifika and Māori people are significantly higher than currently recorded in official data (Queensland Health 2013). Pasifika and Māori populations are largely under-represented in health and other statistics when Country of Birth is recorded, rather than Ancestry and/or Ethnicity. Figure 57 demonstrates the diversity among Pasifika and Māori populations in Queensland, likely reflected within the Brisbane south region (ABS 2016).

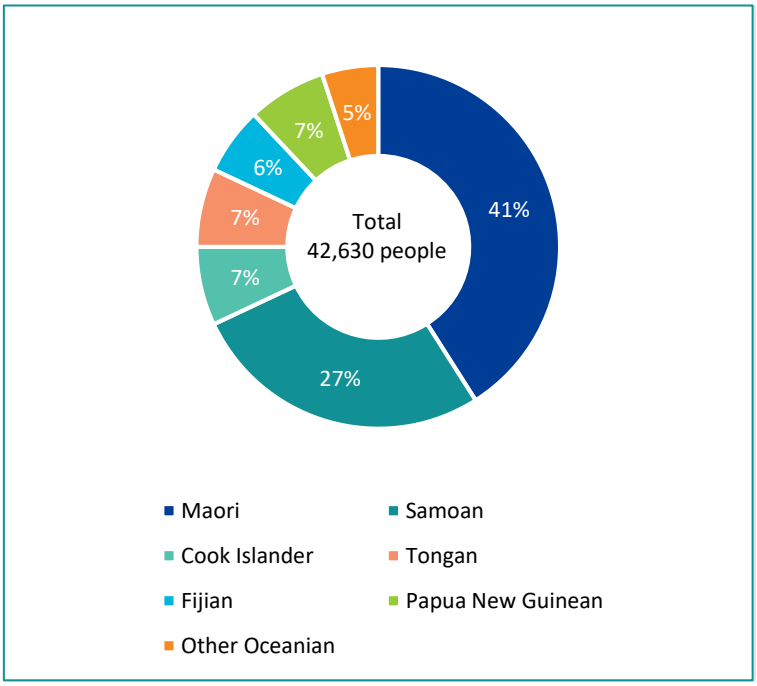

Figure 57. Brisbane South PHN residents with Pasifika and Māori ancestry, 2016
Source: ABS 2016

5.2.1.3 People from a Refugee Background

The United Nations High Commissioner for Refugees (UNHCR) defines refugees as "people who have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country". Refugees are recognised and protected by the *1951 Convention Relating to the Status of Refugees*, with the key guiding principles of non-discrimination, non-penalisation, and non-refoulement (UNHCR 1951).

Figure 58. The refugee journey

Under Australia's Refugee and Humanitarian program, approximately 3,000 refugees settle in Queensland each year across Brisbane, Logan, Toowoomba, Townsville, Cairns, Ipswich and Gold Coast. These new arrivals come from an ever changing and diverse list of countries impacted by change in the world environment, war and conflict, such as Iraq, Syria, the Democratic Republic of Congo, Somalia, Eritrea, Myanmar and Afghanistan (Queensland Health 2017).

Table 87. Settlement locations for new arrivals in Brisbane south, 2018-21

Settlement Location	Number of Clients
Inala	476
Mount Gravatt	89
Yeronga	210
Logan City Council	1,092

Source: Multicultural Australia 2021

As of 2017, Queensland was home to approximately 3,000 asylum seekers residing under a variety of visa classes (Queensland Health 2017). Within the Brisbane south region, Inala and Logan LGAs have seen the greatest number of people with a refugee background settle (Table 87). Settlement figures indicate a steep decline in 2020-21 (Figure 59) (Australian Government Department of Home Affairs 2021) due to restrictions during the COVID-19 pandemic.

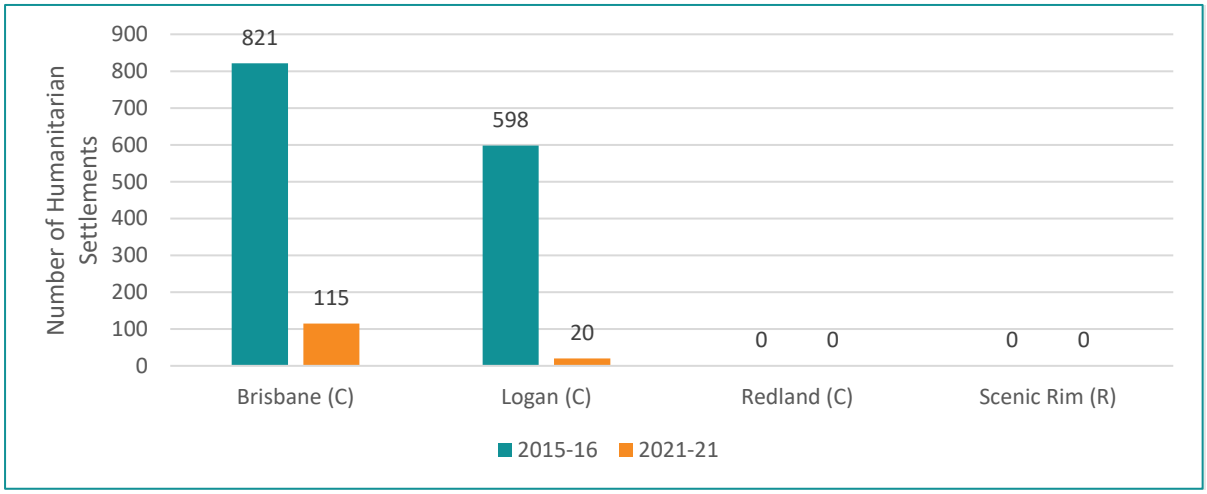

Figure 59. Number of Humanitarian Settlements in 2015-16 and 2020-21
Note that Brisbane LGA figures have not been apportioned to Brisbane South PHN component of this LGA (54%).
Source: Australian Government Department of Home Affairs 2021

Country of birth and/or ethnic origin (maternal origin) is considered an important contributor to pregnancy outcomes. Assessments of the general health of refugees from Asian countries in Australia, reveal poor preconception health including infectious diseases and nutritional deficiencies. Australian women born in South Asia have a higher risk of stillbirth and gestational diabetes compared to Australian-born women (Gibson-Helm et al 2015).

5.2.2 Community strengths

Multicultural communities have many strengths and capabilities, including resilience, resourcefulness, sense of community, collective problem-solving and support. Many speak multiple languages, have navigated multiple countries and systems; some have demonstrated tremendous resilience, surviving wars, torture, trauma, and refugee camps.

The high cultural diversity within the region brings with it a great strength and collectivism, demonstrated by the range of community and faith-based groups and organisations across the region. Religion, strong family bonds, and traditional values in culturally and linguistically diverse groups are protective factors for mental health and suicide (Embrace Multicultural Mental Health n.d.).

Community and sector representatives involved in local consultation highlighted strong connections between multicultural and refugee health services and the community as being a key strength.

5.2.3 Behaviours

While quantitative data is largely unavailable for health behaviours for people from multicultural backgrounds, there were a number of key themes raised by community and sector representatives during local consultation. These included concerns regarding medication safety, particularly the interaction between modern, traditional, and cultural medicines; and relatively low uptake of cancer screening programs such as cervical and breast screening.

Immunisation

People from refugee-like backgrounds are at an increased risk of not being fully immunised, as a result of the forced migration and refugee experiences, and international differences in vaccination schedules. Additionally, some people from refugee backgrounds may have received immunisations, but are unable to access written documentation of these immunisations. While some humanitarian entrants may receive some vaccines in alignment with the Departure Health Check, it is recommended by the *Australian Refugee Health Practice Guide* that full catch-up immunisation is carried out by health care providers (Victorian Foundation for Survivors of Torture Inc 2018). Due to data limitations, immunisations rates for people from refugee backgrounds are not available.

Data regarding the rates of immunisation among the Pasifika and Māori communities, people from refugee backgrounds, and other culturally and linguistically diverse groups are not available due to limitations with data collection and reporting.

Cancer Screening

It is reported that women whose first language is not English may have lower uptakes of preventive health measures (such as cervical and breast screening) and poorer health outcomes compared to those women whose first language is English (Victorian Foundation for Survivors of Torture Inc 2018).

5.2.4 Health Outcomes

Health outcomes data, similar to health behaviours data, is difficult to obtain for this diverse population cohort. Despite these limitations, community and sector representatives involved in local consultation and work with the PHN have identified several trends in health outcomes.

5.2.4.1 Pasifika and Māori people

Reportedly, there is a relatively high proportion of Pasifika and Māori children who are above their healthiest weight, which may place these young people at risk of ill health in later life. Additionally, the mental health and wellbeing of Pasifika and Māori young people was identified as a concern, particularly those young people who use alcohol and other drugs, those who are self-harming, and suicidality.

Presently, there is a reported high incidence of various lifestyle-related chronic diseases, such as type 2 diabetes, heart diseases, and oral health concerns in the adult Pasifika and Māori population Further, there is reportedly a relatively high incidence of cancer among Pasifika and Māori adults, and a need for tailored palliative care services. Finally, as the Pasifika and Māori population in the region is relatively young (41% aged 0-19 years), maternal health services are also a significant priority need for these communities.

As noted in **1.2.5.3 Chronic disease – Cardiovascular diseases**, a high proportion of Pasifika and Māori peoples are living with rheumatic heart disease within the region.

5.2.4.2 People from Refugee Backgrounds

Iron Deficiency and Anaemia

People from refugee backgrounds, particularly women of child-bearing age and children, are at an increased risk of developing iron deficiency and anaemia. Food insecurity and under-nutrition experienced prior to and following arrival in Australia are contributing factors to this increased risk, in addition to increased requirements and losses associated with menstrual blood loss, pregnancy, breastfeeding, and child development. Chronic infections, such as hookworm, may also deplete iron stores (Victorian Foundation for Survivors of Torture Inc 2018).

Hepatitis B and Hepatitis C

It is estimated that people born overseas are overrepresented in the population of people living with chronic hepatitis B virus (HBV) and chronic hepatitis C (HCV), particularly people from refugee backgrounds. A large proportion of the countries from which Humanitarian entrants are arriving from have a relatively high prevalence of HBV and HCV, with Sub-Saharan African refugees, Burmese refugees, and refugees from the Mekong region (Victorian Foundation for Survivors of Torture Inc 2018). Nearly two-thirds (61%) of people living with chronic HBV in 2016 were born overseas, with a large proportion born in the Asia-Pacific region (Department of Health 2018b).

Mental Health

Many people from refugee backgrounds have experienced significant hardships and violations of human rights prior to entering Australia. These experiences include torture, trauma, physical and sexual violence, and separation from loved ones. The hardships associated with immigration detention and prolonged uncertainty for asylum seekers are additional stressors, particularly for children. Activities and factors involved in the settlement process, such as gaining employment, financial and language barriers, and loss of cultural and community connectedness may also contribute significantly to stress and poorer mental health (Embrace Multicultural Mental Health n.d., Victorian Foundation for Survivors of Torture Inc 2018).

For men from refugee backgrounds, there are significant considerations related to context and environment prior to arriving in Australia (such as being combatants or prisoners of war), which can significantly impact mental health. Refugee men may experience barriers to accessing mental health care that are associated with stigma or feelings of reluctance to discuss past traumatic experiences (Victorian Foundation for Survivors of Torture Inc 2018).

Domestic and Family Violence

Domestic and family violence is estimated to be more prevalent in countries that are experiencing war, social upheaval, or conflict. Disclosure of domestic and family violence in women from refugee backgrounds is likely to be underreported. Victim-survivors of domestic and family violence face numerous barriers to disclosure, including financial dependence and fear of loss of custody of children. Women from refugee backgrounds may face additional barriers, such as the impact of disclosure on immigration status (Victorian Foundation for Survivors of Torture Inc 2018).

5.3 Health system

5.3.1 Service utilisation

5.3.1.1 Accessing and navigating services

Health and health care are complex issues, making the health system difficult to access and navigate care needs for many Australians. Accessibility and navigability of the health system for people from multicultural backgrounds can be further complicated by other factors such as language barriers;

racism and discrimination; fear, stigma and isolation, low literacy and low health literacy; and cultural barriers such as different health beliefs.

Local knowledge from the Brisbane south region has identified challenges for both consumer and primary care provider in navigating the health system. This also extends to adjacent systems, such as welfare (Centrelink). It has been reported that a greater understanding of the nuances between Centrelink and the Asylum Seeker Medicare entitlement is required, as this may result in non-renewal of Medicare cards and prevent access to timely care. There are numerous systemic barriers for accessing health services that exist for people from multicultural backgrounds, with two major factors being citizenship and visa status.

For primary care and service providers, there may be difficulties in accessing timely and appropriate interpreter services. It has been reported that appointments have been cancelled when an interpreter has not been available. The uptake of translating and interpreting services could be improved across the region in many disciplines of health and health care settings, including primary care, specialists, pharmacies, mental health, and allied health, including oral health, radiology and optometry.

The *Beyond Barriers of the Community* conducted by highlighted nine key perceptions and barriers to accessing mental health and alcohol and other drugs services in the Brisbane south region. These were:
1. Understanding of Mental Health within the community
2. Acknowledgement and prioritising mental health as a problem
3. Impact of Social Capital
4. The impact of Culture and faith
5. Stigma
6. Lack of Information
7. Role of healthcare professionals
8. Importance of community engagement
9. Accessibility, such as transportation concerns
10. Catering to a diverse Community (Queensland African Communities Council 2021).

Health literacy has also been described as a significant barrier for accessing timely and appropriate health care. This is true for the general population, and notably for people from multicultural backgrounds due to the differences in accessing and navigating the Australian health system, language and cultural differences. The increasing digitisation of health care, such as the use of electronic health records, again increases the complexity of the Australian health system. Cultural differences, such as beliefs about mental health concerns, may influence the uptake of health services, such as mental health services.

5.3.1.2 Medication use and safety

Optimising the use of medicine, and 'ensuring that the right patients get the right choice of medicine at the right time' is a key issue for the safe delivery of quality health care for the general population, specifically in primary health care. Cultural and linguistic barriers can significantly impact on the treatment received by refugees, but few studies have investigated the quality use of medicines in refugee communities (Kay et al 2016). Refugees from minority groups experience a range of barriers to access primary health care and achieving the Quality Use of Medicines, including language, literacy and communication difficulties.

Consistently noted in literature as key systemic barriers to health care and one of the most significant access barriers, is language difficulties and the need for interpreter services. The use of

these interpreter services improves the quality and safety of health care for patients. Despite the appropriate use of interpreter services being part of the Royal Australian College of General Practitioners Standards for General Practice, the free Telephone Interpreting Service is underused and often not well-understood.

In 2004, The Pharmaceutical Society of Australia (PSA) recognised that people from refugee backgrounds have significantly different health needs compared to the non-refugee peers. The PSA also recognised the important role and contribution pharmacists make in increasing access to medicines, providing medication information and delivering culturally appropriate services. Of the approximate 5,000 approved community pharmacies in Australia, only 1,200 have registered for the TIS. A South Australian study on the barriers to primary health care accessibility and medicine-related issues as experienced by refugee women, presented multiple themes:

- Language as a barrier
- Western system and understanding of illness
- Use of interpreters
- Education and literacy
- Local services (Clark et al 2013).

A 2016 study explored the facilitators and barriers of quality use of medicines in refugee communities. There were four key themes identified as facilitators:

- Coordination between healthcare providers
- Community engagement
- Healthcare provider training
- Providing information on medicines (Kay et al 2016).

5.3.2 Service experience

Key themes raised by community and sector representatives during local consultation regarding multicultural service experience included:

- the existence of cultural biases within the health system and services
- culturally inappropriate telehealth services not accounting for language barriers resulting in consumer difficulty utilising this modality
- the lack of culturally appropriate mental health, NDIS and aged care services
- the dismissal of alternative treatments, such as cultural health and traditional medicine, by health professionals and services practicing western medicine
- the lack of acceptance in tertiary settings of spiritual inclusion and healers
- extended waitlists for psychiatry, oral health and allied health services
- lack of service providers' acknowledgement of Brisbane south's diverse communities
- concerns about fraudulent activities by NDIS providers taking advantage of CALD clients
- the lack of resources for people seeking asylum in the region
- the lack of support for children, young people and parents to role model Pasifika values and frameworks
- the lack of mental health services tailored for multicultural men
- lack of alcohol and other drug support tailored to multicultural and refugee communities
- lack of early intervention and prevention for intergenerational trauma in refugee communities.

5.3.2.1 Service experience of Southeast Asian communities in Brisbane south

Brisbane South PHN undertook a project to better understand the health and service needs of its Southeast Asian communities in 2021. Key insights gained from this work revealed that a shared language and ethnicity between the health practitioner and consumer enhanced the development of trust and qualified communication in all groups aside from the Korean cohort engaged. Social vulnerability factors such as age play a part in accessing health services due to a lack of understanding of Medicare and specialist funding streams, e.g., elderly, Vietnamese women unable to access specialist surgery even where options under specialist initiatives (NDIS) exist. Elderly and newly arrived immigrants were unlikely to drive and were therefore reliant on others for transportation. This poses a barrier for access to timely health care. Finally, a lack of awareness of cultural stigma are significant barriers that exist to accessing health services particularly mental health services.

A heavily reliance on a GP or primary care provider to meet all health care needs was noted among these communities. Often, where the service provider relocates, the consumer may disengage entirely from the service. These factors may in turn be associated with poorer health outcomes. On the other hand, the use of community groups with known translators to distribute information on behalf of primary, specialist, and allied health service providers improves care coordination and simplifies messaging. Overall, the integration between primary care and specialist care was perceived as poor and lacking in continuity of care for consumers.

Several challenges were also noted with respect to accessing specialist treatment. These included a relatively limited diversity within the specialist workforce, and therefore greater attrition of patients before reaching specialist intervention. This may potentially have downstream impact on emergency response units and hospitals. Additionally, there was a lack of access to effectively engaging interpreters in specialist appointments, which resulted in feelings of poor cultural safety. Lastly, the lack of coordination and continuity of care through written language was reported to impede consumer engagement in care.

5.3.3 Service mapping

5.3.3.1 Settlement services

Each year, a large proportion of refugees settle in Brisbane LGA and Logan LGA. Settlement has reduced greatly over 2020-21 due to COVID-19. People from refugee backgrounds are supported by Multicultural Australia (formerly Multicultural Development Australia) when they first arrive in Queensland under the Humanitarian Settlement Program which includes case management, linkage to social services, housing, education and training and employment. Humanitarian entrants are connected to their nearest primary health service for their immediate and ongoing care with the support of Mater Integrated Refugee Health Service and Metro South Refugee Health Service who also commence their health assessments. Other services such as Access Community Services, Islamic Women's Association Australia, and Multilink also provide settlement support at different stages of the settlement journey. Loganlea, Mt Gravatt and Southbank TAFEs provide the Australian Migrant English Program in our region to eligible migrants and humanitarian entrants with low English levels to improve their English language skills and to help settle into Australia (Department of Home Affairs 2021).

5.3.3.2 Primary Care & Refugee Health Connect

Needs analysis conducted for the Greater Metro South Brisbane Medicare Local in 2013 identified significant coordination and access issues for people from refugee backgrounds settling in the Brisbane south region. In 2014, Refugee Health Connect was established to help address these

issues. Refugee Health Connect is a partnership between Brisbane South PHN, Brisbane North PHN, Mater Refugee Health Services, and Metro South Refugee Health Service aimed to support primary care in working with people from refugee backgrounds. By providing education and support, Refugee Health Connect builds the skills and capabilities of primary care across the Brisbane South and Brisbane North PHNs to manage the care of refugee families in a culturally and clinically appropriate manner. Refugee Health Connect is also a central point of contact for all aspects of refugee health to assist service providers with navigating the refugee health space and linking people from refugee backgrounds to appropriate providers in order to improve health access and engagement. Fourteen practices in the region (prior to COVID-19) regularly received newly arrived refugee patients. These are located in – Inala, Moorooka, Annerley, Stone Corner, Acacia Ridge, Sunnybank, Salisbury, Kuraby, Woodridge/Logan Central, Crestmead, and Loganlea.

5.3.3.3 Specialist Multicultural Health Services

The **Mater Refugee Complex Care Clinic** offers specialised primary health care including complex case management, treatment and specialist referral when appropriate. Asylum seekers without Medicare who are not able to access a community general practice are offered ongoing care.

The **Queensland Program of Assistance to Survivors of Torture and Trauma** provides flexible and culturally sensitive services to promote the health and wellbeing of people who have been tortured or who have suffered refugee-related trauma prior to migrating to Australia.

Queensland Transcultural Mental Health Centre is a specialist state-wide service that works to ensure people from culturally and linguistically diverse backgrounds receive culturally responsive mental health care and support.

Ethnic Communities Council of Queensland delivers My Health for Life, a chronic disease prevention program, for Chinese, Arabic Speaking, Vietnamese and Pacific Islander communities and also delivers a Hepatitis, HIV/AIDS & Sexual Health Program.

World Wellness Group is a multicultural health and wellbeing service for marginalised migrants, refugees and people seeking asylum, and provides physical and mental health services and traditional medicine services.

Village Connect is a Pasifika Community hub providing holistic maternal and child health services to the Pasifika community in Logan.

Multilink, **Islamic Womens Association Australia** and **Diversicare** specialise in providing aged care and disability services to multicultural communities.

Metro South Health employs three Multicultural Health Nurse Navigators and one Pasifika and Māori Nurse Navigator to support a patient's journey through an increasingly complex health system.

5.3.4 Workforce

Community and sector representatives involved in local consultation regarding multicultural health highlighted the need for services and practitioners that provide culturally safe and responsive services. These needs can in part be met by the provision of cultural safety and responsiveness training provided to health professionals.

The *Pasifika and Māori Strategy and Action Plan* has identified multiple actions related to the health workforce with a focus on:

- Improving the cultural responsiveness of mainstream health services
- Increasing culturally responsive health services for Pasifika and Māori women and their children
- Increasing culturally responsive mental health services

5.4 Health equity

With respect to health equity in Multicultural populations, this section will describe the intersectionality of these aspects of health equity with people from multicultural backgrounds.

5.4.1 LGBTQIA+ community members

There is limited information available relating to the health and wellbeing of multicultural peoples who identify as LGBTQIA+, and is currently a known gap in knowledge for the PHN.

Community and stakeholder engagement has revealed that compounded difficulties may exist for people from multicultural backgrounds who identify as LGBTQIA+, due to cultural or faith-based beliefs about gender diversity and sexual orientation. It has also been identified that there is a perceived lack of CALD-specific LGBTQIA+ services in the region.

5.4.2 People experiencing or at risk of homelessness

Limited data was available for people from multicultural backgrounds experiencing homelessness.

5.4.3 People with a disability

While local data is difficult to obtain for people with disability from multicultural backgrounds, it is estimated that people from CALD backgrounds experience profound and severe disability at similar rates to the wider Australian population. Nationally, it is estimated that 19.4% of all people with a disability were born in non-English speaking countries, with 6.1% having a profound or severe disability (compared to 19.1% and 5.8% for all Australians) (Settlement Services International 2018). As noted in other sections of the Needs Assessment, many people face difficulties in accessing and navigating primary care and disability services (including the NDIS) when proficient in English. These challenges are likely to be compounded for people from non-English speaking backgrounds in particular.

It has been acknowledged at a national level that there is a relatively reduced uptake of NDIS services among people from CALD backgrounds (Senaratna et al 2018). Key findings of Senaratna and colleagues (2018) highlight numerous challenges in:

- Accessing culturally appropriate services that meet needs prior to the NDIS
- Difficulties in gaining entry in to the NDIS, particularly for those people with relatively low English proficiency who had not had previous connections to disability services
- Experience participating in the NDIS process, including development of NDIS plans that accurately and wholly meet needs.

5.4.4 Rural and remote communities

Historically, refugees settling in Australia tended to move to cities where services are more available and accessible. The recent prioritisation of rural resettlement of migrants and refugees in rural areas by the Australian Government provided opportunities to revitalise rural communities, fill needs of employers in the region and to provide new arrivals with a welcoming community to integrate and

settle. Securing employment, discrimination and social isolation have been identified as challenges to rural resettlement, affecting health and wellbeing outcomes for the population. Integration is understood as a two-way process of adaptation that occurs between people arriving in a new place and receiving communities. For people from refugee backgrounds, some of the social determinants of health can impact on health outcomes and the experience of settlement, with integration being a vital aspect of the process. The facilitation of successful integration can have multiple social, economic and health benefits for refugees and receiving communities. Refugee participants in a 2020 study, described difficulties when living in rural communities such as securing employment and a churn in education and employment, barriers to community engagement, experiences of racism, a lack of cultural resources, limitations in settlement support and access to services due to travel requirements. They also described a number of experiences that promoted health and wellbeing such as a sense of safety and security, a quiet atmosphere, a good place to raise children, community support and affordability. The findings of the study suggest that social determinants of health and key elements of integration, are challenged in regional and rural areas for people from refugee backgrounds. Successful resettlement in rural areas should involve consideration of the links between social determinants of health and integration (Ziersch et al 2020).

5.5 Impact of COVID-19

5.5.1 Health status

Key themes raised by community and sector representatives during local consultation regarding the impact of the COVID-19 pandemic on multicultural people's health status included:

- Pasifika and Māori people being disproportionately impacted by unstable employment, loss of employment and financial hardship, compounded by government financial support being limited for New Zealand citizenship holders.
- Cultural differences in the definition of the nuclear family compared to Westernised definitions, and how this impacted on public health directives with respect to social isolation.
- A perceived increase in anxiety and depression among multicultural young people and adults.

5.5.2 Health system

Key themes raised by community and sector representatives during local consultation regarding the impact of the COVID-19 pandemic on multicultural and refugee people in the health system included:

- The lack of culturally appropriate resources regarding the COVID-19 pandemic resulting in people obtaining information from overseas that is not applicable to the Australian context.
- The challenges Pasifika and Māori peoples face in getting prescriptions filled during COVID-19 pandemic isolation and lockdowns.
- The lack of appropriate and accessible communication regarding the COVID-19 vaccine.

5.6 Health priorities and options

5.6.1 Priority unmet needs

Considering the comparative, felt, expressed and normative needs of the Brisbane south region, several multicultural health-related priority unmet needs emerged during triangulation. In order of priority, as determined through the prioritisation process, these needs are:

1. Systems and services are often difficult for people from multicultural backgrounds to navigate and access.

2. Working in partnership with the growing Pasifika and Māori communities, and services, to build on their strengths and support optimal health and wellbeing.
3. Multicultural communities experience disproportionate health and social outcomes compared to the wider population in Brisbane south.

5.6.2 Current activities

5.6.2.1 Refugee Health Connect

Refugee Health Connect is a partnership between Brisbane South and Brisbane North PHNs, Mater and Metro South Health, providing a single point of contact for service providers to access information and support regarding refugee health. Service providers are assisted in navigating the system by linking people from refugee backgrounds to other suitable health care providers based on a range of patient-specific factors such as location, complexity of care needs and cultural requirements. It also aims to build the skills and capabilities of primary health professionals to manage the care of refugee families in a culturally and linguistically appropriate manner. Brisbane South PHN clinical leads provide peer-to-peer education for general practitioners and practice nurses, as well as in-house practice support and guidance, cross-cultural training, clinical education events and resources for clinical and administrative staff.

5.6.2.2 Refugee Health Policy and Action Plan

Queensland's Refugee Health Policy and Action Plan aims to improve the health and wellbeing of people from refugee backgrounds in Queensland using a state-wide, system-wide and action-oriented approach. For identified priority areas for action, it aims to give practical guidance that will increase access to timely, high quality and culturally responsive healthcare services. The action plan recognises the importance of adopting an integrated partnership approach to health care to achieve the vision and completion of the actions. Collaboration involves Hospital and Health Services, Primary Health Networks, primary care, refugee-specific organisations and other non-Government organisations aimed at improving the health and wellbeing of people from refugee backgrounds.

5.6.2.3 Pasifika Māori strategy

Brisbane South PHN's vision for the Pasifika Maori strategy 2020-2025 is to provide a collaborative, family-centred and culturally responsive approach to delivering better health futures for Pasifika and Maori peoples in Brisbane south. The strategy is in alignment with Queensland's *Our Future State* priorities, and aims to ensure

- all Pasifika and Māori Queensland women receive high quality support during their pregnancy,
- all Pasifika and Māori Queensland parents and carers immunise their babies and ensure their children receive the right developmental support at the right time
- early childhood education is promoted to all Pasifika and Māori Queensland families to foster support of early childhood development and achieve overall wellbeing for children
- work is undertaken with all Pasifika and Māori Queensland parents, carers and schools to help children understand healthy choices
- Pasifika and Māori Queensland young people are supported to keep them engaged in education, training and work and to positively contribute to the community
- all Pasifika and Māori Queenslanders can enjoy the benefits of good health and wellbeing and enjoy a good quality of life.

5.6.2.4 DESMOND

Brisbane South PHN, in collaboration with Diabetes Queensland, has identified culturally and linguistically diverse (CALD) communities to address the challenges faced in understanding or adapting type 2 diabetes information and advice from health professions, specifically Maori, Pacific

Islander and Arabic-speaking clients. Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) is an educational initiative designed to support people living with Type 2 diabetes. The one-day program helps people learn about healthy food choices, physical activity, medication and other proactive steps they can take towards general well-being after being diagnosed (Diabetes Queensland reference).

5.6.3 Options for future activity

- Partner, collaborate and lead system reform, delivering measurable and meaningful health and wellbeing impact. This may include working with health system partners, settlement agencies, and other social services to advocate for, and implement, policy reform to enhance the accessibility and navigability of the health system for people from multicultural backgrounds. `
- Integrate and coordinate care systems within a holistic social determinants framework.
- Support community-led action that delivers sustainable change in health and wellbeing. Options for action may include the coproduction of service solutions with local communities, supporting communities to drive their priorities for enhancing health and wellbeing outcomes, and supporting community leaders and natural supports.
- Improve the health and wellbeing outcomes of our community, with a focus on addressing health inequities and inequalities.
- Enable strong and connected primary care to create a person-centred system that improves health access, experiences and outcomes. This may include the capability building of mainstream primary care services to provide culturally safe and inclusive care.

6. Mental health and suicide prevention

While most people will experience good mental health and wellbeing most of the time, many Queenslanders will experience difficulties with their mental health at some point in their lives. For some, these challenges may be temporary, for others they may persist over a long period.

Poor mental health can have a significant negative impact on the overall health and wellbeing of an individual and their ability to cope with stressors, work productively and contribute to their community. Suicide is a tragic event that has long-lasting impacts on families as well as the wider community. Individuals with existing mental health or substance use issues are more likely to attempt suicide, however suicidality does not always occur in the context of mental health concerns.

Please note that this section relates predominantly to adult mental health and suicide prevention. Mental health related to children, young people, and families is discussed in *Section 2 Child, Youth & Family*. This includes perinatal mental health.

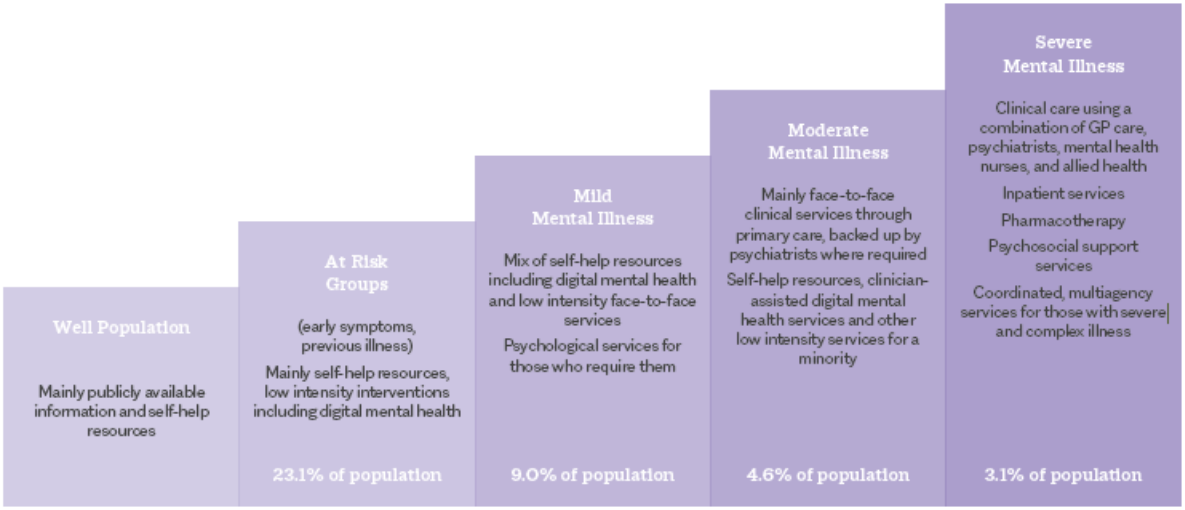

Figure 60. Stepped care continuum of mental health services
Source: Brisbane South PHN 2020

6.1 Strategic environment

6.1.1 National

The *Fifth National Mental Health and Suicide Prevention Plan* (2017) provides a national framework for building a mental health system that enables recovery, prevents and detects poor mental health early, and ensures all Australians can access effective and appropriate treatment and support. The *Fifth Plan* sets out eight priority areas for mental health reform and service delivery, including:

- integrated regional planning and service delivery
- suicide prevention
- coordinating treatment and supports for people with severe and complex mental illness
- improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- improving the physical health of people living with mental illness and reducing early mortality
- reducing stigma and discrimination
- making safety and quality central to mental health service delivery

- performance and system improvement.

The *Fifth Plan* emphasises the responsibilities of PHNs and Local Hospital Networks to support integration at a regional level, leading coordinated activities and working in partnership with local stakeholders including consumers and carers to plan and realise change.

Across Australia, PHNs are provided funding by the Commonwealth Government to commission primary mental health and suicide prevention services across the stepped care continuum to respond to the needs of their communities. Guidance produced by the Department of Health describes stepped care as providing person-centred care, targeted at the individual needs of consumers for mental health services (Figure 60). Stepped care aims to provide a continuum of primary mental health services that, together with specialist and acute mental health services, provides the right service, in the right place, at the right time. PHNs commission services within this stepped care model aligned to several priorities, including:

- low intensity services,
- services for under-serviced, hard to reach groups,
- services for children and young people with or at risk of mental illness,
- services for people with severe mental illness being managed in primary care,
- suicide prevention, and
- First Nations social and emotional wellbeing services.

In May 2021, the Commonwealth Government released its response to the recommendations from the Productivity Commission Inquiry Report on Mental Health and the National Suicide Prevention Adviser's Final Advice — a plan titled *Prevention, Compassion, Care*. This plan invests additional resources across five key pillars to improve mental health outcomes including prevention and early intervention, suicide prevention, treatment, supporting the vulnerable, and workforce and governance (Department of Health 2021e).

6.1.2 State

The Queensland Mental Health Commission's *Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023* (2018) outlines the Queensland Government's approach to improving the mental health and wellbeing of Queenslanders with three focus areas:

- Better lives — including integrated models of care focused on both clinical treatment and psychosocial supports; developing a capable workforce; and strengthening human rights protections
- Invest to save — including strengthening mental health and wellbeing and prioritising early intervention
- Whole-of-system improvement — including integrated needs-based planning at state and regional levels, cross-sectoral approaches and shared leadership.

In 2019, the Queensland Mental Health Commission released *Every Life: The Queensland Suicide Prevention Plan 2019* that aimed to provide a whole-of-government approach to achieve the target of reducing the rate of suicide by 50 per cent by 2026. *Every Life* emphasises that multiple stakeholders and agencies must contribute to an effective suicide prevention response. The role of Primary Health Networks is identified in developing regional suicide prevention plans in partnership with Hospital and Health Services (HHSs) and local communities, and commissioning mental health, alcohol and other drugs, suicide prevention, and social and emotional wellbeing services that meet the needs of their communities.

Developed in 2015, Queensland Health's *Connecting care to recovery 2016 – 2021: a plan for Queensland's State funded mental health, alcohol and other drugs services* (2016) highlights key priority areas for State-funded services. It identifies the need for partnerships and collaborations between HHSs, PHNs, community organisations, Aboriginal Community-Controlled Health Services, private providers, and peak bodies.

6.1.3 Regional

The *Brisbane South Mental Health, Suicide Prevention and Alcohol and Other Drug Strategy 2019-2022* developed by Brisbane South PHN in 2018 outlines a series of strategies to respond to the mental health and wellbeing needs of people and communities in Brisbane south, including:

- Promote integrated planning and service delivery
- Enhance community and stakeholder engagement
- Build strong partnerships
- Develop new models of care
- Improve services for priority population groups
- Improve access to services
- Develop workforce capability
- Build Brisbane South PHN capability to deliver transformational change.

The plan emphasises the specific needs of priority population groups in the Brisbane south region, including First Nations peoples, young people, multicultural communities, and LGBTQIA+ communities.

In July 2020, Brisbane South PHN and Metro South Health released Working Together Differently: Brisbane South Mental Health, Suicide Prevention and Alcohol and Other Drug Foundation Plan 2020-2022. It represents a regional commitment to embedding collaboration and integration into planning, practice and services. The Foundation Plan will build the capacity for Brisbane South PHN and Metro South Health to develop a comprehensive Joint Regional Plan by mid- to late- 2022. The Foundation Plan identifies four key priorities:

- **Governance** — including partnerships, leadership, accountability and quality/safety
- **Information and data** — including evidence-informed planning and system/process development
- **Workforce capability** — including workplace planning and development initiatives
- **Stakeholder engagement** — including consultation and co-design with local stakeholders.

6.1.4 Sector

In mid-2020, the Productivity Commission released an *Inquiry Report on Mental Health* that advocated for the improvement of the mental health system to benefit all Australians. The report states that almost one in five Australians has experienced mental illness in any given year and many don't receive the treatment or support they need. This may result in physical and mental distress, disengagement with education and employment, breakdown of relationships, reduced opportunities, and poor life satisfaction. From an economic perspective, national reform of the mental health system would result in significant financial benefits relating to improvements in quality of life, increased economic participation and reduced health system costs. Brisbane South PHN are positioned well to contribute to each of the priority reforms identified by the Productivity Commission, including:

- **Priority reform 1 – prevention and early help for people:** focus on promoting mental wellbeing from the earliest possible point, reducing stigma at a population, focussing on communities at

higher risk of suicide (e.g. First Nations) and ensuring people are supported after suicide attempts.

- **Priority reform 2 – improve people's experiences with mental healthcare:** create a person-centred mental health system, get people the right services and the right time (e.g. online treatment, access to care at the right intensity and providing options for people other than emergency departments), improve mental healthcare outcomes and provide care continuity and coordination.
- **Priority reform 3 – improve people's experiences with services beyond the health system**: work productively with first responders, community services organisations and government departments to identify and respond to people with mental health concerns and those who are experiencing suicidality.
- **Priority reform 4 – equip workplaces to be mentally healthy:** use the workplace as a key setting to drive raise awareness of mental health and wellbeing as well as support staff to access services and resources to seek help.
- **Priority reform 5 – instil incentive and accountability for improved outcomes:** drive system reform, including regional planning, decision making and commissioning, to generate improved outcomes for people experiencing mental health issues.

In December 2020, the *National Suicide Prevention Adviser and Taskforce* provided their final advice to the Australian Government in relation suicide prevention across Australia. The report provides a compelling case for change in how the sector approaches suicide prevention to save lives and avoid people reaching suicide crisis. Brisbane South PHN has direct line of sight and potential involvement in shaping the local suicide prevention system to improve outcomes for people by supporting the delivery of the driven by four key enablers and four key shifts identified by the National Suicide Prevention Adviser.

- **Key enablers:** Leadership and governance to drive a whole of government approach, lived experience knowledge and insight, data and evidence to drive outcomes, workforce and community capability
- **Key shifts:** Responding earlier to distress, connecting people to compassionate services and supports, targeting groups that are disproportionally affected by suicide delivering policy responses that improve security and safety

Additionally, PHNs are called out specifically to support 'a coordinated and responsive system of care for people experiencing or impacted by suicidal behaviour' through supporting:

- A full range of services and supports to be available to meet diverse needs
- Enhancing service coordination at the local level
- The delivery of a diverse range of services in ways that are appropriate and preferred by priority population groups
- The provision of clinical and non-clinical options across prevention, intervention, aftercare and postvention.

In addition to tackling suicide at a whole-of-government level, Black Dog Institute's *LifeSpan Framework* provides guidance on how to reduce suicide deaths and attempts at a community-level. The *LifeSpan Framework* involves the implementation of nine evidence-based strategies simultaneously within a localised area. For each strategy, the *LifeSpan Framework* identifies and implements the interventions or programs that have the strongest evidence base. These strategies are based on the most up-to-date evidence drawn from similar, large-scale international suicide prevention programs that have shown positive results.

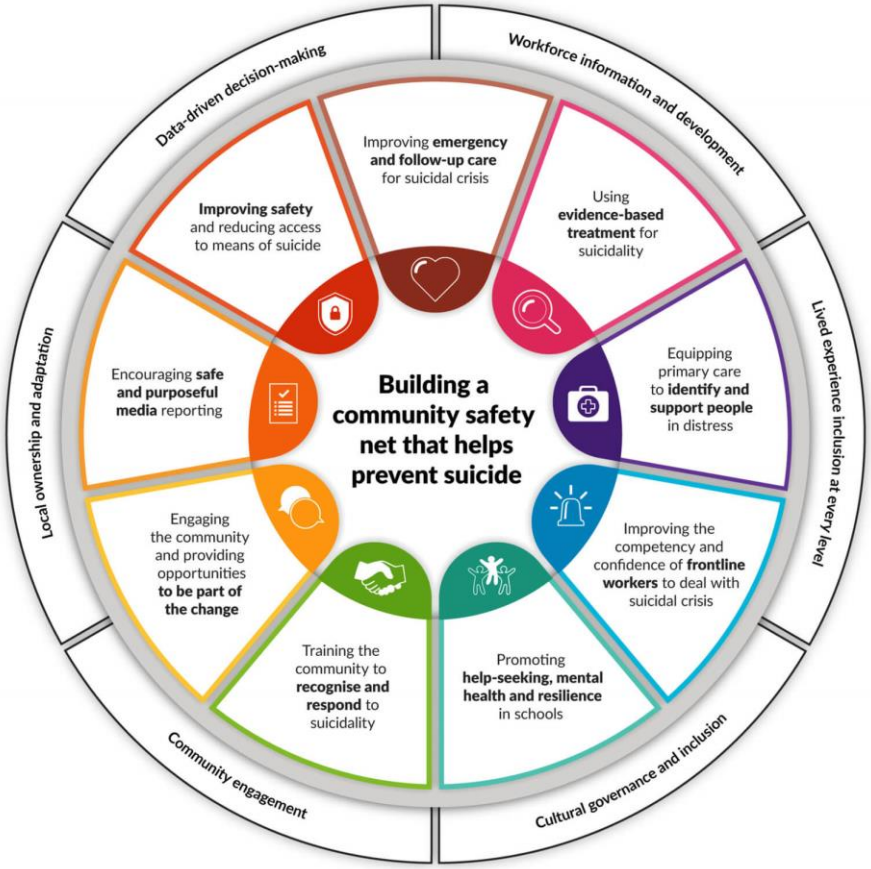

Figure 61. LifeSpan Framework
Source: Black Dog Institute 2021

Although not all directly related to the health system, the LifeSpan Framework articulates nine strategies that Brisbane South PHN may play a role in, either directly or indirectly. These are summarised in Figure 61.

6.2 Health status

The *Fifth National Mental Health and Suicide Prevention Plan* (2017) highlights the diversity in experiences and needs of people living with severe mental health concerns. Whereas some people may experience illness in episodic periods, others may experience more persistent illness that can have an impact on their functional capacity. Service needs may range from time-limited clinical services to hospital-based services and community support (Mental Health Commission 2017).

The Plan also highlights the importance of improving the physical health of people experiencing mental health concerns, with physical health treatment rates in people experiencing mental health concerns notably lower than people living with only physical health concerns. People experiencing mental health concerns are more likely to die at a younger age and experience a range of chronic conditions (such as cardiovascular disease, respiratory disease, diabetes, and cancer). This is particularly the case for people living with psychotic disorders.

There is a strong association between illicit drug use and mental health concerns (AIHW 2018l), as well as a higher likelihood of experiencing mental illness among people living with substantial physical health conditions (Mental Health Commission 2017).

6.2.1 Demography

Mental ill health can impact people from all backgrounds and walks of life, with the underlying causes and contributing factors varying widely. In saying this, research highlights some population sub-groups that are more likely to experience mental health concerns. These population subgroups include:

- veterans,
- young people,
- adult men,
- First Nations peoples,
- people experiencing domestic and family violence, and
- people of low socio-economic status (Australian Institute for Suicide Research and Prevention 2016, AIHW 2018b, Queensland Health 2017).

6.2.2 Socioeconomic

It is recognised that an economic gradient exists between rates of overnight mental health-related separations without specialised psychiatric care and socioeconomic status in Australia. The highest rates of hospitalisation were witnessed among people in the most disadvantaged quintile while the lowest rates witnessed among people in the least disadvantaged quintile (44.6 and 33.4 ASR per 10,000 persons respectively) (AIHW 2021).

Community and sector stakeholders highlighted high youth unemployment as a factor of concern which is negatively impacting the mental health of Brisbane south community members.

6.2.3 Health outcomes

6.2.3.1 Psychological distress

An estimated 116,568 adults residing in Brisbane south self-reported high or very high levels of psychological distress in 2017-18, 57% of which were female (ABS 2018). With an age-standardised rate of 13.3 per 100 persons, Brisbane south's rate of people reporting high or very high psychological distress was slightly higher than Queensland figures and places Brisbane South PHN 14th among the 31 PHNs nationally (Public Health Information and Development Unit 2021). Figure 62 shows the levels of self-reported psychological distress within Brisbane south's SA3 regions. The data highlights several areas of socioeconomic disadvantage, including Forest Lake – Oxley, Beenleigh, Springwood – Kingston, Browns Plains and Jimboomba, had the highest levels of psychological distress while areas of socioeconomic advantage tended to have significantly lower levels of psychological distress (i.e. Brisbane Inner, Brisbane Inner – East, Carindale, Sherwood – Indooroopilly, etc.) (PHIDU 2021).

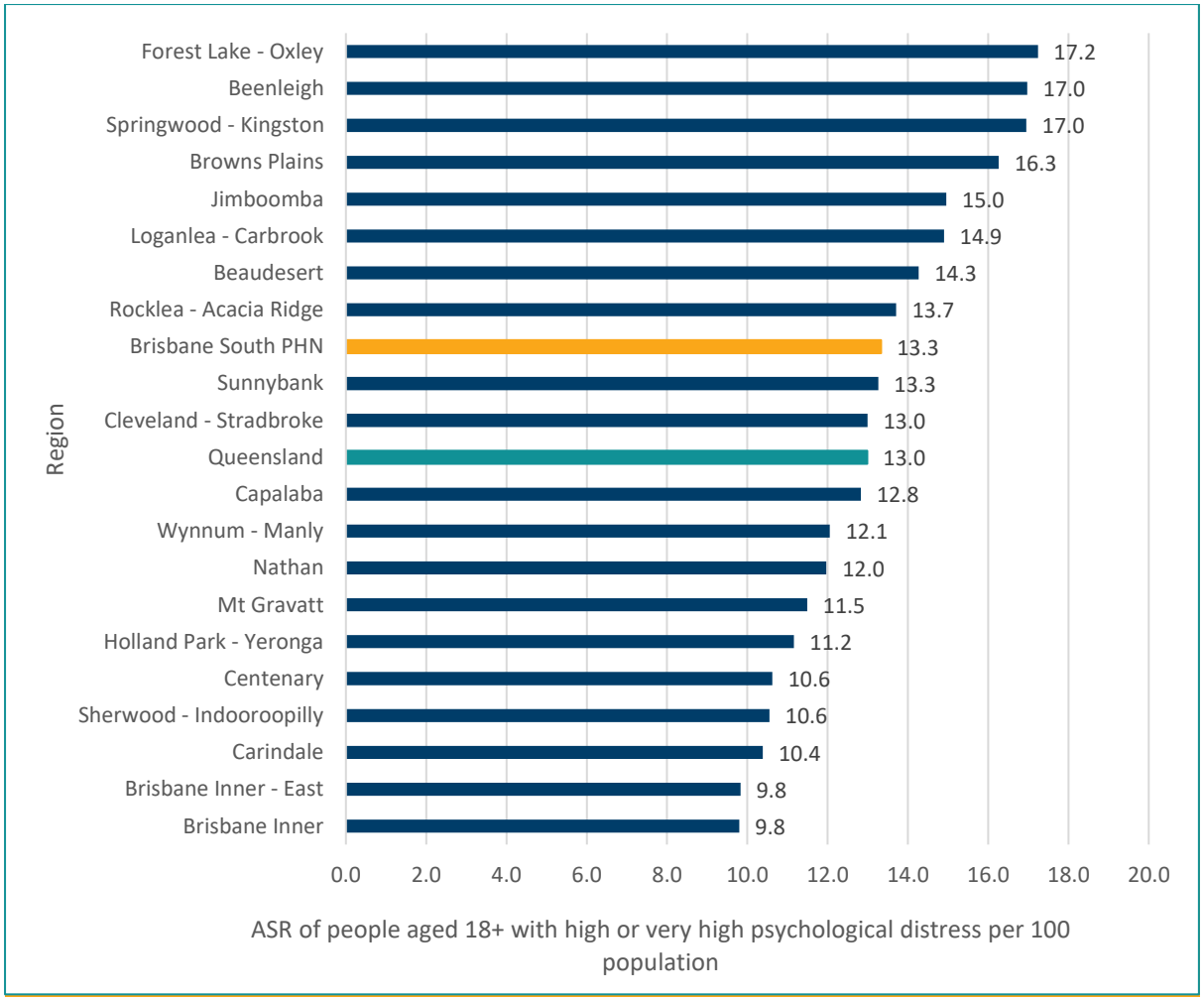

Figure 62 Age-standardised rate of adults with high or very high psychological distress on Kessler 10 Scale (K10) by SA3, Brisbane south and Queensland, 2017-18

6.2.3.2 Mental ill health

The Australian Government Department of Health defines mental illness as a broad term used to describe a group of conditions or disorders that significantly impact on how a person feels, thinks, behaves, and interacts with others (Department of Health 2007). For the purposes of this report, the term mental health condition will be used to describe all diagnosable mental illnesses and mental health concerns that are sub-threshold to clinical diagnosis.

Consistent data on the prevalence of various mental ill health at national or regional level is not systematically collected in Australia. Estimates of prevalence are often derived from self-report surveys with representative samples or modelling of estimated population prevalence.

Based on *National Health Survey* data from 2017-18, an estimated 253,000 people living in Brisbane south reported that they had ever been told by a doctor or nurse that they had one or more of the following mental health or behavioural concerns:

- anxiety-related conditions (such as anxiety disorders/ feeling anxious, nervous or tense)
- mood (affective) disorders (such as depression/ feeling depressed)
- alcohol and drug problems
- problems of psychological development
- behavioural, cognitive and emotional problems with usual onset in childhood/adolescence
- other mental and behavioural problems.

As an age-standardised rate, this equates to approximately 22.3 per 100 persons, which was comparable with the Queensland rate of 22.7 per 100 persons. Figure 63 shows the breakdown of people in the Brisbane South PHN region self-reporting a mental and behavioural problem by SA3 in 2017-18 (ABS 2018).

This data indicates relatively higher rates of 'mental and behavioural problems' in several groupings of SA3s distributed across Brisbane south, including inner parts of the Brisbane LGA (Brisbane Inner, Brisbane Inner – East), two SA3s within Logan LGA (Springwood – Kingston, Browns Plains), Beaudesert within Scenic Rim LGA, and Capalaba within Redland LGA (ABS 2018).
Considering self-reported mental health and behavioural problems by sex, females had a higher rate than males, at 24.6 per 100 persons compared to 20.0 per 100 persons respectively. This trend was consistent with state-wide reporting (ABS 2018).

The *National Mental Health Service Planning Framework (NMSPF)* (2016) developed by the Queensland Centre for Mental Health Research uses epidemiological modelling to estimate the prevalence of mental illness across Australia at various levels of severity (The University of Queensland 2016). While variation of these estimates is likely across the region due to factors such as demographics, socioeconomic conditions, cultural diversity, remoteness and the supply and access of appropriate mental health services to meet demand, they provide a framework for considering population-level need for mental health treatment.

The *NMHSPF* estimated that across Australia, 16.7% of people aged 18 to 64 years' experience either a mild, moderate or severe mental health concern in any year, including:

- 3.1% of the population living with mental health conditions described as 'severe disorders', such as schizophrenia, bipolar disorders and/or severe depression.
- It is estimated that two-thirds of people living with severe mental health conditions will experience episodic periods of ill health, whereas one-third will experience live with persistent ill health.

- A further third of those with severe and persistent disorders (i.e. 0.4% of the total population) will experience significant psychosocial impairment and associated disability.
- 4.6% of the population experiencing moderate severity mental health conditions.
- 9.0% of the population experiencing mild severity mental health conditions.

In addition to these individuals, almost another quarter of the population (23.1%) was estimated to experience some type of mental health concerns or risk factors in a given year without meeting the criteria for a diagnosed mental health condition. It is estimated that 60% of the population will have no mental health needs in a given year.

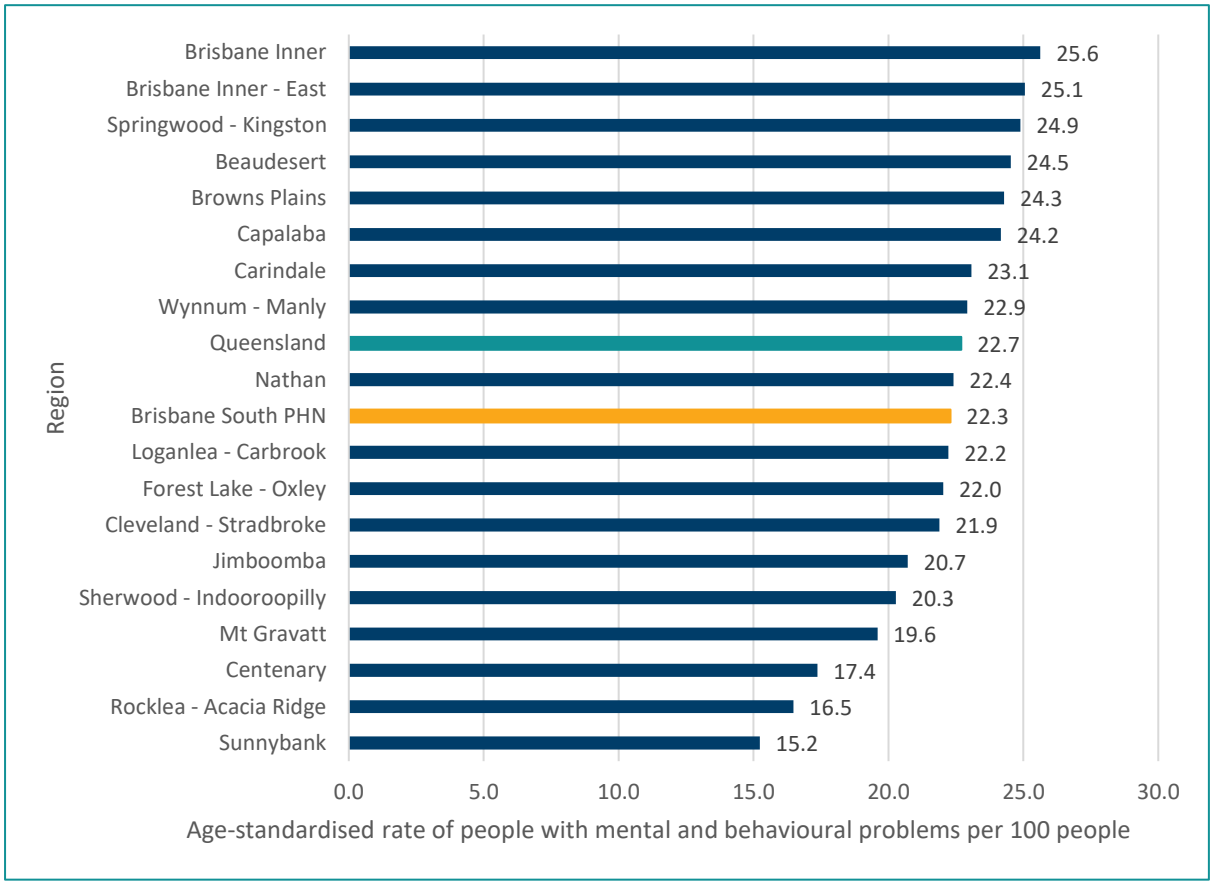

Figure 63. Age-standardised rate of people with mental and behavioural problems by SA3, Brisbane south and Queensland, 2017-18

Source: ABS 2018.

6.2.3.3 Eating disorders

Anecdotally, the prevalence of eating disorders across the Brisbane south region has increased, particularly over the past 18 months with the advent of the COVID-19 pandemic; and has thus been identified as an emerging need.

Eating disorders describes a group of mental health conditions characterised by a persons' unproductive or unhealth preoccupation or control with food, eating, exercise and body weight or shape. Eating disorders are not a lifestyle choice, a diet gone wrong, nor a cry for attention. Eating disorders can be present at any weight. They take many different forms and impair a person's day to day functioning. Without appropriate intervention as early as possible during illness, eating disorders are likely to persist long term, with life-threatening physical and psychological complications. Eating disorders encompass the following mental health conditions:

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Body Dysmorphic Disorder
- Avoidant or Restrictive Food Intake Disorder
- All sub-clinical diagnostic behaviours related to the above conditions (Other Specified Feeding and Eating Disorders) (Eating Disorders Queensland 2021, Brisbane South PHN n.d.)

Estimates of the prevalence of eating disorders were difficult to obtain, and were variable depending on the type of eating disorder. For Australians aged 15+ years, the estimated prevalence of any eating disorder was 4 - 16% (depending on whether broader behavioural criteria or a narrower clinical diagnostic criterion were used). While a person may experience an eating disorder at any stage of life, data from hospital admissions with a principal diagnosis of an eating disorder indicated most hospitalisations occurred for women aged 15 to 24 years (57% of all eating disorder hospitalisations) (AIHW 2018f).

6.2.3.4 Hoarding disorder

Hoarding disorder is characterised by the persistent difficulty in discarding with possessions, regardless of their value, which results in accumulation of possessions in active living areas that significantly impact on their functionality. These difficulties in discarding possessions are underpinned by a perceived need to retain the items, and notable person distress with the thought of discarding them. The consequences of hoarding disorder are wide-ranging, with great impact on the individual and their family, and local community (Collett 2019).

The prevalence of hoarding disorder is estimated between two and six per cent, and disproportionately affect males (Collett 2019), however, localised data is not available at a state or regional level. Stakeholder engagement revealed a growing need for services to support people experiencing hoarding behaviours, particularly within the Brisbane LGA.

6.2.3.5 Intentional Self-harm

While no universally-agreed definition exists, intentional self-harm is commonly described as the deliberate “injuring or hurting of oneself, with or without the intention of dying” (AIHW 2021). While self-harm is a risk factor for suicide, the majority of people who engage in self-harm behaviours do not end their lives (AIHW 2021).

Analysis conducted by the Australian Institute for Suicide Research and Prevention (AISRAP) on intentional self-harming behaviours in the Brisbane south region highlighted that the most frequently presenting age groups to ED were those aged 15-19 years and 20-24 years. This report notes that poisonings (such as antiepileptic and psychotropic drugs) and cutting and piercing were the most frequently used methods for intentional self-harm, with females more likely to overdose on analgesics that males. This report also highlighted that while typically repetitive in nature, repeat presentations for intentional self-harm may occur over a number of years, with 14% presenting within one week (AISRAP 2016).

6.2.3.6 Suicide

Age-standardised rate of death attributed to suicide per 100,000 persons in Brisbane south in 2014-18 (12.7) was slightly higher than national levels (12.3) but significantly lower than that seen across Queensland (15.3). Within the region, Brisbane Inner (19.3), Jimboomba (18.1) and Beenleigh (17.3) had the highest rates of death attributed to suicide, while Jimboomba (5.9%), Brisbane Inner – East

(4.3%) and Brisbane Inner (4.2%) had the greatest proportion of all-cause deaths attributed to suicide. 76 deaths in Brisbane Inner were attributed to suicide between 2014 and 2018, significantly more than any other SA3 (Figure 64) (Table 88) (AIHW 2021).

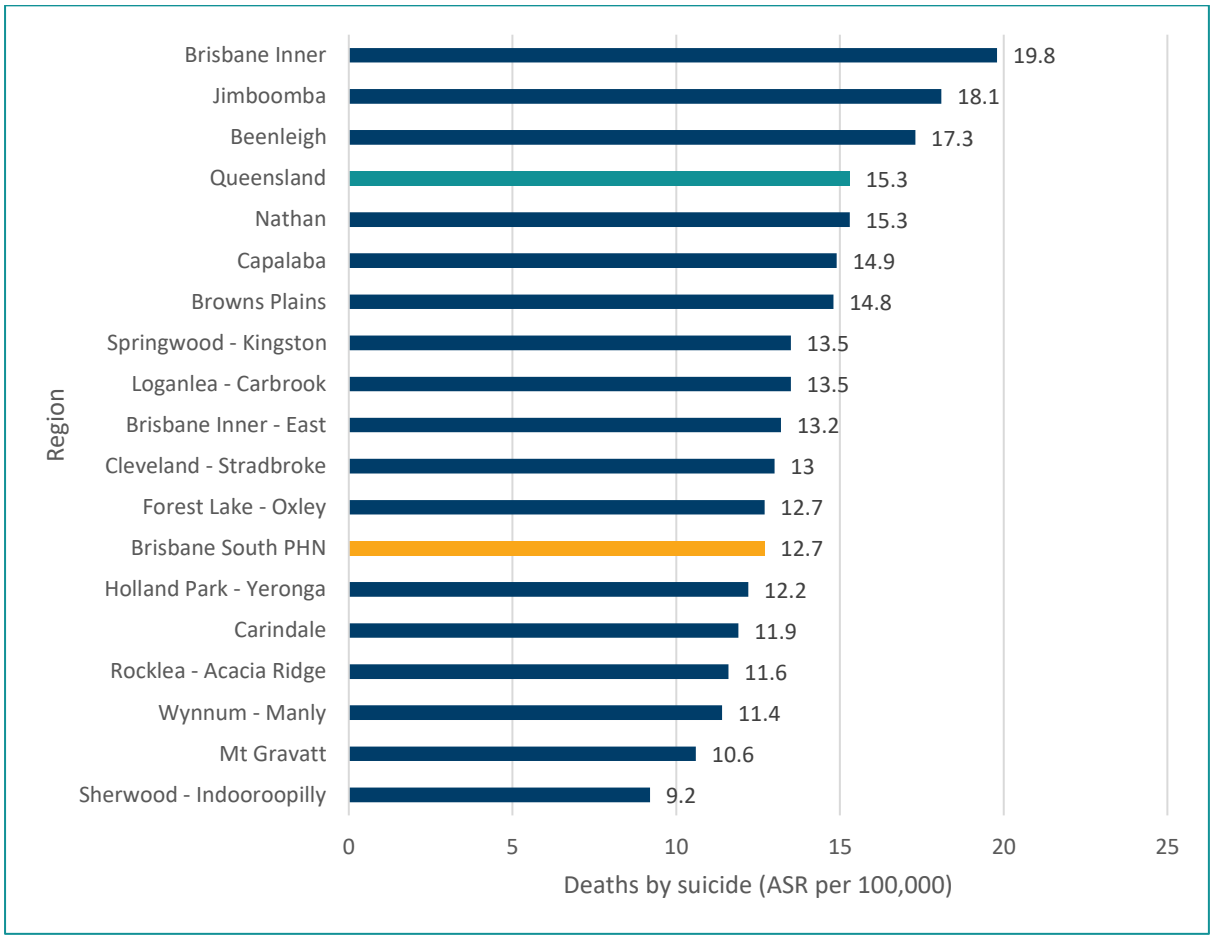

Figure 64. Age-standardised rate of deaths by suicide in Brisbane south by SA3, 2014-18
Source: AIHW 2021

Table 88. Rate of deaths attributed to suicide in Brisbane south by SA3, 2014-18

SA3	Number of Deaths	% of all cause deaths	Rate of deaths attributed to suicide (ASR per 100,000 persons)	
			Persons	Males
Brisbane South PHN	**721**	**2.4**	**12.7**	**19.4**
Queensland	**3,698**	**2.5**	**15.3**	**23.9**
Australia	**15,100**	**1.9**	**12.3**	**18.8**
Brisbane LGA				
Brisbane Inner [a]	76	4.2	19.8	31.7
Brisbane Inner - East	31	4.3	13.2	21.0
Carindale	32	2.2	11.9	20.4
Centenary	16	1.5	NA	NA
Forest Lake - Oxley	47	2.6	12.7	19.0
Holland Park - Yeronga	48	2.3	12.2	16.6
Mt Gravatt	40	1.9	10.6	15.0
Nathan	31	3.1	15.3	25.5
Rocklea – Acacia Ridge	37	2.3	11.6	16.9
Sherwood – Indooroopilly [a]	25	2.4	9.2	NA
Sunnybank	19	1.6	NA	NA
Wynnum - Manly	40	1.9	11.4	16.2
Logan LGA				
Beenleigh	35	2.9	17.3	23.8
Browns Plains	58	2.9	14.8	21.7
Jimboomba	40	5.9	18.1	27.6
Loganlea - Carbrook	42	2.2	13.5	21.8
Springwood - Kingston	52	2.5	13.5	21.9
Redland LGA				
Capalaba	52	2.3	14.9	21.3
Cleveland - Stradbroke	52	1.6	13.0	20.9
Scenic Rim LGA				
Beaudesert	11	1.7	NA	NA

[a] partial SA3 within Brisbane South PHN; figures have/have not been apportioned by % geography/population
Source: *AIHW 2021*

While long-term PHN-level data was not available to analyse the trend of deaths by suicide over time, state-level data showed that in the 15 years prior to and including 2020 the rate of death by suicide increased at a rate of approximately 0.26 ASR per 100,000/year on average. Positively, the rate of deaths by suicide did decline consistently in the 4 years prior and including 2020 (Figure 65) (AIHW 2021).

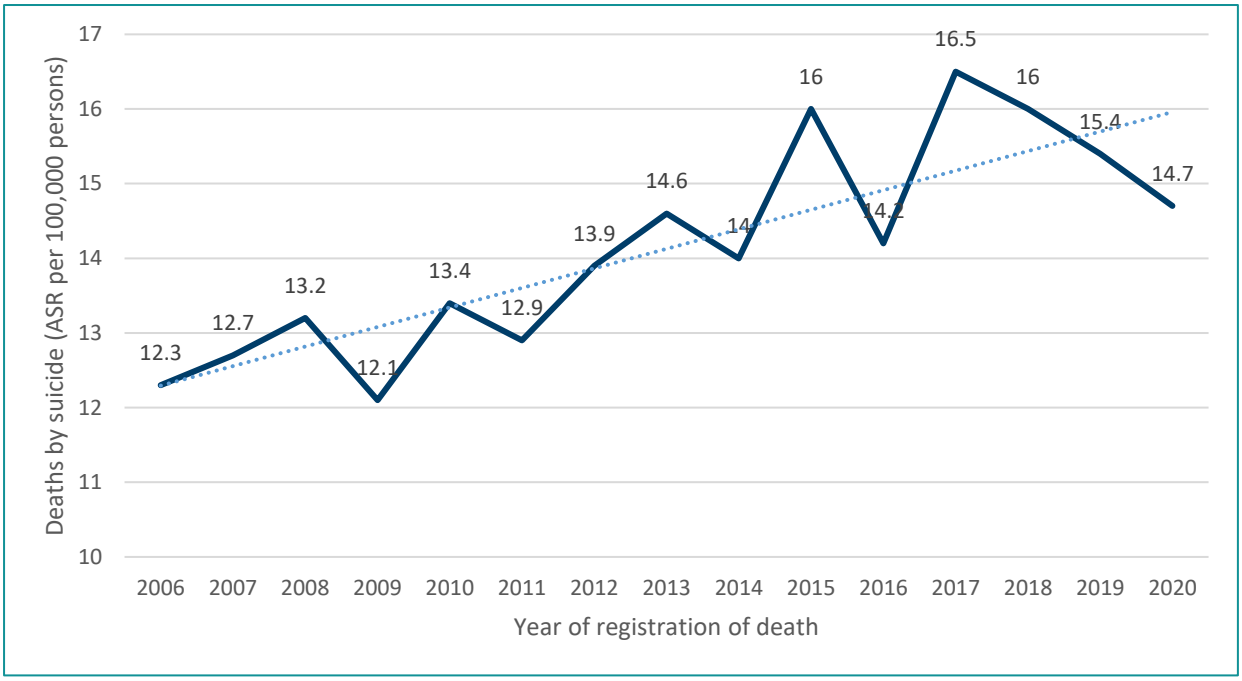

Figure 65. Age-standardised rate of deaths by suicide in Queensland, 2006-2020
Source: AIHW 2021

Data published in 2019 indicated that of the 1,865 drug induced deaths recorded nationally, 24% were considered intentional. Males had the highest rate of intentional drug-induced deaths at 63% while the highest prevalence of drug-induced deaths was in people aged 45 to 54 years (AIHW 2018l).

Priority populations for suicide prevention

Veterans, particularly men aged 30 years and younger

The *National Commissioner for Defence and Veteran Suicide Prevention* (Jones et al, 2019) and current *Royal Commission into Defence and Veteran Suicide* (RCDVS) (RCDVS 2021) demonstrate the national profile and need for further understanding the contributing factors to past Australian Defence Force (ADF) and Veteran suicide in Australia.

At a national level, men who were serving full-time or were in the reserves had significantly lower age-standardised rates of death attributed to suicide than Australian men in the same age range. However, the rate of death due to suicide was significantly higher for ex-serving men (veterans) aged under 30 than for their non-serving counterparts (AIHW 2018k).

Ex-serving men aged under 30 had a suicide rate 2.2 times than that of Australian men of the same age, for 2014– 2016. Please note that data limitations exist for in-depth statistical analysis for female and gender diverse peoples (AIHW 2019f); however, ex-serving 18-24-year-old males were 2.6 times more likely to die due to suicide compared to ex-serving females of the same age (Jones et al 2019).

Young people, particularly those who have experienced abuse and neglect

In Queensland, mental health conditions and substance use disorders were a leading contributor to the burden of disease for both males and females between the ages of 15 and 44 years (Queensland Health 2017). Children and young people aged up to 17 years were also identified by community and sector representatives as a vulnerable cohort with high mental health and suicide prevention needs. This was especially prevalent in Logan (particularly in Eagleby), Beaudesert, Redland (particularly the Southern Moreton Bay Islands), Wacol, Inala, and Inner Brisbane (particularly in the Princess Alexandra Hospital catchment) areas.

Child abuse and neglect is a leading risk factor contributor to the burden of disease for suicide and self-inflicted injuries. In the most recent Burden of Disease study, it was estimated that child abuse and neglect was responsible for:

- 27% of the disease burden due to anxiety disorders
- 26% of suicide and self-inflicted injuries burden
- 20% of depressive disorders burden (AIHW 2020b).

Further information relating to the mental health and wellbeing of children and young people is discussed in 2.2.5.2 Children who have experienced abuse and neglect.

Adult men

In Brisbane south in 2014-18, 3.5% of male deaths were attributed to suicide, at a rate of 19.4 ASR per 100,000 persons. These results are elevated by comparison to the general Brisbane south (2.4%) and Australian (1.9%) populations. Among males, the highest age-specific suicide rates were exhibited in the 35 to 39 and 40 to 44 age groups (29 and 35 per 100,000 respectively). Within the region, Brisbane Inner (19.8), Jimboomba (18.1) and Beenleigh (17.3) had the highest rates of death attributed to suicide per 100,000 persons (Table 88) (AIHW 2021).

People experiencing domestic and family violence

10% of suicide and self-inflicted injuries, and 8% of depressive disorders were attributed to domestic violence in Queensland (Queensland Health 2017). Further information relating to the mental health and wellbeing of children and young people is discussed in 2.2.5.1 Domestic and family violence.

LGTQIA+ peoples

People who identify as LGBTQIA+ are often statistically hidden. Regardless of this notion, it is known that LGBTQIA+ peoples experience disproportionate suicidality. The *LGBTI Health Alliance* in the *Beyond Urgent: National LGBTIQ+ Mental Health and Suicide Prevention Strategy 2021-26* note the following statistics which draw significant strength for the need to prioritise suicide prevention services:

- LGBTIQ+ young people aged 16 to 27 are five times more likely to have attempted suicide
- Transgender people aged 14-25 are fifteen times more likely to have attempted suicide
- People with an intersex variation aged 16 and over are nearly six times more likely to have attempted suicide
- Rates of psychosocial distress and suicidal ideation are higher among those who identify as bisexual, pansexual, queer or asexual (National LGBTI Health Alliance 2021, p6).

People who have recently relocated for work or study

Community and sector representatives noted the density of international and domestic students, and individuals from rural and remote backgrounds who have recently relocated to study, work and

live independently in Woolloongabba and surrounding regions. These cohorts are vulnerable to heightened mental health challenges and suicide due to their increased social isolation and limited access to natural support structures.

Key themes raised by community and sector representatives during local consultation regarding mental health and suicide prevention health outcomes included:

- increases in the prevalence of anxiety and depression as a consequence of social disconnectedness
- increases in social anxiety and body image issues amongst young people
- the elevated mental health need and lack of consumer health literacy in the Logan East community
- an increasing number of consumers being diagnosed with chronic suicidal ideation
- an increasing number of young people seeking support for eating disorders
- an increase in GP reporting of type 1 autism spectrum disorder (ASD), with 50% of CYMHS referrals having ASD noted on the referral
- the significant number of people (approximately 45,000 in the Brisbane City Council area) experiencing a hoarding disorder
- the pronounced increase in the number of young people who have died by suicide.

6.3 Health system

Mental health and suicide prevention support are provided in a range of service settings including inpatient and outpatient hospital services, residential services, community-based services (government and non-government), disability and homelessness support services, primary care and allied health services delivered in private clinical practices, as well as informal supports from carers, families, friends and communities.

A range of mental health services delivered in community and hospital settings funded by various levels of government are available to the population in the Brisbane south region. They include public sector ambulatory services traditionally delivered in a community setting, bed-based services of various levels of acuity, MBS services delivered by primary care practitioners and stepped care and suicide prevention services commissioned by Brisbane South PHN (Department of Health 2019m).

6.3.1 Service utilisation

Demand for and uptake of mental health services within the Brisbane South PHN region was high by comparison to other metropolitan PHNs and national levels, especially with regards to schizophrenia and delusional disorders, and intentional self-harm.

6.3.1.1 Tertiary healthcare

Hospitalisations

In 2018-19, approximately 271,000 mental-health related hospitalisations occurred in Australia, with 63% of these being in specialised psychiatric care. Over the past decade, the rate of mental-health related hospitalisations has been steadily increasing by approximately 2% per annum, making up 6% of all overnight hospitalisations in 2018-19 (AIHW 2021).

For young females the rate of hospitalisation more than doubled between 2006-07 and 2018-19 from 37 to 78 ASR per 10,000 persons. The rate of young females admitted with specialised

psychiatric care was 2 to 3 times higher than that of their male counterparts, varying slightly by age group (AIHW 2021).

The highest rates of overnight mental health-related separations without specialised psychiatric care were observed in patients aged 85 years and older, having increased by 82% between 2006-07 and 2018-19 (AIHW 2021).

Within the Brisbane south region 12,417 overnight mental health-related hospitalisations occurred in 2018-19, 85% of which involved specialised psychiatric care. This is one of the highest rates of psychiatric care provisioning in Australia. In line with national trends the rate of overnight mental health-related hospitalisations in the Brisbane south region has steadily increased over the past decade (AIHW 2021).

While the rate of hospitalisations in the Brisbane south region was approximately on par with other metropolitan PHN's and Australia (97, 96 and 102 ASR per 10,000 persons respectively), the rate of bed days within the region was considerably higher (1,520, 1,376 and 1,401 ASR per 10,000 persons respectively). This indicates that while a comparable proportion of people were admitted to hospital on mental health grounds in the region, their average length of stay was considerably longer than those in other Metropolitan PHNs and the broader Australian cohort. Brisbane Inner had particularly high rates of overnight hospitalisations (213 ASR per 10,000 persons), while bed days were highest in Forest Lake - Oxley (4,846 ASR per 10,000 persons) (AIHW 2018f).

Considerable geographic differentials for overnight mental-health related hospitalisations exist within the region. Admissions in Brisbane Inner and Holland Park - Yeronga were 4 and 3.5 times higher than Jimboomba (Table 89) (AIHW 2021). Although some geographical variation in the prevalence of mental health conditions is likely, it is plausible to conclude these variations are mostly reflective of inequitable access to hospital services.

Table 89. Overnight admitted mental health-related hospitalisation rates by SA3

Ranking (highest - lowest)	SA3 in BSPHN region	Mental health hospitalisations (ASR per 10,000 persons)
1	Brisbane Inner	204
2	Holland Park - Yeronga	193
3	Brisbane Inner - East	121
18	Browns Plains	74
19	Sunnybank	64
20	Jimboomba	55

Source: AIHW 2021).

Schizophrenia and delusional disorders

Similar trends occurred in overnight hospitalisations related to schizophrenia and delusional disorders, with Brisbane south having on-par overnight hospitalisation rates but considerably higher bed days by comparison to other Metropolitan PHNs and Australia. Brisbane Inner had the highest rate of overnight hospitalisations (59 ASR per 10,000 persons) while Forest Lake - Oxley had the highest rate of bed days (3,571 ASR per 10,000 persons) (AIHW 2018f).

Intentional self-harm

A suicide attempt is one of the strongest predictive factors of future suicide attempts, with the period immediately after discharge from inpatient psychiatric care representing a very high risk of death by suicide. Continuity of care following hospital and inpatient discharge remains a priority in decreasing the risk of future self-harm, suicide attempts and death by suicide (Black Dog Institute 2020).

Across the Brisbane south region there were 1,758 intentional self-harm hospitalisations in 2018-19, a rate of 151 per 100,000 people. Population rates were substantially higher for females and younger people (Table 90) (AIHW 2021).

Females accounted for almost two thirds of intentional self-harm hospitalisations and exhibit rates substantially higher than their male counterparts (187 vs. 114 per 100,000 persons). Young people aged 0 to 24 years accounted for 39% of intentional self-harm hospitalisations, at a rate of 173 per 100,000 persons. Females under 24 years of age had the highest rates across all age groups (245 per 100,000 persons) while the highest rates among males were witnessed in 25 to 44-year olds (172 per 100,000 persons) (Table 90) (AIHW 2021).

Table 90. Intentional self-harm hospitalisations by age and sex (2018-19) (rate per 100,000 persons)

Sex	0 to 24 years	25 to 44 years	45 to 64 years	65+ years	All
Females	245	226	137	57	187
Males	103	172	95	38	114
Persons	173	199	116	48	151

Source: AIHW 2021.

The rate of overnight hospitalisations (22 ASR per 10,000 persons) and bed days (113 ASR per 10,000 persons) related to intentional self-harm in the Brisbane south region was considerably higher than other Metropolitan PHNs and Australia. The highest rate of overnight hospitalisations and bed days attributed to intentional self-harm were exhibited in Holland Park - Yeronga (Table 91) (AIHW 2018f).

Table 91 Mental health indicators of service need in the Brisbane south region.

Indicator	Brisbane South PHN (ASR per 10,000 persons)	SA3 in BSPHN region with highest need	SA3 rate (ASR per 10,000 persons)	Metropolitan PHNs (ASR per 10,000 persons)	Australia (ASR per 10,000 persons)
All overnight mental health-related hospitalisations	97	Brisbane Inner	213	96	102
All mental health-related bed days	1,520	Forest Lake - Oxley	4,846	1,376	1,401
Overnight hospitalisations related to schizophrenia and delusional disorders	20	Brisbane Inner	59	18	19
Bed days related to schizophrenia and delusional disorders	652	Forest Lake - Oxley	3,571	457	471
Overnight hospitalisations related to intentional self-harm	22	Holland Park - Yeronga	33	15	17
Bed days related to intentional self-harm	113	Holland Park - Yeronga	137	76	81

Source: AIHW 2018f

Emergency department presentations

For many people, emergency departments fill service gaps in mental health treatment. They are often either the initial point of care for those seeking mental health services for the first time or an alternative service for those seeking care after hours (Morphet et al. 2012).

In 2018-19, 3.6% of all emergency department presentations in the Brisbane south region were for mental and behavioural disorders, a slightly lower proportion than in Queensland (4%) and other Queensland metropolitan PHNs (Brisbane North: 4.5%, Gold Coast: 4.1%). The rate of presentations in the Brisbane south region was also lower at 1,018 ASR per 100,00 compared with Australia (1,195), Queensland (1,184) and other metropolitan Queensland PHNs (PHIDU 2021).
Within the region, considerable geographical variation again presents itself in emergency department presentations with mental health-related presentations in the Brisbane LGA accounting for almost 5% of all emergency department presentations while attribution was lower in Logan (2.9%) and Redland (2.8%) LGAs (Table 92) (PHIDU 2021). This further demonstrates the inequitable access of hospital services across the region.

Table 92. Emergency department presentations for mental and behavioural disorders, 2018-19

Region (PHN/LGA)	Number	As % of total ED presentations	ASR per 100,000
Brisbane South PHN	12,120	3.6%	1,018
Brisbane (C) - part b	8,061	4.9%	1,135
Logan (C)	3,226	2.9%	993
Redland (C)	1,487	2.8%	972
Scenic Rim (R) - part a	112	4.0%	794

Source: *PHIDU 2021*

People aged between 15 and 44 years accounted for two thirds of emergency department presentations for mental and behavioural disorders in Brisbane south in 2018-19, marginally higher than Brisbane North and Gold Coast PHNs. People in these age brackets (15 to 24 years and 25 to 44 years) also exhibited substantially higher rates of presentation than other age groups (Table 93). Logan LGA had a high rate of presentations for very young people (aged 0 to 14 years), 310 ASR per 100,000 persons by comparison to the PHN rate of 246 ASR per 100,000 persons (Table 94) (PHIDU 2021).

Table 93. PHN emergency department presentations for mental and behavioural disorders by age group and PHN (%), 2018-19

PHN	0 to 14 years	15 to 24 years	25 to 44 years	45 to 64 years	65 to 74 years	75+ years
Brisbane North	5%	23%	39%	21%	5%	7%
Gold Coast	5%	23%	39%	22%	4%	7%
Brisbane South	5%	25%	41%	20%	4%	5%

Source: PHIDU 2021.

Table 94. PHN emergency department presentations for mental and behavioural disorders by age group and PHN (ASR per 100,000 persons), 2018-19

PHN	0 to 14 years	15 to 24 years	25 to 44 years	45 to 64 years	65 to 74 years	75+ years
Brisbane North	337	2,070	1,692	1,113	709	1,516
Gold Coast	300	1,980	1,600	1,015	518	1,052
Brisbane South	246	1,861	1,415	893	560	920

Source: PHIDU 2021.

6.3.1.2 MBS mental health services

MBS mental health services play a central role in the delivery of mental health support across the country and include services delivered by general practitioners and allied mental health professionals and specialists (AIHW 2021).

GPs deliver assessment, monitoring and treatment, structured psychological therapies, pharmacotherapy and physical health services for clients with all levels of severity. They also act as

gatekeepers and refer patients to other providers. Allied mental health professionals deliver structured, evidence-based psychological therapies which cover different types of treatment including cognitive behavioural and family therapies (AIHW 2021).

Across the Brisbane south region, 646,789 MBS mental health services were provided to 200,456 distinct patients in 2019-20, an average of 3.2 services per patient. While this rate is lower than the national average of 4.5 services per client, it is similar to other Queensland metropolitan PHNs (Brisbane North: 3.3, Gold Coast: 3.0) (AIHW 2021).

Despite delivering less services per client, the Brisbane south region had higher mental health service coverage, 563 services per 1,000 people, than Australia (486 services per 1,000 people). Geographical disparities again exist, with Brisbane Inner and Holland Park - Yeronga having the greatest coverage while Sunnybank and Rocklea - Acacia Ridge had the lowest coverage (Table 95). Comparing MBS service coverage and overnight mental-health related hospitalisation rates (Figure 66), a close correlation emerges with those SA3s with the highest service coverage also having the highest overnight mental health-related hospitalisation rates and vice versa. This indicates that the provision of both primary and tertiary mental health services in the Brisbane south region are centred around similar geographical locations, leaving considerable gaps in other areas (AIHW 2021).

Table 95. MBS mental health-specific services delivered by provider type in the Brisbane South PHN region, 2015-16 to 2019-20

Provider type	2015–16		2019–20		% change	
	no.	%	no.	%	no.	%
Psychiatrists	157,725	28	172,100	27	9%	-1
General practitioners	155,770	28	177,746	27	14%	0
Clinical psychologists	95,212	17	122,963	19	29%	2
Other psychologists	135,572	24	151,169	23	12%	-1
Other allied health providers	19,175	3	22,811	4	19%	0
All providers	563,454	-	646,789	-	15%	-

Source: AIHW 2021

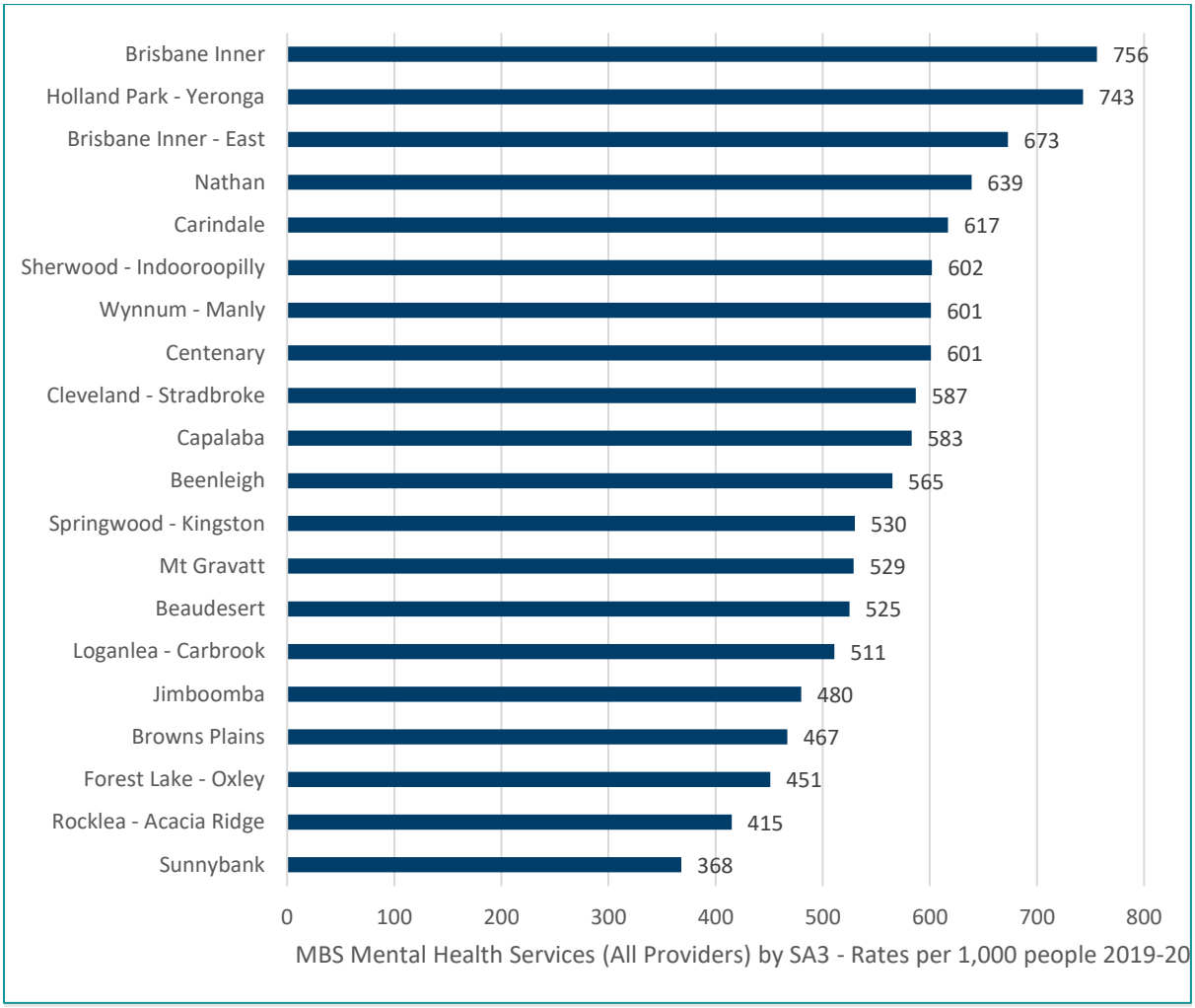

Figure 66. MBS mental health service coverage (all providers) by SA3, 2019-20 (rate per 1,000 people)
Source: AIHW 2021.

National data indicated the highest rate of MBS mental health service uptake amongst people aged 18 - 24 years (696 per 1,000 persons). Females reported substantially higher utilisation rates than males (608 vs. 362 per 1,000 persons) (AIHW 2021). PHN-level data regarding the age and sex of MBS mental health service recipients was not available.

Similar to national trends, the number of mental health-specific services delivered within Brisbane south increased by 15% between 2015-16 and 2019-20. While this growth is positive, it is important to note it is 10% lower than the growth witnessed in Brisbane North and 4% lower than Gold Coast. Services provided by clinical psychologists exhibited the greatest increase in service numbers (29%) between 2015-16 and 2019-20, increasing their 'market share' of service provision by 2%. Services provided by psychiatrists and other psychologists exhibited the lowest rates of growth (9% and 12% respectively), and respectively lost 1% of their 'market share' (AIHW 2021).

Child and Youth services

Please refer to 2.3.1.3 Mental Health Services for child and youth mental health service utilisation. Key themes raised by community and sector representatives during local consultation regarding mental health and suicide prevention service utilisation included:

- the lack of education and information detailing mental health support services available to consumers

- the lack of community rehabilitation services to support consumers to manage their health at home post-discharge from acute care
- the general lack of health and mental health literacy amongst consumers across the region
- the lack of proactive mental health screening in primary care
- limited services to support people applying for and accessing the NDIS, with many young people who could meet the criteria not having current support packages
- increased demand for bulk-billed and public mental health services in light of MBS changes
- limited access to outpatient or private psychiatry services
- ever increasing demand for headspace services, with a lack of capacity to meet demand
- increase in child and youth mental health-related emergency service call-outs and presentations at emergency departments
- increased demand for sexual assault support services.

6.3.2 Service experience

Key themes raised by community and sector representatives during local consultation regarding mental health and suicide prevention service experience included:

- the lack of timely access to community mental health services due to extended waitlists in both the public and private sector
- challenges for consumers navigating care pathways due to the complex nature of the system, lack of sub-acute pathways and lack of navigation support
- the lack of follow-up care and support to connect with community mental health services post-discharge from acute care
- transactional care
- the volume of people not being admitted to acute care after presenting to the emergency department for mental health reasons
- children with behavioural issues not qualifying for services despite likely having emerging mental health issues
- limited headspace service literacy amongst GPs resulting in misguided referrals
- the limited availability of information and resources written in simple English
- practitioners observing perceived inadequate client outcomes with telehealth modalities compared to face-to-face
- lack of multidisciplinary, team-based care involving both primary and tertiary providers, including effective communication and continuity of care.

6.3.3 Service mapping

Telephone-based services

There are a number of telephone-based mental health and suicide support and access services operating in the Brisbane south region. These include:

- Lifeline Australia: crisis support and suicide prevention
- Suicide Call Back Service: crisis support and suicide prevention
- PANDA's National Perinatal Mental Health Helpline
- 1300 MH Call: single point of access to Metro South Addiction and Mental Health Services tele-triage.

Please refer to 2.3.3.4 Child and Youth Mental Health Services.

Services offered by Brisbane South PHN are noted in 6.6.4 Current activities.

Public Tertiary Services

Metro South Health, through Metro South Addiction and Mental Health Services, is a major provider of public acute mental health services in the region. The Acute Mental Health Inpatient Services Academic Clinical Unit provides care to people experiencing acute episodes of mental illness. Acute Mental Health Inpatient Services are available at:

- Logan Hospital
- Princess Alexandra Hospital
- Redland Hospital (Metro South Health 2017)

The Mood Academic Clinical Unit provides specialist assessment and treatment for people experiencing severe disorders of mood, anxiety, behaviour, and eating disorders. Inpatient services are noted as per above, and community-based services available in the following locations:

- Beenleigh Community Health Centre
- Browns Plains Community Health Centre
- Inala Community Health Centre
- Logan Central Community Mental Health Centre
- Woolloongabba Community Health Centre
- Wynnum-Manly Community Health Centre
- Bayside Community Addiction and Mental Health Service
- Macgregor Community Health Centre (Metro South Health 2017).

Private Tertiary Services

The Greenslopes Private Hospital operates the following day programs:

- Trauma recovery program
- Depression management
- Anxiety management
- Anger management

The Belmont Private Hospital offers a range of inpatient services and day programs for mental health concerns, including anxiety, depression, and borderline personality disorder. Belmont Private Hospital also provides DVA-approved trauma recovery for Veterans with post-traumatic stress disorder.

Key themes raised by community and sector representatives during local consultation regarding mental health and suicide prevention service mapping included:

- a general lack of capacity within the Brisbane south mental health and suicide prevention service sector to meet consumer demand
- the limited number primary and secondary prevention programs, and funding for health promotion
- a lack of appropriate and accessible alternatives to the emergency department for people experiencing mental health crisis

- a lack of psychologists willing to engage with consumers with a mental health care plan for a small out-of-pocket expense
- known 'gaps' in the provision of existing services (e.g. the 'missing middle' between headspace and CYMHS, long-term support/case management for financially disadvantaged consumers who do not meet the criteria for MHCCC, NPS or public mental health services)
- lack of mental health outreach assessment and support programs in Redland LGA
- 'siloing' between complementary services (e.g. mental health, domestic and family violence, alcohol and other drugs services etc)
- a lack of mental health services available locally at Beaudesert Hospital
- service efficiencies compelling programs to deliver in urban areas rather than regional areas
- a lack of coordination and integration between service providers, schools and health professionals.

6.3.4 Workforce

The mental health workforce encompasses a broad range of professions, including psychologists, social workers, psychiatrists, occupational therapists, credential mental health nurses, lived experience and peer support workers, and other allied health professionals. Stakeholder engagement and consultation has noted recruitment challenges across the mental health workforce, particularly in regional areas. These shortages were reported to be exacerbated by the COVID-19 pandemic, which coupled with staff burnout, have placed additional pressure on the mental health system.

Stakeholders have also noted the impact of the shift from 10 to 20 sessions of allied mental health supports under the Better Access to Mental Health initiative. While the extension of sessions was welcomed, it is reported that mental health practitioners now have fuller cases for longer periods of time, which has impacted on the ability for new consumers requiring assistance to access timely care.

The broader primary care workforce plays a significant role in managing consumer's mental health in the community. In the short time that the GP Psychiatry Support Line had been established over 300 GPs from over 100 general practices in the region had registered for the service. The predominant reason for accessing the Support Line was with respect to medication consults.

6.4 Health equity

6.4.1 First Nations peoples

Key themes raised by community and sector representatives during local consultation regarding mental health and suicide prevention amongst First Nations people included:

- the need for culturally appropriate and accessible mental health services across the region, especially in Logan, Beaudesert and Redland LGAs
- reluctance at headspace services to accept young First Nations people due to the complexity of circumstances these individuals often present with
- strong demand for headspace's Social Inclusion program demonstrating high need for inclusive mental health services in the Logan community
- limited support and information regarding developmental disorders in First Nations communities.

There are inequities in the prevalence of suicide and intentional self-harm, with First Nations people experiencing suicide at younger ages at approximately two times the rate of non-First Nations peers.

6.4.2 People from Multicultural backgrounds

Key themes raised by community and sector representatives during local consultation regarding mental health and suicide prevention amongst people from CALD backgrounds included:

- the failure of the mainstream mental health system and services to meet the specialised needs of multicultural communities
- the systemic lack of data capture to enable identification of the needs of multicultural communities
- the lack of interpreter services utilised in acute mental health services
- significant intergenerational trauma experienced by refugee and multicultural community members
- the need for specialised, appropriate and accessible mental health initiatives for communities from multicultural backgrounds across the region, especially in Logan and Redland LGAs
- the lack of appropriate communication around health issues, services and culturally safe environments for people from multicultural backgrounds
- people from refugee and multicultural backgrounds not identifying with discrete mental health 'categories' or 'conditions', and self-excluding due to this
- cultural and societal stigma regarding mental health
- high rates of suicidality and domestic violence experienced by multicultural young people, particularly those aged 17 to 24 years
- limited support and information regarding developmental disorders in multicultural communities.

6.4.3 People who Identify as LGBTQIA+

People who identify as LGBTQIA+ report several barriers to accessing safe and appropriate health care, due to factors such as discrimination.

The LGBTIQ+ Health Australia *Beyond Urgent: National LGBTIQ+ Mental health and Suicide Prevention Strategy 2021-26* highlights that poor mental health and suicidal ideation is more common in people who identify as LGBTQIA+ The Strategy also notes that engaging in intentional self-harm behaviours is more common in some LGBTIQ+ cohorts (Figure 67).

Figure 67. Likelihood of engaging in intentional-self harming behaviours

6.4.4 People experiencing or at risk of homelessness

The interconnectedness between homelessness and mental health is well-established, with the relationship varying person to person. Many people experiencing homelessness and mental health concerns have complex needs, yet many struggle to receive appropriate treatment in an inpatient setting. The experience of mental health concerns, particularly those severe in nature, and/or living with comorbid substance use concerns, may increase the difficulty in sustaining tenancy (Homelessness Australia 2011).

The proportion of specialist homelessness service clients with a current mental health issue differed considerably by age and sex in Brisbane LGA. Clients aged 24 - 44 years had the highest rates of co-occurring current mental health issues, with female rates being highest at 25 - 34 years while male rates were highest at 35 - 44 years (Table 96) (AIHW 2021).

Table 96. Proportion of specialist homelessness service clients with a current mental health issue, by age and sex, 2019-20

Age group (years)	Males (%)	Females (%)	All clients (%)
10 - 14	5.1	3.8	4.3
15 - 17	6.7	7.8	7.4
18 - 24	17.7	20.7	19.5
25 - 34	19.2	24.0	22.1
35 - 44	23.5	21.9	22.5
45 - 54	18.4	14.4	16.0
55 - 65	7.2	5.5	6.2
65+	2.3	1.9	2.0

Source: AIHW 2021.

As described in 1.3.4 People experiencing or at risk of homelessness, the Brisbane Inner SA3 reported the highest rate of people experiencing homelessness in the Brisbane south region (QGSO 2021). Brisbane Inner also had the highest rate of overnight mental health-related hospitalisations and hospitalisations due to schizophrenia and delusional disorders (AIHW 2018f), while the Brisbane LGA had the highest rate of mental health-related emergency department presentations (PHIDU 2021).

While tertiary mental health service utilisation extends far beyond people experiencing homelessness, it is known that people who are homeless are far less likely to access primary care and preventative health service than the general population (Davies and Wood 2018). Pairing this knowledge with the aforementioned service data, it is likely service utilisation numbers witnessed in tertiary settings in the Brisbane Inner SA3 and Brisbane LGA were bolstered by homeless individuals using tertiary services as their first port-of-call in place of primary health care.

Key themes raised by community and sector representatives during local consultation regarding mental health and suicide prevention amongst people with a disability included:

- lack of community-based mental health support targeted and tailored towards individuals experiencing homelessness.

6.4.5 People with a disability

Commissioned psychosocial support services aim to support people experiencing psychosocial disability in the community including assisting them to gain access to the NDIS. Measuring the gaps left by the NDIS allows for the service needs of a region to be identified.

6.4.6 Rural and remote communities

Key themes raised by community and sector representatives during local consultation regarding mental health and suicide prevention amongst rural and remote communities included:

- lack of outreach services in Beaudesert and the Southern Moreton Bay Islands
- limited transport options available in the Beaudesert region impacting consumers ability to access mental health services
- limited communication and information technology infrastructure, such as internet connectivity, in the Beaudesert region limiting service provision
- rural and remote communities carrying a high load of undiagnosed mental health conditions, low mental health literacy and growing cohort of young people whose needs are considered too complex for available services (e.g. headspace) but not complex enough for CYMHS (the 'missing middle').

6.5 Impact of COVID-19

6.5.1 Health status

Key themes raised by community and sector representatives during local consultation regarding the impact of the COVID-19 pandemic on mental health and suicide prevention included:

- mental health needs going unmet due to the health system and community's focus on the pandemic
- young people reporting increased financial insecurity at both personal and familial levels negatively impacting their mental health
- exacerbation of known systemic issues such as financial hardship, loss of employment, dire living situations and homelessness, engagement issues, extended wait times and inaccessibility of services
- the impact on parents' emotional availability for their children and adolescents
- the COVID-19 pandemic demonstrating the mental health vulnerability of the wider community
- increases in problem gambling, youth justice issues and substance misuse
- young people experiencing elevated anxiety returning to school
- witnessing increased rates of domestic and family violence, heightened by COVID-19 restrictions, home isolation and lockdowns.

6.5.2 Health system

Key themes raised by community and sector representatives during local consultation regarding the impact of the COVID-19 pandemic on the mental health and suicide prevention system included:

- increased demand for mental health services due to increased social isolation, economic instability and COVID-19 interventions (i.e. home isolation, lockdowns, etc)
- challenges engaging and delivering mental health education and information to young people amidst visitor restrictions in schools and cancelled community events
- increased referrals for individuals experiencing difficulty adjusting to work or study-relocation due to their inability to integrate and successfully navigate work and/or study during COVID.

6.6 Health priorities and options

6.6.1 Priority unmet needs

Considering the comparative, felt, expressed and normative needs of the Brisbane south region, a number of mental health and suicide prevention-related priority unmet needs emerged during triangulation. In order of priority, as determined through the prioritisation process, these needs included:

1. The need for mental health support across the stepped care continuum.
2. Priority populations experience higher levels of need relating to mental health and suicide prevention: young people (particularly those experiencing abuse and neglect), adult men, ex-serving veterans, people who identify as LGBTQIA+.
3. Local mental health service system is not able to meet people's mental health needs.
4. High levels of need for suicide prevention support in Brisbane south.
5. Barriers for people experiencing mental health concerns to find and access the right support.
6. Developing and supporting a skilled and capable workforce is an important enabler of the mental health service system.
7. Emerging issues driving mental health concerns in the community: eating disorders, hoarding disorder.
8. Impact of the COVID-19 pandemic on the mental health of people in Brisbane south.

6.6.2 Current activities

6.6.2.1 National Psychosocial Support Measure

Based on findings from the psychosocial support planning and needs assessment activities undertaken in 2018-19, Brisbane South PHN will deliver services to support people living with severe mental health conditions who require associated non-clinical psychosocial functional services, and who are not more appropriately supported through National Disability Insurance Scheme accordance with the NPS Guidance material. Brisbane South PHN will integrate services under the National Psychosocial Support Measure with other mental health and suicide prevention commissioned services, while maintaining separate reporting and accountability. The inclusion of both non-clinical services to improve social skills, relationship maintenance, family connections, achieving educational goals, as well as individual and group base services, ensures priority populations gain access to evidence-based interventions that align with their mental health needs.

6.6.2.2 Low intensity mental health services

Brisbane South PHN aims to establish a regional service model across Brisbane South PHN in three sub-regions (Brisbane, Logan-Beaudesert, Redlands). The place-based approach to the delivery of care will ensure target populations gain access to evidence based interventions aligned to mental health needs when an individual's early warning signs are emerging. The service model will build on system strengths, and barriers to access will be addressed. Linkages across layers of support will ensure seamless transitions through the continuum of care. A focus on priority groups such as Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse peoples and lesbian, gay, bisexual, transgender, inter-sex and queer or questioning people, will be present within these activities.

6.6.2.3 Child and youth mental health services

The objectives of the headspace primary services are to support region-specific, cross sectoral approaches to services for children and young people living with, or at risk of developing a mild to moderate mental illness, as well as the implementation of an equitable and integrated approach to primary mental health services for children and young people.

The Headspace youth early psychosis program holds the same objectives, with a focus on development of early psychosis. Brisbane South PHN aims to continue to deliver these services aimed at 12-25-year old's, specific to their mental health needs.

Headspace's low-intensity services target the development of mental illness in the prevention of symptom escalation. Brisbane South PHN aims to enhance the headspace primary model over time to enable flexible service delivery based on the young person's needs, with transitions across the spectrum enabled as their needs change. This is the same for mild and moderate, and severe and complex mental health needs, targeting those living with, or at risk of developing a mental illness across the spectrum of care from early intervention to services for those with severe and complex needs.

Brisbane South PHN will work with the identified headspace to develop and implement a wait time reduction strategy and program. The objectives of the program are to develop a strategy in a collaborative manner to reduce wait time to services for children and young people accessing Meadowbrook headspace centre, and to implement an equitable program to increase accessibility of identified headspace centre.

6.6.2.4 Psychological therapies for rural and remote, underserviced and/or hard to reach groups

Brisbane South PHN commissions a range of mental health services to meet the needs of adults experiencing mild to moderate severity of mental health concerns in the region. The aims of the mild to moderate mental health activity is to establish a regional service model across the region, which ensures target populations gain access to evidence-based interventions aligned to their needs, as well as build on the strengths of the current system and addressing barriers. Activities will have a particular focus on priority groups such as Aboriginal and Torres Strait Islander peoples, CALD and LGBTQIA+ communities.

6.6.2.5 Mental health services for people with severe and complex mental illness including care packages

The aim of the severe and complex mental health care services delivered by Brisbane South PHN is to commission primary mental health care services for people with severe mental illness being managed in primary care. These include clinical care coordination for people with severe and complex mental illness, and will be delivered across three sub-regions: Brisbane, Logan-Beaudesert and Redlands. The same place-based approach will be adopted for the severe and complex mental health activities and programs.

6.6.2.6 Community based suicide prevention

Brisbane South PHN also delivers community-based mental health services, targeting suicide prevention. The aim is to encourage and promote a regional approach to suicide prevention through suicide prevention through community-based activities and liaise with local Hospital and Health Services (HHS) and other providers. Clinical and non-clinical services are provided, including individual and group programs specific to particularly priority populations. Brisbane South PHN also works towards service integration within the region about the need to support follow up care to individuals who have self-harmed or attempted suicide, and building capacity of primary care service workforce and the community to support people at risk of suicide.

6.6.2.7 Workforce development activities

Brisbane South PHN, in partnership with Metro South Addiction and Mental Health Services, have been delivering cross-sectoral dialectical behaviour therapy skills training to practitioners in the acute and community-based mental health sector. Dialectical behaviour therapy has been shown to be effective for consumers who present with emotional dysregulation concerns, such as those

experienced by people with borderline personality disorder and chronic suicidality. A significant demand for this professional development has been recognised through the rapid uptake of training.

Brisbane South PHN has implemented a GP Psychiatry Support Line, offering telephone-based consult support for GPs in the region to enhance care and address queries for managing their consumers in the community.

6.6.3 Options for future activity

- Partner, collaborate and lead system reform, delivering measurable and meaningful health and wellbeing impact. This will include the progression of the Working Together Differently Foundation Plan and development of the Comprehensive Joint Regional Plan between health system partners.
- Integrate and coordinate care systems within a holistic social determinants framework. This may include partnerships with social services, community-based services, and Local Government to enhance support options for people transitioning between primary and tertiary care, and coproduction of service solutions.
- Support community-led action that delivers sustainable change in health and wellbeing.
- Improve the health and wellbeing outcomes of our community, with a focus on addressing health inequities and inequalities. This may include a focus on priority populations through contracting mechanisms, market development, and workforce development and education opportunities.
- Enable strong and connected primary care to create a person-centred system that improves health access, experiences and outcomes.

7. Alcohol and Other Drugs

Alcohol and other drugs are another issue that has been identified in recent years as requiring urgent cross-jurisdictional and cross-agency action. Rates of alcohol and other drug use have been steadily on the rise, indicating a need for a more targeted approach than in previous Health Needs Assessments. While mental health, suicide, and alcohol and other drugs have been grouped under one topic area of the Needs Assessment in the past, to meet the increasing need for targeted and tailored approaches to tackle each of these distinct challenges they have been separated into their own entities within this Health Needs Assessment report.

Despite the rate of overnight hospital admissions for alcohol and other drug-related issues being slightly lower in Brisbane south than the national average and other metropolitan Queensland PHNs, there is still an urgent need to address the issue due to the high risk of negative down-stream health outcomes for individuals and the wider community.

7.1 Strategic environment

7.1.1 National

The *National Drug Strategy 2017 – 2026* (Department of Health 2017b) provides a national framework for building safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities. It highlights several priorities across national actions, population groups and substances for coordinated action around alcohol and other drugs (AOD) over a 10-year period, as seen in the Table 97.

Table 97. National Drug Strategy 2017 – 2026 Priorities

Priority Actions	Priority Populations	Priority Substances
Enhance access to evidence-informed, effective and affordable treatment Develop and share data and research, measure performance and outcomes Develop new and innovative responses to prevent uptake, delay first use and reduce alcohol, tobacco and other drug problems Increase participatory processes Reduce adverse consequences Restrict and/or regulate availability Improve national coordination	First Nations people People with mental health conditions Young people Older people People in contact with the criminal justice system CALD populations People identifying as LGBTQIA+	Methamphetamines and other stimulants Alcohol Tobacco Cannabis Non-medical use of pharmaceuticals Opioids New psychoactive substances

While regional approaches to alcohol and other drugs prevention and treatment services are not specifically referred to in the National Drug Strategy, it is underpinned by several principles that align closely with a regional-level response to alcohol and other drugs including:

- evidence-informed responses,
- partnerships (integrated, holistic and systems partnerships),
- coordination and collaboration, and
- national direction, jurisdictional implementation.

7.1.2 State

At a state-wide level, the *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018 – 2023* (2018) outlines a five-year direction for a whole-of-person, whole-of-community and whole-of-government approach to improving mental health and wellbeing, preventing suicides and reducing the impacts of problematic alcohol and other drug use. *Shifting Minds* advocates for the integration and targeting of mental health, suicide prevention and alcohol and other drug services to people who need them most. Specifically from an alcohol and other drugs perspective, *Shifting Minds* calls out the need to continually build the capability of the health and social services workforce, targeting investment to upstream programs and services (particularly harm minimisation approaches that prevent, delay and reduce risky alcohol and other drugs use) and providing intensive supports for families at higher risk of problematic use of drugs or alcohol. Lastly, Shifting Minds suggests that PHNs, Hospital and Health Services, Non-Government Organisations, and the private sector should routinely engage in joint planning to increase the local effectiveness and accessibility of alcohol and drug treatment services.

7.1.3 Regional

At a regional level, Brisbane South PHN and Metro South Addiction and Mental Health Services are committed to Working Together Differently: Brisbane South Mental Health, Suicide Prevention and Alcohol and Other Drug Foundation Plan 2020-2022. From an alcohol and other drugs perspective, Working Differently adopts the National Framework for Alcohol, Tobacco and Other Drug Treatment, which outlines the type of programs and services that are in-scope for joint action, including: interventions to reduce harm (e.g. family support, drop-in services), interventions to screen, assess and coordinate (e.g. screening and brief intervention, assessment, case management and care coordination and intensive interventions (e.g. withdrawal management, psycho-social counselling).

The intent of *Working Together Differently* is to build the foundations for collaboration between Brisbane South PHN and Metro South Health, with the development of a comprehensive Joint Regional Plan to be produced by June 2022. As time goes on, more opportunities for collaboration and co-commissioning of alcohol and other drug treatment services will arise.

7.1.4 Sector

Historically, there has a strong focus on the treatment of alcohol and other drug concerns in specialised and hospital settings; with limited treatment options available in the primary care setting. Recently, the Royal Australian College of General Practitioners (RACGP) has invested in the development and implementation of an Alcohol and Other Drugs GP Education Program. This education program aims to build GPs skills to better support patients who are experiencing AOD-related concerns.

7.2 Health status

7.2.1 Socioeconomic

The *National Drug Strategy* (Department of Health 2017b) highlights the harmful direct and indirect impacts alcohol, tobacco and other drugs have spanning health, social, and economic harms. Alcohol and other drug use and the accessibility of treatment services are associated with social and health determinants such as discrimination, unemployment, homelessness, poverty, and family breakdown.

The *Strategy* provides evidence that maintenance of recovery is strongly associated with quality of life. Quality of life factors include family life, connection to community, employment and recreational opportunities. Therefore, investing in strategies to enhance social engagement, and where indicated, re-integration with community, is central to successful interventions that can reduce alcohol and other drug demand and related problems, including dependence.

7.2.2 Behaviours

In 2021, 15% of adults aged 18+ years in Brisbane south exceeded the National Health and Medical Research Council's guidelines for alcohol intake (PHIDU 2021), with adult males being 3.4 times more likely to drink at risky levels over their lifetime compared to females (Queensland Health 2020*)*. A similar trend was seen across the state, with Queensland males three times more likely to drink at risky levels over their female counterparts (27% vs. 9%) (PHIDU 2021). PHAs within the region that demonstrated the highest proportion of persons aged 18+ years who consumed more than two standard alcoholic drinks per day on average included Brisbane Port - Lytton/Wynnum with 23 ASR per 100 persons, Victoria Point with 23 ASR per 100 persons and Wellington Point with 22 ASR per 100 persons (PHIDU 2021).

It is estimated that one in six (16%) people aged 14+ years in Brisbane south had used illicit drugs in the previous 12 months in 2019, on par with Queensland (17%) and Australian (16%) rates. Similarly to alcohol intake, males were more likely to use illicit drugs compared to females in Queensland (21% vs. 13%) (AIHW 2020q).

Key themes raised by community and sector representatives during local consultation regarding alcohol and other drug related behaviours included:

- a perceived increase in risky drinking behaviours within the Brisbane south region
- the increasing complexity of alcohol and other drug presentations due to exacerbated psychosocial impacts including domestic and family violence, mental health issues, suicidality and homelessness.

7.2.3 Health Outcomes

The detrimental health impacts of alcohol and other drug use are well established. Alcohol use is closely associated with alcohol use disorders, 12 types of injury (predominantly road traffic injuries, suicide and self-inflicted injuries), chronic liver disease, liver cancer and many other cancers and neoplasms, coronary heart disease, and a number of other major health conditions (Queensland Health 2020). Recent studies have reviewed the "known" impacts of alcohol consumption, finding increased evidence of the relationship between alcohol use and the aforementioned negative health outcomes, and weakened evidence of any protective effects of low-level consumption (Queensland Health 2020).

Illicit drug use is linked to over ten health conditions including poisoning, drug use disorders, suicide and self-inflicted injuries, chronic liver disease, and liver cancer. Specific linked conditions differed by the type of illicit drug (Queensland Health 2020). There is a strong association between illicit drug use and mental health conditions (AIHW 2018l).

Nationally, alcohol use accounted for 4.5% of total disease burden in 2015, including 5.6% of early death burden (an estimated 1,200 deaths in Queensland) and 3.4% of the disability burden (Queensland Health 2020). Illicit drug use accounted for 2.7% of the total disease burden. This included 3.7% of early death burden (an estimated 500 deaths in Queensland) and 1.7% of disability burden in 2015. Of the individual drug use types, opioid use posed the highest risk, contributing to 1.0% of Australia's total burden, followed by amphetamine use (0.6%) and unsafe injecting practices (0.5%) (Queensland Health 2020).

7.3 Health system

Since the first iteration of *Australia's National Drug Strategy* in 1985, the country has built a consistent and evidence-based approach to alcohol and other drugs underpinning a commitment to harm minimisation. This has included providing funding for, and delivering, evidence-based treatments for substance use disorders (Queensland Health 2017). Available treatments range from prevention and early intervention to intensive residential treatment. These services are provided across various settings including outpatient clinics, correctional facilities, hospitals, primary care settings, and community specialist drug and alcohol treatment services. Robust quantitative data regarding primary care alcohol and other drug treatment in general practice settings is lacking in Brisbane south. The following analysis draws on available data with a focus on hospital and community-based alcohol and other drugs specialist treatment services.

7.3.1 Service utilisation

7.3.1.1 Hospital services

The most common reasons for the provision of hospital bed-based services for alcohol and other drug-related use are alcohol and other drug rehabilitation, counselling, treatment due to substance-induced health conditions (such as acute intoxication, withdrawal, and drug-induced psychosis).

The rate of overnight hospitalisations attributed to alcohol and other drug use in Brisbane south was slightly lower than other Queensland metropolitan PHNs and the national average (AIHW 2017d). Between 2013-14 and 2015-16, the ASR of overnight hospitalisations for alcohol and other drug use per 100,000 persons steadily increased in the region (14 to 17), and nationally (17 to 20).

Despite this relative comparability to State and national benchmarks, there are distinct geographic hotspots within the region for closed alcohol and other drug treatment episodes, which tended to be centred around service provider locations. The SA3s of Holland Park - Yeronga and Brisbane Inner demonstrated the highest number of closed alcohol and other drug treatment episodes in 2016-17, contributing 33% and 18% respectively towards the region's total. Five of the 23 SA3s which comprise the Brisbane South PHN region accounted for approximately 84% of the region's total episodes across both 2015-16 and 2016-17 (8,176 and 6,588 episodes respectively). These five SA3s were Holland Park – Yeronga, Brisbane Inner, Browns Plains, Forest Lake – Oxley, and Springwood – Kingston (AIHW 2018l). Male consumers made up 70% of closed alcohol and other drug treatment episodes in 2016-17, a slight reduction from 72% in 2015-16 (AIHW 2018l).

The leading principal drugs of concern by proportion of closed treatment episodes in Brisbane south were cannabis (34%), amphetamines (27%) and alcohol (25%) in 2018-19. This comes in contrast to national trends with alcohol (34%), amphetamines (27%) and cannabis (22%) being of greatest concern (AIHW 2020o). Cannabis and amphetamines were reported more frequently as the principal drug of concern amongst younger age groups (19 years and younger to 39 years) while people aged 40+ years were more likely to seek treatment for alcohol-related concerns (AIHW 2018l).

7.3.1.2 Specialist alcohol and other drug treatment services

The Commonwealth Government funds specialist alcohol and other drug treatment services to deliver treatments in both residential and non-residential settings. In 2019-20, publicly funded alcohol and other drug treatment services provided treatment to 139,295 people across Australia. That is, 624 per 100,000 or approximately 1 in 160 people (AIHW 2021).

In 2018-19, Brisbane South PHN had the ninth lowest rate of clients receiving publicly funded alcohol and other drug treatment services. At 550 clients per 100,000 persons in the general population, Brisbane South PHN's rate is lower than that of other Queensland metropolitan PHNs including Brisbane North (926 per 100,000 persons) and Gold Coast (726 per 100,000 persons) (AIHW 2021).

The *National Drug Strategy Household Survey* (2020) indicated that 16% of people had recently used illicit drugs in Brisbane south in 2019, 3% lower than Brisbane North and 6% lower than Gold Coast. Lifetime 'risky' consumption of alcohol within the PHN was 15%, 5% lower than Brisbane North and 8% lower than Gold Coast. In this way, the reduced rate of people accessing alcohol and other drug treatment services in Brisbane south may be reflective of the lower prevalence of risky alcohol and illicit drug consumption, but also insufficient service provision. Findings from community consultation support this, with community and sector stakeholders highlighting the limited availability and accessibility of alcohol and other drugs services in the region as an ongoing issue.
In line with national trends, in 2018-19 over two-thirds of clients at specialist alcohol and other drug treatment services in Brisbane south identified as being male and over half of all clients were aged between 20 and 39 years. Brisbane south had a lower proportion of clients aged 40 years and over (29%) and a higher proportion of young people aged 10 to 19 years (17%) accessing specialist services by comparison to national levels (35% and 12% respectively) (AIHW 2021).

Main treatment types

In 2018-19, 'counselling' was the most common treatment type for alcohol and other drug treatment episodes in Australia (39%), but that was not the case in Brisbane south or any of the metropolitan PHNs in Queensland. In Brisbane south, 'information and education services' represented 32% of all treatment episodes (vs. 8% in Australia), followed by 'counselling' (27%) and 'assessment only' (17%) (AIHW 2021).

Information and education services are the least intensive type of alcohol and other drug treatment services, referring to those instances when no treatment is provided to the client other than information and education. While the provision of information and education services has declined since 2014-15 (Table 98), the fact they still account for almost one third of treatment episodes delivered in the Brisbane south region, compared to one tenth nationally, suggests there is scope for improving availability and access to more intensive services in the region (AIHW 2021).

Table 98. Alcohol and Other Drug Treatment Service Provision by Treatment Type, Year and Region

Treatment Type	Brisbane South PHN		Australia (Benchmark)	
	2014-15	2018-19	2014-15	2018-19
Counselling	27%	27%	40%	39%
Withdrawal Management	8%	7%	13%	11%
Assessment Only	16%	17%	17%	18%
Support and Case Management Only	4%	10%	9%	12%
Rehabilitation	4%	6%	6%	6%
Pharmacotherapy	0%	1%	2%	2%
Information and Education Only	40%	32%	10%	8%
Other	2%	1%	3%	4%

Source: AIHW 2021.

Queensland's rate of prescriptions dispensed for opioid medicines in 2016-17 was 66,923 per 100,000 persons (age-standardised). This is the third highest rate in Australia when comparing states and territories, and is considerably higher than the national rate. In Brisbane south the provision of opioid replacement therapies was highest in Cleveland - Stradbroke, Springwood - Kingston, and Browns Plains SA3; accounting for 27% of the region's total dispensed prescriptions for opioid medicines in 2016-17 (Table 99) (ACSQHC 2018).

Table 99. Number of PBS/RPBS Prescriptions Dispensed for Opioid Medicines

SA3	Proportion of BSPHN Opioid Prescriptions		
	2013-14	2016-17	% Change
Brisbane LGA			
Brisbane Inner	3.99%	3.90%	-0.09%
Brisbane Inner - East	2.42%	2.48%	0.06%
Carindale	3.60%	3.40%	-0.20%
Centenary	2.29%	2.23%	-0.06%
Forest Lake - Oxley	6.94%	6.61%	-0.33%
Holland Park - Yeronga	4.82%	4.88%	0.06%
Mt Gravatt	4.98%	4.94%	-0.04%
Nathan	3.05%	3.06%	0.02%
Rocklea - Acacia Ridge	4.05%	3.96%	-0.09%
Sherwood - Indooroopilly	2.61%	2.30%	-0.31%
Sunnybank	2.72%	2.77%	0.05%
Wynnum - Manly	6.58%	6.62%	0.04%
Logan LGA			
Beenleigh	5.63%	5.80%	0.17%
Browns Plains	8.37%	8.45%	0.08%
Jimboomba	4.16%	4.41%	0.25%
Loganlea - Carbrook	6.66%	6.75%	0.10%
Springwood - Kingston	9.58%	8.75%	-0.83%
Redland LGA			
Capalaba	7.13%	7.56%	0.42%
Cleveland - Stradbroke	9.01%	9.58%	0.57%
Scenic Rim LGA			
Beaudesert	1.42%	1.55%	0.13%

Source: Australian Commission of Safety and Quality in Health Care 2018.

Delivery settings

Across the PHN in 2018-19, 59% of alcohol and other drug treatment episodes were delivered in a non-residential facility. The second most prevalent delivery setting was outreach (31%). In line with the less intensive nature of services available in the region, only 5% of treatments were delivered in a residential treatment facility, by comparison to 10% nationally (Table 100) (AIHW 2021).

Table 100. Number of Distinct Clients by PHN, by Treatment Delivery Setting, 2018-19

PHN	Treatment Setting (%)				
	Non-residential Treatment Facility	Residential Treatment Facility	Home	Outreach	Other
Australia	69	10	1	15	5
Brisbane South	59	5	1	31	5
Brisbane North	53	4	1	42	1
Gold Coast	61	10	1	25	3

Source: AIHW 2021.

Reasons for treatment cessation

National data from 2018-19 indicated that 61% of closed treatment episodes for client's own drug use were expected or planned completions; with a further 7% ending due to the client being referred to another service or changing their treatment mode. One in five (21%) closed treatment episodes ended due to an unplanned completion. These figures have remained relatively stable in the 10 years since 2010-11 (AIHW 2020q). PHN-level data is not available regarding treatment cessation, however it is reasonable to surmise that Brisbane south's outcomes would be similar to national levels.

Key themes raised by community and sector representatives during local consultation regarding alcohol and other drug service utilisation included:

- limited service awareness and literacy within the community regarding existing services and available treatment options
- witnessing a significant increase in all emergency department presentations with co-occurring mental health and alcohol and other drug concerns
- an increase in female clients presenting for support, especially those experiencing domestic and family violence
- an increase in presentations where alcohol was the primary drug of concern
- the lack of primary care screening for alcohol and other drug issues.

7.3.2 Service experience

Key themes raised by community and sector representatives during local consultation regarding consumers' experiences accessing alcohol and other drug services included:

- the alcohol and other drug service system being fragmented and difficult to navigate causing accessibility challenges
- the lack of timely access to services, especially detoxification facilities and opioid replacement therapies, due to extended waitlists
- the inefficient use of acute hospital resources and increased risk being held by service providers due to the inaccessibility of rehabilitation services
- lack of support for individuals experiencing alcohol and other drug related conditions that either fall outside of eligibility criteria or make them ineligible for publicly funded mental health services.

7.3.3 Service mapping

There are a number of state-wide and community-based alcohol and other drugs treatment services available in the Brisbane south region. These include:

- **AMEND Program** delivered region-wide by Anglicare Southern Queensland specialising in supporting pregnant and parenting people aged 18 years and over who identify concerns related to substance use, and children and family members who may be affected.
- **Community & Family Support Service (CAFSS) Program** delivered region-wide by Drug Arm specialising in supporting people aged 16 years and over who have recently accessed withdrawal management (detoxification) services or residential rehabilitation, and/or those involved with the justice system.
- **Lives Lived Well (LLW)** specialising in supporting people aged 18 years and older in the Logan and Beaudesert regions who have recently accessed withdrawal management services or residential rehabilitation, and/or those involved with the justice system.
- **Queensland Injectors Health Network (QuIHN)** specialising in supporting people aged 18 years and older in the Redland and Southern Moreton Bay Island regions who have recently accessed withdrawal management services or residential rehabilitation, and/or those involved with the justice system.
- **CHAMP** is a program delivered by Mater Mother's Hospital, which aims to support pregnant and parenting people to make positive changes to their drug-using behaviours.
- **Adolescent Drug and Alcohol Withdrawal Service (ADAWS)** is a residential detoxification program for young people aged 13 through 18 years. This is a state-wide service operated by Mater Health Services.
- **Metro South Addiction and Mental Health Services** operate an array of alcohol and other drug treatment services across the region, including:
    - The **Logan Adolescent Drug Dependencies Early Response Service (LADDERS)** provides support to young people, their families and close supporters, who are experiencing problematic use of substances.
    - The **Needle Syringe Program** is operated at various locations (Bayside Community Mental Health Centre, and Beenleigh, Browns Plains, and Inala Community Health Centres) throughout the region, assisting with harm minimisation for people who inject drugs by supplying sterile injecting equipment. Self-service vending machines for sterile injecting equipment are also available at the Marie Rose Centre (North Stradbroke Island), Redlands Health Service Centre, Wynnum Health Service, Logan Central Community Health Centre, and Beaudesert Hospital.
- The **Belmont Private Hospital** offers Addictions Recovery and a Department of Veterans Affairs approved program for relapse prevention and addiction treatment (Belmont Private Hospital 2021).

Despite the range of services available, two key themes regarding services in the region were raised by community and sector representatives during local consultation regarding alcohol and other drug service mapping. These were:

- a general lack of capacity within the Brisbane south alcohol and other drug service sector to meet consumer demand, and
- a lack of future capacity and resource planning within the sector.

7.3.4 Workforce

Quantitative figures are difficult to ascertain for the alcohol and other drugs workforce, therefore relying heavily on stakeholder views. Key themes raised by community and sector representatives during local consultation regarding the alcohol and other drug workforce included:

- The need for coordinated education of GPs to strengthen their capacity to identify and address alcohol and other drug use in the community.
- Workforce burnout due to pressure on service staff in the face of heightened demand.
- Recruitment challenges, including high rates of staff turnover and difficulty backfilling positions which in turn results in longer periods of disrupted service delivery.

7.4 Health equity

7.4.1 First Nations peoples

Across the PHN, 11% of clients accessing specialist alcohol and other drug treatment services identified as First Nations. With First Nations peoples comprising only 2% of the Brisbane south population, it is evident this minority group has a higher level of need when it comes to alcohol and other drug-related issues (AIHW 2021). A key theme raised by community and sector representatives during local consultation was the lack of alcohol and other drug services in Brisbane south specifically designed for First Nations people.

7.4.2 People from CALD backgrounds

A key theme raised by community and sector representatives during local consultation was the increasing demand for culturally responsive and appropriate alcohol and other drug services for people from CALD backgrounds and refugee communities, with a lack of services in the region to meet this demand.

7.4.3 LGBTQIA+ community members

Within the Brisbane South PHN region, 25% of people aged 14+ years who identify as homosexual or bisexual drank at risky levels over their lifetime, compared to 17% of heterosexuals. It is estimated that approximately one-third (36%) of the same cohort had engaged in illicit drug use in the previous 12 months, compared to 16% of heterosexuals (AIHW 2020q).

Due to limitations in current data collection and reporting methods, it is difficult to ascertain the gender diversity and diversity in sexual orientation of clients taking up specialist alcohol and other drugs services in the region. For example, national data collections do not currently routinely collect client sexual orientation. Further, underreporting of gender diversity may occur due to structural limitations in the current data collection (for example, the collection of sex as “male”, “female”, and “other”). With these limitations in mind, it is noteworthy that less than one per cent of specialist alcohol and other drug treatment services clients in the region reported a non-binary or other diverse gender identity. This may reflect both poor data collection quality, and/or a lack of appropriate and accessible alcohol and other drugs services in the region for persons who identify as LGBTQIA+; and warrants further exploration.

7.4.4 People experiencing or at risk of homelessness

There is a strong relationship between problematic use of alcohol and other drugs and experiences of homelessness (AIHW 2019a). While the misuse of alcohol and other drugs may act as a pathway into homelessness or develop after homelessness occurs, it is known that substance misuse can inhibit people's ability to obtain stable housing and compound the effects of limited service engagement and increased social isolation (Robinson 2014, Johnson and Chamberlain 2008).

People with problematic use of alcohol and other drugs, particularly those experiencing homelessness, are at greater risk of serious and preventable health issues and death (AIHW 2020t). Data published by the AIHW (2020) indicated in 2019 1 in 10 special homelessness service clients identified as having problematic drug and/or alcohol use. This rate was significantly higher amongst First Nations peoples (1 in 3). Queensland had the lowest rate of clients with problematic alcohol and other drug use in the country, 7.7 ASR per 10,000 persons. Approximately 44% of clients who reported problematic alcohol and other drug use also reported a current mental health issue, with 31% reporting experiencing both a current mental health issue and domestic/family violence.

Outcomes of the *500 lives 500 Homes campaign*, published by Micah Projects (2017), indicated 71% of adult individuals aged 25 years or over accessing special homelessness services in Brisbane south

identified themselves as a substance user. Of those who identified as having a mental health condition (83% of clients), 64% also reported a dual diagnosis with substance use and 47% reported a tri-morbidity of substance use and a serious health condition (Figure 68).

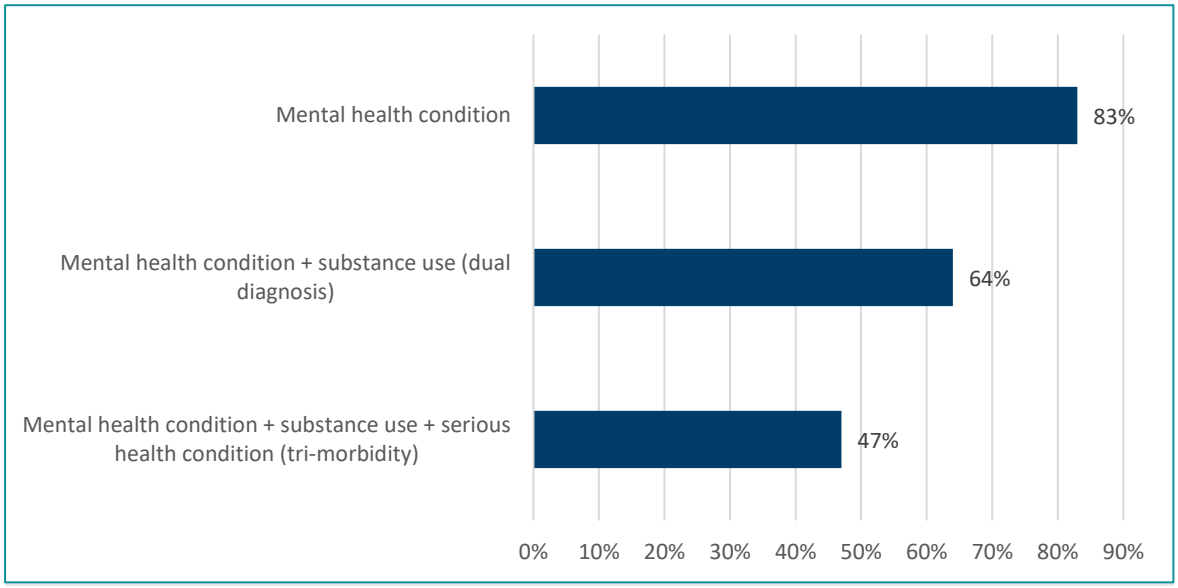

Figure 68. Mental Health, Substance Use, and Physical Health of People Experiencing Homelessness in Brisbane south

Source: Micah Projects 2017.

Community and sector stakeholders involved in consultation highlighted the increasing number of alcohol and other drug service clients reporting insecure housing and risk of homelessness in Brisbane south.

7.4.5 People with a disability

Limited information was available for alcohol and other drugs service needs for people with a disability.

7.4.6 Rural and remote communities

Community and stakeholder engagement has revealed concerns regarding problematic use of alcohol and other drugs in the remote areas of the Southern Moreton Bay Islands. Since 2019, the Commonwealth Government has provided additional funds to PHNs to enhance the service response for alcohol and other drugs treatment services in rural and remote communities.

7.5 The Impact of COVID-19

7.5.1 Health status

Key themes raised by community and sector representatives during local consultation regarding the alcohol and other drug health status implications of the COVID-19 pandemic included:

- the impact of transport restrictions on the supply of illicit drugs into the region resulting in users transitioning to more readily available substances such as alcohol
- increased concern amongst community members about their alcohol use during periods of lockdown and isolation.

7.5.2 Health system

Key themes raised by community and sector representatives during local consultation regarding the alcohol and other drug health system implications of the COVID-19 pandemic included:

- increased demand for all alcohol and other drug services including inpatient and day programs, and information and education services.
- decreased engagement with GPs to undertake mental health treatment and planning amongst people with alcohol and other drug concerns.
- challenges delivering a range of services to meet client's needs, including face-to-face rehabilitation and opioid replacement therapy.
- Increased risk carried by services due to higher complexity cause by impacts of COVID including Domestic violence, suicidal ideation, homelessness, unemployment and interactions with child safety.

7.6 Health Priorities and Options

7.6.1 Priority unmet needs

Considering the comparative, felt, expressed, and normative needs of the Brisbane south region, a number of alcohol and other drug-related priority unmet needs emerged during triangulation. In order of priority, as determined through the prioritisation process, these needs included:

1. Priority populations experience higher levels of need relating to alcohol and other drugs support.
2. Focussing on the prevention of alcohol and other drugs issues alongside treatment.
3. Alcohol and other drugs service system not able to meet the needs of all people accessing support.
4. A capable workforce as an important enabler of the alcohol and other drugs system.

7.6.2 Current activities

Currently, Brisbane South PHN invests in a small number of local service providers to deliver a range of treatment services. The target groups for these services include:

- Pregnant and parenting people experiencing difficulties with substance use.
- Persons living in the Redlands region and SMBI Islands.
- Persons over 18 only.
- Persons living in the Beenleigh and Beaudesert regions.
- Persons who are inmates at the Arthur Gorrie Correctional Centre.
- Persons requiring counselling support.
- Persons requiring nursing support within a AOD residential service.
- Parents referred by Department of Child Safety.
- Aboriginal and Torres Strait Islander community members requiring AOD support.
- All services are working to appropriately manage their waiting lists due to the high rate of demand for AOD support in the community.

7.6.3 Options for future activity

- Partner, collaborate and lead system reform, delivering measurable and meaningful health and wellbeing impact. This will include the progression of the Working Together Differently Foundation Plan and development of the Comprehensive Joint Regional Plan between health system partners.
- Integrate and coordinate care systems within a holistic social determinants framework. This may include partnerships with social services, community-based services, and Local Government to enhance support options for people transitioning between primary and tertiary care, and coproduction of service solutions.

- Support community-led action that delivers sustainable change in health and wellbeing.
- Improve the health and wellbeing outcomes of our community, with a focus on addressing health inequities and inequalities. This may include a focus on priority populations through contracting mechanisms, market development, and workforce development and education opportunities.
- Enable strong and connected primary care to create a person-centred system that improves health access, experiences and outcomes.

S1. Digital Health

S1.1 Strategic environment

S1.1.1 National governance

The Australian Digital Health Agency (ADHA) is a national organisation formed by the various governments of Australia to "evolve digital health capability through innovation, collaboration and leadership to facilitate digital health integration in the health system" (ADHA 2017). In 2017, the ADHA released the *National Digital Health Strategy* to facilitate meeting the agency's objective through several strategic priority outcomes, to be achieved by 2022. These priorities focus on the availability and secure exchange of health information, interoperability of high-quality clinical data, convenient and safe access to prescriptions and medications, quality improvement of digital services, comprehensive usage of health technologies and a world-class innovative digital health industry (ADHA 2017).

S1.1.2 State

The Queensland Government has made significant progress toward the adoption and improvement of digital health systems within the state. In 2015, the *eHealth Investment Strategy* was developed in an effort to prioritise support for the equitable distribution of funding for health technologies and systems across the state that are effective, responsive, efficient, affordable and innovative (Queensland Health 2015). To further support digital health systems, the Queensland Government released the *Digital Health Strategic Vision for Queensland 2026* that builds upon the *eHealth Investment Strategy*. The strategic vision outlines the role of digital health through eight strategic goals that support the achievement of Queensland's 10-year vision for health (Queensland Health 2017). As of 2019, clinical systems operating within the Hospital and Health Service (HHS) have undergone significant expansion and consolidation of the Integrated Electronic Medical Record (ieMR) is in progress across the state (Queensland Health 2019).

S1.1.3 Regional

In order to provide guidance and support toward the adoption and continued use of digital health technologies for primary health care within the region, Brisbane South PHN developed the *Primary Health Care Digital Health Strategy and Roadmap 2018-2021* (Brisbane South PHN 2018). The roadmap was developed through evidence-based research and in consultation with various stakeholders to reflect the current situation, needs, barriers and pathways to improving digital health potential in the region. The Strategic Framework component outlines the vision, purpose, goals and strategies of the PHN as related to digital health technologies in primary health care settings. The Roadmap component serves to summarise the actions of the PHN over the three-year duration of the strategy, to work toward the goals outlined in the strategic framework. Brisbane South PHN has an ongoing commitment toward improving digital health technologies within the region and as such, will update the Primary Health care Digital Health Strategy and Roadmap every three years to continue working toward improving the overall health and wellbeing of those within the Brisbane south catchment.

S1.2 Digital technologies

S1.2.1 Electronic Medical Records

Electronic Medical Records (EMR) were implemented across Queensland to improve timely access to relevant clinical information and support clinical decision making in various point of care settings (Queensland Health 2017). In primary care settings, clinicians can access and update a consumers EMR through an ADHA supported clinical information software system or via the Healthcare Provider Portal (HPP) (RACGP 2019). EMR's across various services are all reflected in an individual's My Health Record, serving as a national central database. The national My Health Record system, previously named the Personally Controlled Electronic Health Record (PCEHR), was introduced in 2012 with a focus to improve the continuation of patient care through clinically relevant digital health records that can be easily accessed in a timely manner (AIHW 2020u). The My Health Record system does not replace local records held by primary care providers and still requires direct communication between clinicians regarding the continuity of consumer care (RACGP 2019). My Health Record is governed by the *My Health Record Act 2012*, which establishes the requirements of the system operator, provides a registration framework for various parties that participate in the My Health Record System and institutes a stringent privacy framework that is aligned with the *Privacy Act 1988* (ADHA 2021b).

In tertiary care settings, Queensland Health clinicians can access data pertaining to an individual's healthcare through integrated systems. The ieMR application facilitates health provider access to a consumer's My Health Record to enhance clinical access to patient information (Queensland Health 2021). The ieMR system further supports digitalised patient medical records to be electronically created, filed and shared within the Queensland HHS (Queensland Health 2019). Optimisation of the ieMR system is currently being achieved through a number of functionality upgrade initiatives that align to the needs of specialist health providers and continue to support the integration of various clinical systems within the HHS to guarantee continuity of patient information and care (Queensland Health 2019).

The Viewer (HPP) is a Queensland Health initiative that consolidates patient information from various Queensland Health clinical systems, to facilitate timely and secure access for general practitioners, HHS staff, mater health clinicians and other service providers (Queensland Health 2019). The overall purpose of this digital service is to assist health providers in delivering point-of-care services to the consumer in a consistent and efficient manner (Queensland Health 2021). The Viewer is interoperable across primary and tertiary care settings. However, the application is read-only and as such cannot be used to create or alter healthcare information (Queensland Health 2021).

S1.2.2 Clinical Decision Support Tools

In an effort to deliver patient-centred care from a digital perspective, Metro South Health and BSPHN collaboratively support the SpotOnHealth Health Pathways initiative. Health Pathways is a digital clinical decision support tool that is derived from an initiative developed by the Canterbury District Health Board in New Zealand (Metro South Health 2016). Health Pathways supports clinical autonomy and patient-centred care by providing clinicians with evidence-based information on the assessment, management and referral pathways for over 550 different health conditions (Metro South Health 2016). This online point-of-care tool is designed to help health providers navigate various care systems within the Brisbane south region and supports effective yet systematic approaches to health care.

S1.2.3 Electronic Referral Management Systems

Integrated electronic referral management systems (ERMs) exist on a state-wide level to simplify patient referrals to specialist outpatient services (Queensland Health 2016). Smart Referrals are integrated within various general practice management software systems to facilitate continuity of patient care across all levels of the health service (Queensland Health 2020). The program streamlined the creation and management of referrals by auto populating patient data, electronic processing and triaging of clinical information to ensure consistency and timely access to services (Queensland Health 2016). Referrals created and directed to specialist outpatient services in the Brisbane south region are processed through the Metro South Health Central Referral Hub (BSPHN 2018). Each referral is assessed by a central referral hub clinician against clinical prioritisation criteria and categorised accordingly (Metro South Health 2020). The focus of the central referral hub is to coordinate referrals to outpatient services in a standardised yet equitable manner, in line with their clinical urgency (Metro South Health 2020).

S1.2.4 Secure messaging

Secure messaging enables the sharing of clinical documents and other confidential information between healthcare organisations and professionals, directly or alternatively through a number of secure messaging providers. Secure message delivery operates by encrypting messages from the sender to then be decrypted by the receiver. Furthermore, practice-specific clinical information systems must be conformant with secure messaging providers to ensure exchange of data. In order to meet the requirements for the eHealth Practice Incentive Payment, general practices must have standards-compliant secure message delivery (ADHA 2021c).

S1.2.5 Telehealth

Queensland Health's telehealth program currently operates to increase access to health care services for individuals that reside in regional and remote communities (Queensland Health 2021). Telehealth services are available within both primary and tertiary care settings, allowing for improved service access at all stages of the patient journey. With the avenue of the coronavirus (COVID-19) pandemic, the Australian Government allocated additional funding for all consumers to access telehealth services through the Medicare Benefits Scheme (MBS) (Snoswell et al. 2020). Temporary MBS telehealth items were made available from February 2020 to mitigate the risks associated with community transmission of COVID-19 amongst both patients and health care providers (Australian Government 2020).

S1.2.6 Quality improvement

Brisbane South PHN is invested in providing Quality Improvement (QI) support for general practices across the region. In an effort to promote continuous QI practices within general practice settings, the Australian Government introduced the Practice Incentives Program (PIP). The PIP QI scheme incentivises practices to participate in QI measures in partnership with their local PHN. General practices can monitor QI through the use of CAT4, a clinical audit tool that easily converts patient cohort data into actionable insights aligned with the PIP QI program. Data collected from CAT4 is de-identified and measured against the 10 QI practices outlined within the PIP QI program, to measure performance and drive further QI.

S1.3 Health system

S1.3.1 Service utilisation

This section examines the utilisation of digital health technologies in primary care settings within the Brisbane South PHN region. The use of digital health technologies within the region is increasing as evidenced by primary health monitoring reports. As of June 2020, 360 general practices within the region were registered for My Health Record.

- Over the course of 2020 to 2021, there was a 55% increase in shared health summaries uploaded to the My Health Record system by general practices. In line with this, there was additionally a 38% increase in general practitioners viewing documents uploaded to the My Health Record system by another author.
- Within the region, other primary health care services registered for My Health Record included: 277 pharmacies, 102 allied health and 102 specialist services.

Over a 12-month period from 2020 to 2021, there was an increase in the proportion of general practitioners registered for access to The Viewer. Of the 1693 general practitioners within the region, 944 were registered to The Viewer. There was a 9% increase in registration relative to the total number of general practitioners working within the region, compared with 12-months prior. The Viewer is linked to Health Pathways, in the month of July 2020 The Viewer was accessed 443 times following use of the Health Pathways system (Queensland Health 2019).

The Health Pathways system had 912 users in the month of August 2021. Combined, these users accessed some 14,600 live pathways and averaged approximately 5 sessions each throughout the month. 58% of engagement was done so directly to the Health Pathways system. This was closely followed by access through Metro South Health at 29%.

S1.3.2 Impact of COVID-19

Consumer engagement with telehealth services increased significantly in 2020 to 2021 due to the addition of MBS telehealth items. Throughout this period GP telephone appointments were the most frequently billed item, compared to other telehealth services. GP video-enabled health services were the second most utilised form of telehealth delivery within the region. The utilisation of telehealth items remained prevalent until August 2020, at which point utilisation declined, potentially due to a number of factors such as lack of resourcing for telehealth, lack of education and limited tech support for both consumer and provider alike. Despite the uptake of telehealth throughout COVID, face to face modes of health care were still preferred. This may potentially be attributed to the ease of reviewing a patient in person as opposed to digitally.

Throughout the course of the pandemic, mobile phone applications were used as a contact tracing system to alert individuals of exposure to COVID-19 within their community. Data related to an individual's movement were stored for a short period of time in order to slow transmission of the virus through earlier identification of exposed contacts and subsequent positive cases that developed as a result of exposure (AIHW 2021).

S1.3.3 Service experience

Brisbane South PHN produces a monthly benchmark and trend report for each general practice within the region, to help identify key areas for potential improvement. As of June 2021, 287 general practices were registered and participating in the PIP QI program. For those general practices who received QI reports from the PHN, only 26% accessed the benchmark report and 30% accessed the trend report. In 2020-21, the region recorded lower proportions of data for 8 out of 10 QI measures, when compared to the national PIPQI aggregate average. For example, the proportion of consumers aged 65+ with a recorded influenza immunisation status updated within the previous 15 months was 59.6% compared to the national aggregate average of 64.2%. Additionally, within the region, the

proportion of regular consumers with their height, weight and BMI recorded (QIM3) and the proportion of regular consumers with alcohol consumption status recorded (QIM7) were higher than the national aggregate average (AIHW 2020i).

- In terms of the Brisbane south region alone, the proportion of regular female consumers with an up-to-date cervical screening test record over the last five years was 37.1%.
- Additionally, the proportion of regular consumers between the ages of 47-74 years who had a digital record of the necessary risk factors for a cardiovascular disease risk assessment was 44.6% (AIHW 2020i).

It is important to note that the recorded PIPQI data has recorded information following one year of implementation of the PIPQI program. Additionally, there are a number of caveats relating to client visits and particular limitations of certain clinical information systems.

S2. Oral Health

S2.1 Background

Oral health is a key indicator of quality of life (WHO 2021e) but the effect of oral health on the general health and overall wellbeing of a person is often undervalued (Nursing Times 2009). According to Global Burden of Disease Study 2017, oral diseases affect 3.5 billion people globally per year (WHO 2021e). More than 63,000 Australians get hospitalised every year for oral conditions, which are the third highest reason for acute preventable hospital admissions. Tooth decay is the most common condition with four out of every 10 Australian adults (39%) often untreated and is seen affecting more than 90% of adults and 40% of young children at some stage of life (Council of Australian Governments Health Council 2015).

In Queensland, 22.6% of people aged 15 and above have untreated coronal decays (Australian Research Centre for Population Oral Health 2014) and 53% of children aged between 5 to 15 have four or more teeth affected by decay (Metro South 2017). According to a study conducted in 2010, 74% of the 190 emergency cases studied in a Metro South Health Service District clinic were caries related such as toothache and dental abscesses (Wong et al 2012).

The impact of oral conditions on the quality of life is estimated to be more than the effect of all chronic conditions combined or of either lung or breast cancer over a 12-month period (Russell 2014) (Figure 69). Often defined as simple cosmetic problems (Russell 2018), the overall consequences of oral diseases on people, the health care system and the economy as a whole are widely disregarded (Russell 2014). The eating and speaking disabilities caused due to pain, infection and tooth loss resulting from untreated dental caries impact sleep and productivity of people and the degeneration of oral soft tissues often result in disability and even death. Though its risk factors such as poor hygiene, poor dietary intakes, smoking and excessive alcohol consumption are similar to coronary diseases and cancers, many studies have linked oral diseases as a cause or aggravating factor for cardiovascular diseases, pregnancy and birth complications, pneumonia, diabetes, HIV/AIDS etc (Mayo Clinic 2021).

Though the Australian Government increased its expenditure on dental health services from $5.1 billion in 2004-05 to $8.3 billion in 2011-12, 57% of the total cost of dental care is still covered by the individual as compared to only 12% of other health services being out of pockets payments (Council of Australian Governments Health Council 2015). Socially disadvantaged or low-income people, Aboriginal and Torres Strait Islander population, People living in regional and remote areas and people with additional/specialised healthcare needs are twice more likely to suffer from poor oral health outcomes than their counterparts (AIHW 2021). The National Oral Plan 2015-2024 aims to reduce the prevalence, severity and impact of poor oral health and inequalities in access to oral health treatment, required coordinated action at national, state and territory level and by researchers, educational institutions, and public and private providers (AIHW 2020v).

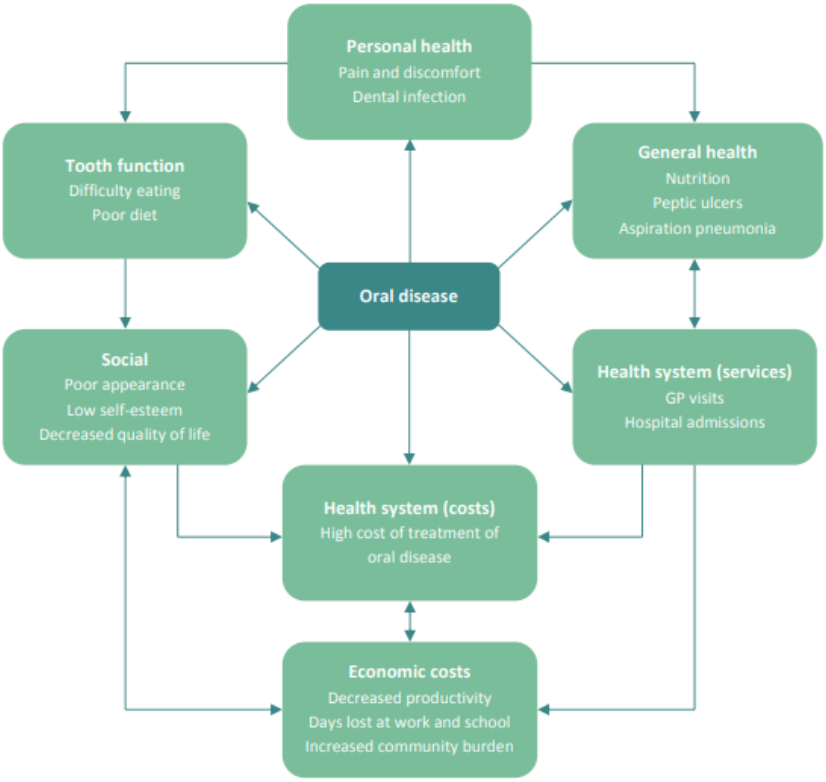

Figure 69. Impact of oral diseases
Source: Council of Australian Governments Health Council, 2015

S2.2 Strategic environment

S2.2.1 National

Health Mouthy Healthy Lives: National Oral Health Plan 2004-2013 is the first national attempt at addressing oral health issues by the National Advisory Committee on Oral Health (NACOH, n.d) which comprised of representatives from the Commonwealth, State and Territory governments, professional and consumer groups, and academic and educational bodies. The NACOH was established in the Australian Health Ministers' Conference in August 2001. National Oral Health Plan was designed based on the Oral Health of Australians: National Planning for Oral Health Improvement: Final Report in 2001 which was released by the AHMAC Steering Committee for National Planning for Oral Health (NACOH, n.d).

It provided a blueprint for the whole nation to improve oral health and reduce the oral disease burden with an aim to establish oral health as an integral part of general health, provide affordable and quality oral health services and educate. Since its implementation, several successful attempts can be noted such as

- the increased access to optimum levels of fluoridated water (69.1% in 2003 to 82.2% in 2012)
- increased number of dental practitioners
- several publications and surveys regarding oral health
- Oral health promotion campaigns such as Rethink Sugary campaign and oral cancer images on cigarette packages
- Increased engagement and investment by the Australian Government such as the Medicare Chronic Disease Dental Scheme 2007--2012, Dental Relocation and Infrastructure Support Scheme 2013-2014 and several other programs (NACOH 2001).

This attempt proved to be highly effective in bringing the attention towards oral health and improving several flawed aspects that hindered better oral health for Australians. Though this was the case, socioeconomic and organisational barriers impacted the oral health outcomes evidentially and many Australians were still suffering with the consequences of oral diseases. Hence, the National Oral Plan 2015-2024 was implemented to address these barriers that impeded the road to healthy mouths and ultimately healthy lives.

National Oral Health Plan 2015-2024 provides a national strategic direction and is more elaborative in outlining guiding principles which requires collaborative action at national, state and territory levels and by researchers, educational institutions, and public and private providers. This required input from stakeholders from various fields, thus this plan was developed through consultation with Commonwealth, state and territory governments, representatives of the oral health workforce (public, private, and non-government sectors), consumer groups, academics, dental practitioner students as well as other health professionals and stakeholders. Majorly, it focuses its strategies in six Foundation Areas and across four Priority Populations (COAG 2015).

S2.2.2 State

Unlike Victoria and New South Wales, Queensland does not have an oral health action plan specific to its population. The Victorian action plan to prevent oral disease 2020-30 and Oral Health 2020: A Strategic Framework for Dental Health in NSW are structured according to the needs of its populations, with its priorities and foundations based on the National Oral health plan 2015-24 (NSW Ministry of Health 2013) (State of Victoria, Department of Health and Human Services 2020).

The oral health strategies, programs and initiatives created in Queensland follow the National Oral Health Plan 2015-2024. The office of Chief Dental Officer (OCDO) is responsible for overlooking the public dental services in the state and it ensures that safe, appropriate, and sustainable public dental services are provided to Queenslanders through strategic leadership, high level monitoring of the services provided, Oral health promotion and prevention programs and Capacity building and sustainability (Queensland Health 2021).

Based on the Water Fluoridation Act 2008 and Water Fluoridation Regulation 2020, Queensland regulates the fluoridation process but the decision to provide fluoridated water supply within their areas is made by the local governments. Queensland Water Fluoridation Code of Practice provides the local governments with the designs and infrastructure and safety measures as well as forms to comply with the obligations. The water supplies with fluoride are checked daily in Queensland and reported to the Department of Health on a regular basis (Queensland Health 2021). Since the compulsory fluoridation of water supply was changed to decision of local governments, only 76% of Queensland has access to fluoridated water which is the least compared to other states in Australia (AIHW 2021).

S2.3 Outcomes

Queensland Child Oral Health Survey 2010-12 which included Brisbane region and rest of Southeast Queensland children aged 5-14 years in the survey reported the following with its severity mostly related to age, sex, income, and locations:

1. Moderate or severe accumulation of dental plaque prevalence was 47.1% for all ages seen by naked eye.
2. Gingivitis was 18.8% for all ages, with highest at 9-10 years (22.1%) and lowest at 5-6 years (11%).
3. Dental trauma in permanent teeth was 7.9% and oral mucosal conditions such as ulcers or other non-ulcerated mucosal conditions was 7.8% in all ages.
4. Enamel hypoplasia is visible loss of enamel due to development abnormalities or demineralisation. 13.1% of all ages children reportedly displayed these symptoms.
5. 55.1% of parents rated their children's' (of all ages) oral health to be excellent or very good (Do L and Spencer AJ 2014).

National Study of Adult Oral Health 2017-18 reported oral health status of adults aged 15 and above at national level. The findings were as follows with higher rates in successively older age groups:

1. One-fifth (20.2%) suffered from toothache in the last 12 months.
2. Periodontal pocket of >4mm was reported in 28.8% which was only 19.8% in 2004-06 survey.
3. Complete tooth loss was reported to be only 4% with a mean 4.4 of missing teeth due to dental decay and periodontal diseases.
4. Around 10.2% of people aged 15 and over reportedly had less than 21 natural teeth.
5. One-tenth (11.3%) wore dentures and 5.6% had dental implants (Chrisopoulos et al 2020).

According to National Study of Adult Oral Health 2017-18 and National Survey of Adult Oral Health 2017-18, the average DMFT in Queensland was higher than the national average for all age groups. A trend of oral health deteriorating with age can be observed (Table 101) (AIHW 2021).

Table 101. Average Decayed Missing, or Filled Team

Age (in years)	Average DMFT (decayed, missing or filled teeth)
5-10	2.1
6-14	0.8
15-34	4.3
35-54	10.6
55-74	20.7
75 years and over	23.9

S2.4 Health system

Dental services are available through public or private dental clinics. Most of the costs incurred availing dental services are not covered under Medicare, thus out of pocket payments are 57% of the total treatment costs (COAG 2015). Medicare covers for some eligible children and adults availing specific types of dental services which differ according to different state and territory governments (Queensland Government 2021).

In Queensland, adults and their dependents who are residents of Queensland are eligible for free public dental services and should have any of the following concession cards:

1. Pensioner Concession Card issued by the Department of Veterans' Affairs
2. Pensioner Concession Card issued by Centrelink
3. Health Care Card
4. Commonwealth Seniors Health Card
5. Queensland Seniors Card (Queensland Government 2021).

Children should have the following criteria to be eligible in Queensland:

1. be a Queensland resident or attend a Queensland school; and,
2. be eligible for Medicare; and,
3. meet at least one of the following criteria:
    - be aged four years or older and have not completed Year 10; or,
    - be eligible for the Medicare Child Dental Benefits Schedule; or,
    - hold, or be listed as a dependent on, a valid Centrelink concession card (Queensland Government 2021).

S2.4.1 Child Dental Benefits Schedule (CDBS)

CDBS is a dental benefits program by the Commonwealth government that provides around $1013 in benefits to eligible children for basic dental services in public or private clinics. These basic dental services include examination, X-rays, cleaning, fissure sealant treatment, fillings, root canal treatment and extractions excluding cosmetic and orthodontic treatments (Queensland Government 2021).

Eligibility:

- 2 to 17 years old for at least 1 day that year
- eligible for Medicare
- getting an eligible payment, or have a parent getting a payment, from Centrelink at least once a year, including Family Tax Benefit Part A (Queensland Government 2021).

Additional eligibility criteria:

- Eligible patients under the Commonwealth cleft lip and cleft palate scheme.
- Eligible patients residing in other state/territory requiring emergency dental treatment.
- Patients of public hospitals if the care is considered essential to the recovery and rehabilitation of the patient, or the treatment of dental emergencies while in hospital
- Non-eligible patients on a fee for service basis in rural and remote areas where there is no private service
- Offenders in Queensland Correctional Services, including emergency care for short term and remand prisoners, and general care for longer term prisoners
- Eligible adults under the Forde Foundation oral health agreement
- Refugee and Asylum Seekers within the eligibility criteria are entitled to priority general course of care and require eligible referral forms (Queensland Health 2021).

Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane deliver a wide range of oral health services to eligible patients from three sites: Woolloongabba, Logan and the Murri School. Services are available 5 days a week, 52 weeks in a year and includes services such as (QAIHC 2020):

- emergency treatment for toothache, trauma and wisdom teeth
- routine dental check-ups and screening
- fillings
- extractions
- root canal on anterior teeth
- wisdom teeth extractions
- dentures and crowns
- mouth guards and splints
- specialist referrals

Eligibility: Resident of South East Queensland who is of Aboriginal or Torres Strait Islander background and should be an ongoing patient with ATSICHS or if new patient, need to be reviewed by ATSICHS GPs (QAIHC 2020).

S2.4.2 Workforce

There was an increase from 612 dental practitioners to 811 from 2013 to 2020 in Brisbane south which means there is only 1 dental practitioner for approximately every 1,586 people in this region. According to the Oral Health Professions Workforce Survey 2020, only 43% of the respondents reported to work for 30-39 hours in a week with high proportions of females working only 20-29 hours per week. Post COVID, there was a decrease in the hours per week for dentists who worked 20-29 hours or 30-39 hours but the percentage of people working more than 20 hours increased by almost 10% (Stormon et al 2020).

In the 13 approved dental specialists in Australia, 35% of the dentists have a specialisation in Orthodontics with only 11 dentists specialised in public health dentistry and 15 in special needs dentistry (AIHW 2021).

In Queensland, full time equivalent (FTE) dental practitioners per 100,000 population in the year 2019 were as follows:

- Dental Hygienists – 3.7
- Dental Prosthetists – 5.1
- Dental Therapists – 2.5
- Dentists - 63
- Oral Health Therapists - 6.8 (AIHW 2021).

There was a major difference in the number of FTE dentists available in public and private sector in all the states in Australia. In Queensland, there were 6.9 public dentists per 100,000 people. In private practice there were 50.2 dentists per 100,000 people, which is around 10 times more than in the public sector (AIHW 2021). Figure 70 shows the main employment settings of dentists practicing in Queensland.

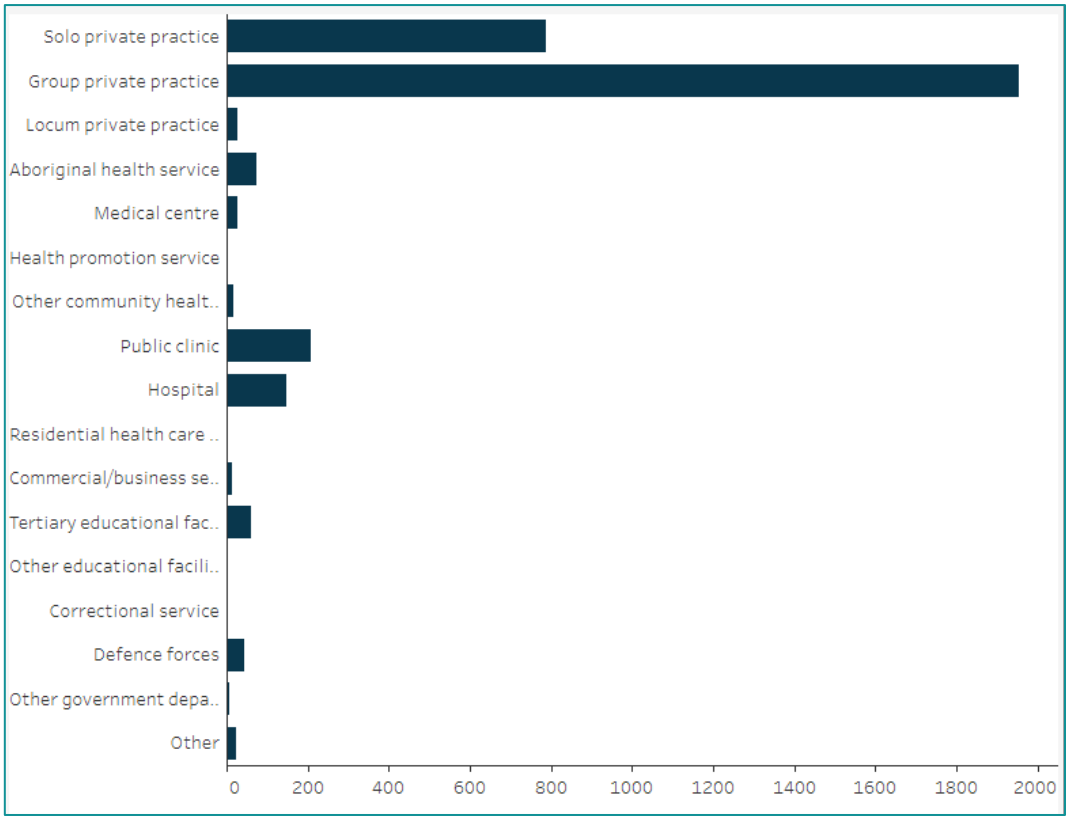

Figure 70. Number of dentists by main employment setting in Queensland (AIHW 2021)

S2.5 Health Equity

S2.5.1 Aboriginal and Torres Strait Islander People

Indigenous people suffer from poor oral health in greater proportion earlier in life and in great severity and prevalence than the general population. Quite often, Aboriginal and Torres strait islanders require emergency treatments due to delay in preventing, addressing, and receiving treatments for oral conditions (QAIHC 2020). In the year 2017, more than 400 indigenous children suffering from severe tooth decay under age nine were admitted to hospitals in Queensland (Queensland Health 2018).

Adults:

- Indigenous adults aged 15 and above are three times more likely to suffer from dental caries and twice more likely to suffer from severe gum diseases (COAG 2015)
- Indigenous adults reported financial burden in paying dental bills 1.7 times more than non-indigenous (COAG 2015)
- The limited representation of indigenous people in oral workforce makes the clinical services culturally unsafe and do not improve health literacy (QAIHC 2020).
- Indigenous adults require dentures 2.82 times more likely and 1.48 times more for extraction or filling than the general population (QAIHC 2020).
- Indigenous population reported 1.75 times more percentage of toothaches and 1.29 times more percentage of being uncomfortable about their dental appearance (QAIHC 2020).

Children:

- Indigenous families reported delay in early brushing with toothpaste in children and less likely to brush twice a day.

- Untreated decays prevalence in primary teeth was 48% in Indigenous while only 28.4% in non-indigenous and the average number of decayed teeth per child was two times more in indigenous children.
- Untreated decays prevalence in permanent teeth was 20.4% in indigenous and only 11.7% in non-indigenous (Do L and Spencer AJ 2014).

S2.5.2 People from CALD Backgrounds

People from CALD background, refugees, migrants, and non-English speaking backgrounds fail to identify their oral health needs or are unable to look after their dental health due to common barriers such as:

- Language and cultural barriers
- Limited access to information regarding services available
- Limited availability of interpreters
- Costs incurred while accessing these services (transport and services) (NSW Health 2021).

People from countries with non-fluoridated water access, improper diet and nutrition, high incidence of trauma and improper oral hygiene techniques can also be considered contributing factors (NSW health 2021). Statistics for oral health status of CALD communities was not available.

S2.5.3 LGBTQIA+ Community Members

Within the Australian population, 11% identify as LGBTQIA+ community. As there is no data available particular to Brisbane South PHN, it is estimated that 120,000 people in this region belong to the community based on the overall percentage (refer to section to 1.3.3). It is perceived that this community face additional challenges and fears while accessing healthcare services such as discrimination and limited understanding by the staff, stigma, and failure to handle these patients by the health professionals (Coller 2021). LGBTQIA+ community members are more likely to smoke, use drugs, consume alcohol and be diagnosed with sexually transmitted diseases than the general population which are known to aggravate oral health conditions (Coller 2021).

S2.5.4 People experiencing or at risk of homelessness

Currently, there are around 6,000 people experiencing homelessness in Brisbane South PHN which is higher than average Queensland level (refer to section to 1.3.4). It 2014, it was reported that Inner Brisbane has 9% of Brisbane population of which 38% of it is homeless people. Queensland and Western Australia have the highest number of homeless compared to rest of the country. Queensland homeless population is around 27,000 people in 2014 (Ford et al 2014).

Prevalence, severity and extent of oral diseases were three times higher than the general population (Ford et al 2014). Homeless are subjected to excessive levels of drugs, cigarettes, alcohol, and unhealthy diets which are risk factors for most of the oral health problems. Dental phobia and dental anxiety are commonly reported in this population mainly due to the attitudes of providers towards them. The unavailability of information regarding services and access to affordable services increased the percentage of homeless people that prefer seeking emergency care over comprehensive care (Goode et al 2018).

S2.5.5 People with a disability

People with mental illness, physical, intellectual, and developmental disabilities, complex medical needs, and older frail people have higher incidence of poor oral health. Brisbane South PHN recorded 43,533 people with profound or severe disability which is 4.8% of the total population according to 2016 Census. People with disability require additional specialised equipment, training, time, and resources to avail dental services. The presence of very few dental practitioners that are

specialists in Special Needs Dentistry is the most common problem faced resulting in longer waiting lists and delay in treatment or preventive measures.

- People with mental illness often suffers from complications due to medications causing mouth dryness, increased risk of alcohol, caffeine and drug consumption and smoking. They are three times more likely to become edentulous and have an average of 6 more DMFT than people without mental illness.
- People with disabilities suffer from lack of self-reporting capacity or fail to perceive their oral health needs. Often under disability support pension or welfare benefits, oral care is not included, or the carer often considers their oral health as the least priority.
- Majority of the people with complex medical conditions require maintaining good oral health to avoid complications and death. Several chronic conditions such as cardiovascular diseases, diabetes, malnutrition, and obesity are known to be aggravated due to periodontal diseases.
- Frail old people require oral health care in a timely manner to ensure there is no adverse impact on their overall health. Old people living in residential facilities have higher prevalence of oral diseases. Usually, the comorbidities and poly-pharmacy issues are the reason maintaining oral health in this population is complex (COAG, 2015).

S2.5.6 Rural and remote communities

In Brisbane south only 3.5% of the total population lives in rural and remote areas. In the Redland Islands SA2, 38% of the population live in outer regional areas and 23% in remote areas. Communities of the Southern Moreton Bay Islands, such as Russell and Macleay Islands and North Stradbroke Island, suffer from disproportionate health and social outcomes compared to the mainland (refer to section to 1.3.6).

- Smaller proportion of dental practitioners in regional and remote areas per head of population compared to metropolitan regions, thus there an increase in cost for availing dental services in such regions.
- Limited access to healthy food and oral hygiene products making them more costly than usual.
- Inadequate accessible clinical infrastructure, requiring people to travel to the mainland or metropolitan areas. This is further complicated with the absence of funding, programs and providers that make these services affordable and accessible (COAG 2015).

S2.6 Health Priorities and Options

S2.6.1 Priority unmet needs

Lack of oral health data: There is an essential need for prioritising oral health and implementing programs and strategies to understand and improve the oral health of the people in Brisbane south. This requires a thorough statistical analysis of the oral health picture in the region to ensure the oral health needs of the region are understood.

Lack of oral health promotion and preventive programs: Interventions at early stages would eliminate the circumstances in which patients have to receive emergency or severely debilitated treatments. This requires a better understanding of how to address their needs and where.

Lack of adequate dental practitioners available per 1,000 people: There is only one dental practitioner per 1,586 people approximately. People eligible for free services through public sector could be faced with long waiting lists. This also makes it difficult for the priority populations to access dental services with convenience and avail services.

Water fluoridation and its positive influence as a public health intervention has been proven scientifically and by many health and professional organisations. It is a highly effective method to reduce the incidence of tooth decay in a population by increasing the community's exposure to fluoride in controlled quantities, and in due course it reduces pain, negative impact and will be cost-effective for people and the government. Community water fluoridation is part of the foundation area: oral health promotion in the national oral health plan. Though it is ideal to have access to fluoridated water in all communities, currently its provision depends on local governments' decisions (COAG 2015).

Summary of Priority Areas, Needs, Actions, & Lead Agencies

Brisbane South PHN approached its Health Needs Assessment through examining six priority areas, noted below. Surfacing health and service needs statements through the needs assessment process allowed for 12 sub-priority areas for action to be identified.

Priority areas for action	**Sub-priority areas for action**
Alcohol and other drugs	Access
Child, Youth & Family	Chronic disease
First Nations Peoples	Digital health
Mental health and suicide prevention	Integration and coordination
Multicultural Communities	Person-centred care
Older Persons	Prevention and early intervention
Primary Health	Priority populations (demographic)[1]
	Priority populations (geographic)[2]
	Social determinants
	System navigation
	System reform
	Workforce

Notes:

[1] Priority populations (demographic) refers to population subgroups with common demographic characteristics that experience disproportionate health status, experience difficulties accessing timely and appropriate health services, and/or necessitate a greater need to receive targeted or niche services. These population subgroups include First Nations peoples, people from Multicultural backgrounds, People with Disability, and people who identify as LGBTQIA+.

[2] Priority populations (geographic) refers to population subgroups within a defined geographic location that experience disproportionate health status and/or difficulties accessing timely and appropriate health services. These priority populations include Beaudesert (Beaudesert SA3), Southern Moreton Bay Islands (Redland Islands SA2), and the Logan area (Logan LGA).

Prioritised need statement	Priority area	Sub-Priority	Options	Partners & Lead Agencies
PHN1. A need to focus on the social determinants of health – these are associated with health behaviours and health outcomes.	Primary Health	**Social determinants**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Social care agencies. Local Government.
PHN2. Several geographic areas within the Brisbane south region experience higher levels of health needs – Beaudesert SA3, Southern Moreton Bay Islands, North Stradbroke Island and Logan LGA (particularly Jimboomba SA3).	Primary Health	**Priority populations (geographic)**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Social care agencies.
PHN3. Chronic disease continues to have considerable impact and burden on communities in Brisbane South. These include cardiovascular diseases, respiratory diseases (asthma and COPD), musculoskeletal conditions, and cancers.	Primary Health	**Chronic disease** System reform Digital health Workforce	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Peak bodies. Local Government.
PHN4. Several priority populations within the community experience disproportionate health and wellbeing outcomes – First Nations peoples, peoples from	Primary Health	**Priority populations (demographic)**	Partner, collaborate & lead system reform. Integrate & coordinate care systems.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs.

Prioritised need statement	Priority area	Sub-Priority	Options	Partners & Lead Agencies
multicultural backgrounds, people who identify as LGBTQIA+, people experiencing homelessness, people transitioning into community from correctional facilities.			Enable strong & connected primary care. Focus on addressing health inequities and inequalities.	Social care agencies.
PHN5. A need to focus on health behaviours, as these mediate health outcomes as protective or risk factors. These include nutrition, physical activity and alcohol consumption.	Primary Health	**Prevention & early intervention** Digital health	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Social care agencies. Local Government.
CYF1. Priority populations experience higher levels of child, youth and family health needs, including children and families in regional areas, First Nations communities, multicultural families and LGBTQIA+ young people.	Child, Youth & Family	**Priority populations (demographic)**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Education sector. Social care agencies.
CYF2. Maintaining the health and wellbeing of children, youth and families to enhance positive	Child, Youth & Family	**Prevention & early intervention**	Partner, collaborate & lead system reform.	Hospital & Health Services. General practice & primary care.

Prioritised need statement	Priority area	Sub-Priority	Options	Partners & Lead Agencies
health outcomes and improve quality of life.		Integration & coordination Workforce	Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Education sector. Social care agencies. Local Government.
CYF3. Working to address the broad range of factors that contribute to mental health challenges experienced by young people in the Brisbane south community.	Child, Youth & Family	Social determinants Prevention & early intervention **Integration & coordination**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Education sector. Youth justice & Justice sectors. Social care agencies. Local Government.
OPN1. Developing and supporting a skilled and capable workforce as an important enabler of the aged and health care service systems.	Older persons	**Workforce** Digital health	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Aged care sector. Disability sector. Social care agencies.

Prioritised need statement	Priority area	Sub-Priority	Options	Partners & Lead Agencies
OPN2. Continued need for empathetic and high-quality end-of-life planning and palliative care to support the ageing population in Brisbane South to age with dignity.	Older persons	**Person-centred care**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Aged care sector. Disability sector. Social care agencies.
OPN3. Maintaining the health and wellbeing of older people in protecting against negative health outcomes and improving quality of life.	Older persons	Social determinants Prevention & early intervention **Integration & coordination**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Aged care sector. Disability sector. Social care agencies. Local Government.
FNN1. Working to address the social and emotional wellbeing challenges that First Nations peoples disproportionately experience.	First Nations	**Person-centred care**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Disability sector. Social care agencies. Local Government.

Prioritised need statement	Priority area	Sub-Priority	Options	Partners & Lead Agencies
			Support community-led action.	
FNN2. First Nations people disproportionately experience chronic health conditions, including cardiovascular diseases and type 2 diabetes.	First Nations	**Chronic disease**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Aboriginal Community Controlled Health Organisations. Community-based services & NGOs. Aged care sector. Disability sector. Social care agencies. Local Government.
FNN3. Systems and services are often difficult for people multicultural background to navigate and access.	Multicultural Communities	**System navigation** Access Workforce Integration & coordination	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Community-based services & NGOs. Education sector. Aged care sector. Disability sector. Social care agencies. Local Government.
MCN1. Working in partnership with the growing Pasifika and Māori communities and services to build on their strengths and	Multicultural Communities	**Priority populations (demographic)**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care.	Hospital & Health Services. General practice & primary care. Community-based services & NGOs. Education sector. Aged care sector. Disability sector.

Prioritised need statement	Priority area	Sub-Priority	Options	Partners & Lead Agencies
support optimal health and wellbeing.			Focus on addressing health inequities and inequalities. Support community-led action.	Social care agencies. Local Government.
MCN2. Multicultural communities experience disproportionate health and social outcomes compared to the wider population in Brisbane South.	Multicultural Communities	Social determinants **Prevention & early intervention** Workforce	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Community-based services & NGOs. Education sector. Aged care sector. Disability sector. Social care agencies. Local Government.
MHN1. Need for mental health support across the stepped care continuum, from prevention and low intensity supports through to psychosocial supports and clinical care coordination for people living with severe and complex mental health concerns.	Mental health & suicide prevention	Prevention & early intervention **Person-centred care**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Community-based services & NGOs, incl. grass-roots & lived experience organisations. Education sector. Disability sector. Social care agencies. Local Government.
MHN2. Priority populations experience higher levels of need relating to mental health and suicide prevention. These include	Mental health & suicide prevention	**Priority populations (demographic)**	Partner, collaborate & lead system reform. Integrate & coordinate care systems.	Hospital & Health Services. General practice & primary care.

Prioritised need statement	Priority area	Sub-Priority	Options	Partners & Lead Agencies
people who identify as children and young people and people who identify as LGBTQIA+.			Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Community-based services & NGOs, incl. grass-roots & lived experience organisations. Education sector. Disability sector. Social care agencies. Local Government.
MHN3. The local mental health service system is not able to meet people's mental health needs.	Mental health & suicide prevention	System reform **Integration & coordination** Person-centred care	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Community-based services & NGOs, incl. grass-roots & lived experience organisations. Education sector. Disability sector. Social care agencies. Local Government.
MHN4. There are numerous barriers for people experiencing mental health concerns to find and access the right support.	Mental health & suicide prevention	System navigation **Access** Integration & coordination	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Community-based services & NGOs, incl. grass-roots & lived experience organisations. Education sector. Disability sector. Social care agencies. Local Government.

Prioritised need statement	Priority area	Sub-Priority	Options	Partners & Lead Agencies
AOD1. Priority populations experience higher levels of need relating to alcohol and other drugs support. These include adult men and First Nations peoples.	Alcohol & other drugs	**Priority populations (demographic)**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Community-based services & NGOs, incl. grass-roots & lived experience organisations. Education sector. Disability sector. Social care agencies. Local Government.
AOD2. Focusing on the prevention of alcohol and other drugs issues alongside treatment.	Alcohol & other drugs	Prevention & early intervention **Person-centred care**	Partner, collaborate & lead system reform. Integrate & coordinate care systems. Enable strong & connected primary care. Focus on addressing health inequities and inequalities. Support community-led action.	Hospital & Health Services. General practice & primary care. Community-based services & NGOs, incl. grass-roots & lived experience organisations. Education sector. Disability sector. Social care agencies. Local Government.

Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACCHS	Aboriginal Community Controlled Health Service
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
ASD	Autism Spectrum Disorder
ASGS	Australian Statistical Geography Standard
CALD	Culturally and linguistically diverse
CHB	Chronic hepatitis B
CHC	Chronic hepatitis C
CHSP	Commonwealth Home Support Program
CKD	Chronic kidney disease
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular disease
DVA	Department of Veterans Affairs
ED	Emergency department
FTE	Full time equivalent
GP	General practitioner
GPMP	GP Management Plan
HHS	Hospital and Health Service
IARE	Indigenous Area
LGA	Local Government Area
MBS	Medicare Benefits Scheme
MSH	Metro South Health
NBCSP	National Bowel Cancer Screening Program
NDIS	National Disability Insurance Scheme
NESB	Non-English Speaking Background
PAD	Potentially-avoidable deaths
PBS	Pharmaceutical Benefits Scheme
PCOC	Palliative Care Outcomes Collaborative
PHA	Public Health Areas
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PPH	Potentially preventable hospitalisation
PSA	Pharmaceutical Society of Australia
QGSO	Queensland Government Statistician's Office
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
RAS	Regional Assessment Service
SA2/ SA3	Statistical Area Level 2 / Statistical Area Level 3
SMBI	Southern Moreton Bay Islands
UTI	Urinary tract infection

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