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Health in Tasmania

PRIMARY HEALTH TASMANIA HEALTH NEEDS ASSESSMENT 2022–23 TO 2024–25

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Abbreviations

Abbreviation	Definition
ABS	Australian Bureau of Statistics
ACAT	aged care assessment team
ACCHO	Aboriginal Community Controlled Health Organisations
AHA	allied health assistant
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AOD	alcohol and other drugs
AODTS–NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASC	adult severe and complex (mental health needs)
ASGS	Australian Statistical Geography Standard
BMI	body mass index
COPD	chronic obstructive pulmonary disease
COVID	coronavirus disease
FTE	fulltime equivalent
GP	general practitioner
HNA	health needs assessment
HPV	human papillomavirus
IAHP	Indigenous Australians' Health Programme
ITC	integrated team care
LGA	local government area
LGBTIQ+	lesbian, gay, bisexual, transgender, intersex, queer and other sexuality and gender diverse
MBS	Medicare Benefits Schedule
NDIS	National Disability Insurance Scheme
NHMRC	National Health and Medical Research Council
PCA	Palliative Care Australia
PHN	Primary Health Network
PHIN	Primary Health Information Network
RACGP	Royal Australian College of General Practitioners
SEIFA	socioeconomic indexes for areas
WHO	World Health Organization

Executive summary

Improving the health of Tasmanians is at the centre of Primary Health Tasmania's vision and purpose. As our community's primary healthcare needs change, so must our plan to address these needs. The COVID-19 pandemic has had a significant impact on our community over 2020–21. We have fortunately avoided widespread community transmission of COVID-19; however, people's mental and physical health have been affected in different ways, with some people avoiding consultations with primary care providers.

The health of Tasmanians is improving but there are significant ongoing challenges related to ageing, disability and chronic conditions. Ensuring that all Tasmanians have access to comprehensive primary care will result in better health outcomes for our community.

Chronic conditions remain one of the greatest challenges facing our health system. Improving health outcomes for people with chronic conditions will not only improve quality of life but will ease the burden on our hospitals. We are committed to using data-driven approaches to implement comprehensive, evidence-based, person-centred primary care for people with chronic conditions.

Aboriginal people in Tasmania continue to experience inequities in health outcomes. Improving the health and wellbeing of Tasmanian Aboriginals is a priority for Primary Health Tasmania. Central to this priority is supporting culturally safe primary care.

Mental health problems are a major issue in our community and have a substantial social and economic impact on the Tasmanian population, with about one in five people in our community experiencing mental health problems in any year. We will continue to commission services that deliver primary and community mental healthcare to Tasmanians and improve management of chronic conditions in people with mental health problems.

Use of alcohol and other drugs is a major cause of preventable harm, illness, and death in Tasmania. Substance use contributes to mental illness, chronic conditions, and social and economic harms. It places unnecessary strain on our society and health system. We will continue to commission primary care services for alcohol and other drug use that are integrated across the boundaries of primary, community and acute services.

This Health Needs Assessment 2022–23 to 2024–25 sets out our priorities for the coming three-year period to inform our cycle of planning and commissioning health services. It clearly commits Primary Health Tasmania to be a key partner in improving primary care in Tasmania.

Our organisation

Primary Health Tasmania is one of 31 Primary Health Networks (PHNs) nationally. Our purpose, set by the Australian Government, is to increase the efficiency and effectiveness of medical services for people, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure people receive the right care in the right place at the right time.

Our Strategic Plan

Primary Health Tasmania's Strategic Plan 2021–25 describes strategies our organisation has adopted to address primary healthcare issues and priorities in our community.

Our vision

Our vision is for healthy Tasmanians.

Our purpose

Our purpose is to create enduring health and wellbeing solutions within the Tasmanian community.

Our priority areas

Our Board has set five strategic goals, each with associated priority actions that we will work towards.

Our strategic goals

In each chapter of this document under Priority Actions, the following icons represent our strategic goals, as expressed in the Strategic Plan. Each action is directly linked to one or more of our strategic goals.

Strategic goal	Icon
1. Health outcomes	
2. Person-centred care	
3. Engaged and skilled primary care workforce	
4. Integrated health system	
5. Value, effectiveness and efficiency	

Figure 1. Primary Health Tasmania's Strategic Plan 2021–25

Our needs assessment methodology

The Australian Government Department of Health mandates each PHN undertake and maintain an evidence-based health needs assessment (HNA) to identify unique regional and local priorities. This work is guided by national health priorities. The purpose of the HNA is to:

- inform each PHN's understanding of their region by undertaking a detailed and systematic assessment of the regional population's health needs, local healthcare services, gaps and opportunities for improved health outcomes
- provide a basis for subsequent service planning and commissioning of services.

Our needs assessment methods

Primary Health Tasmania's needs assessment methods include:

- background analysis of policy and strategy environment
- data analysis (mix of qualitative and quantitative)
- stakeholder consultation.

Our data analysis includes analysis of:

- Australian epidemiological datasets obtained through the Australian Institute of Health and Welfare, Australian Bureau of Statistics and similar organisations
- Australian Health Workforce service mapping obtained through the Australian Government Health Demand and Supply Utilisation Patterns Planning Tool
- Tasmanian Government hospital, emergency department and population survey data
- Primary Health Tasmania general practice data
- Primary Health Tasmania health workforce service maps
- Primary Health Tasmania commissioned service provider datasets
- qualitative analysis of commissioned provider feedback and reports.

Our stakeholder consultation included workshops, interviews, surveys and written feedback from Primary Health Tasmania clinical and community advisory councils, the Tasmanian Health Service, public and private sector medical, nursing and allied health service providers, consumers, Aboriginal Community Controlled Organisations, rural workforce agencies, people from culturally and linguistically diverse backgrounds, and other relevant stakeholder groups.

Our priority-setting process was informed by triangulation of issues and needs from:

- background analysis
- health needs analysis
- service needs analysis
- stakeholder consultation.

Priorities align with our strategic plan, national, Tasmanian and regional priorities and the priorities of our partner organisations.

The HNA process was led by Primary Health Tasmania's Program Strategy and Performance team.

Additional data needs and gaps

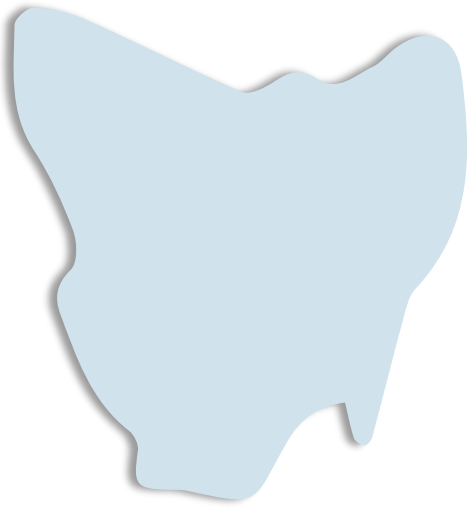
We are committed to building upon the findings of this HNA to better understand the health needs of the Tasmanian population with an aim of improving the health of Tasmanians. The HNA methodology will be subject to ongoing review and refinement. This will ensure a rigorous process is in place to build on this important work as we embed our major role as a commissioning organisation.

As part of this quality improvement process, we are undertaking a program of work with the Tasmanian Data Linkage Unit at the University of Tasmania to improve our health intelligence capability through the analysis of linked health data.

Additional opportunities

During the HNA process, a range of complex issues and ideas for solutions emerged across the identified priority areas.

In preparing potential options as part of the HNA, we developed whole-of-program strategies and program logics for our chronic conditions, mental health, and alcohol and other drugs program areas. These program strategies and logics will inform prioritisation of Primary Health Tasmania's resources to achieve our overarching goal to improve the health of Tasmanians.



1

Our general health

1 Our general health

1.1 Overview

The health of Tasmanians is improving with longer life expectancy. However, Tasmania still ranks poorly compared with other Australian states and territories on many health measures.

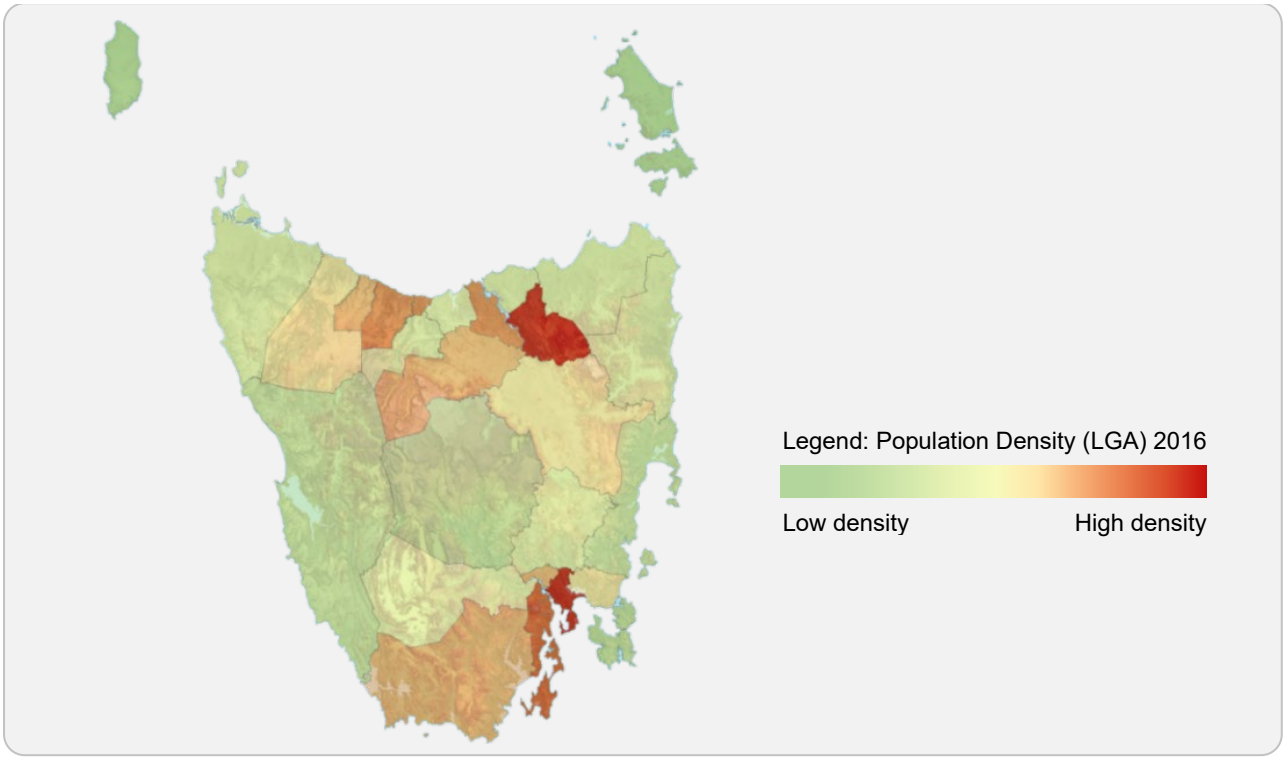
Access to health care is problematic for many Tasmanians, particularly for people living in rural areas, for those experiencing socioeconomic disadvantage, for Aboriginal and Torres Strait Islander people, and for people who are from culturally and linguistically diverse backgrounds.

Tasmania is home to a regionally dispersed population of over 540,000 people. An ageing population and socioeconomic disadvantage are contributing to significant pressure on our entire health system. Primary Health Tasmania must have a clear plan to support the provision of primary healthcare in the community.

1.1.1 About our community

At the last census (2016), there were 540,780 people who were residents of Tasmania, approximately 2.1% of Australia's total population.[1] Most of our population lives in or around the Hobart, Launceston, Devonport and Burnie localities (Figure 2).

Figure 2.Tasmanian population density by local government area | 2016

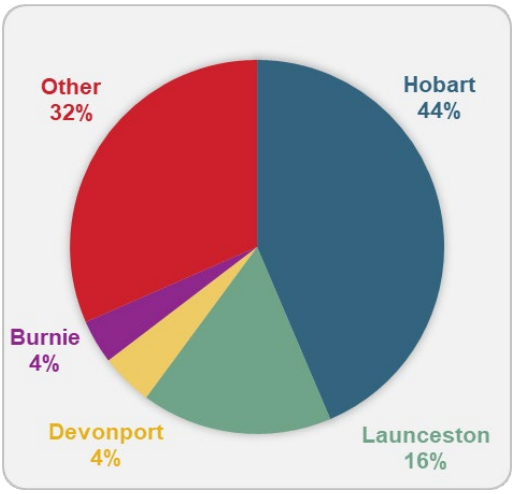


Source: maps.thelist.tas.gov.au

Tasmania's Aboriginal people account for 5.5% of Tasmania's population, higher than the national average of 3.3%, and second only to the Northern Territory.[2]

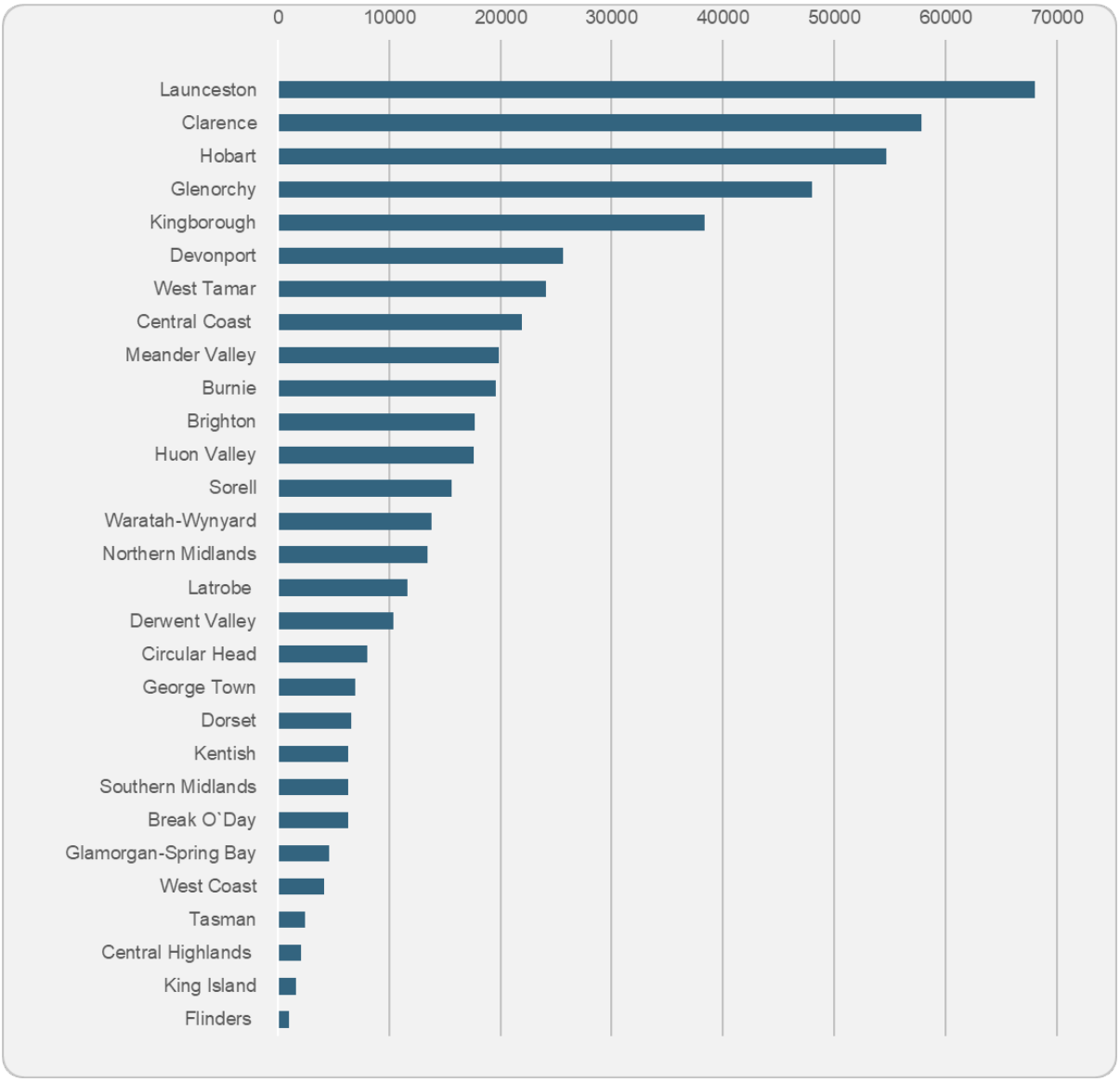
In Tasmania, 88% of people only spoke English at home. Other languages spoken at home include Mandarin (0.8%), Nepali (0.3%) and German (0.3%).[3]

Figure 3. Proportion of population distribution by population centre, Tasmania | 2019



There are 29 local government areas (LGAs) in Tasmania. Of our 29 LGAs, 21 are classified as outer regional or remote. The estimated population for each LGA is shown in Figure 4.[4]

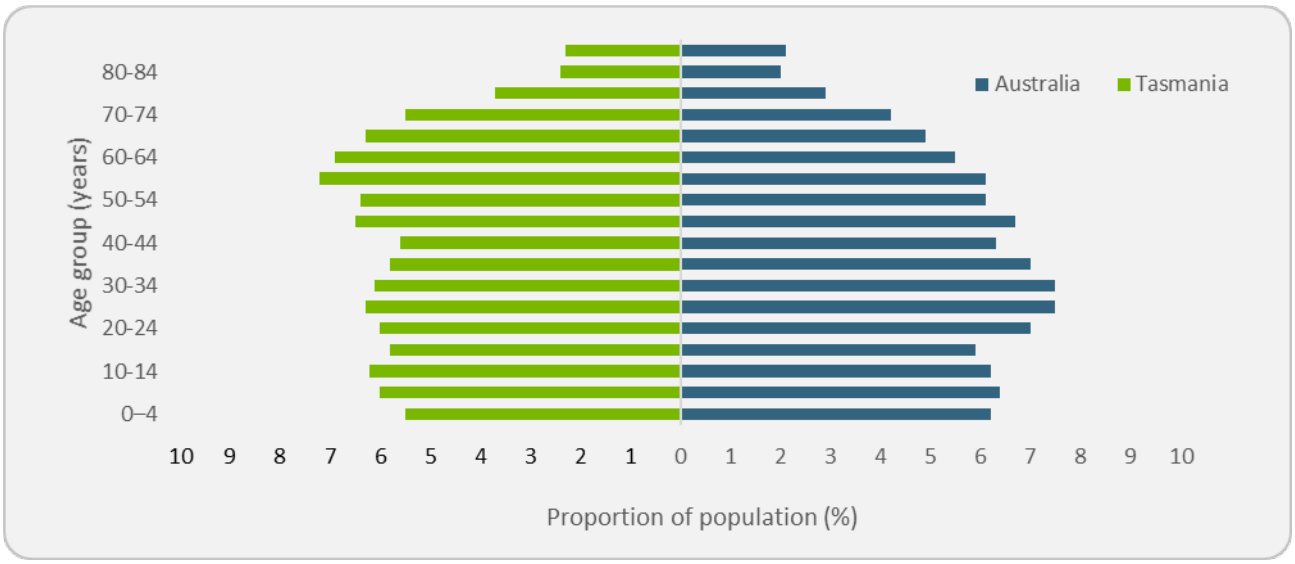
Figure 4. Population estimates by local government area, Tasmania | 2019



1.1.2 We have an ageing population

Figure 5 shows the proportion of population by age group for Tasmania and Australia. The population pyramid demonstrates a bulge where Tasmanians aged between 45 and 74 years are more strongly represented than younger age groups in the population.

Figure 5. Population age distribution, Tasmania and Australia | 2019

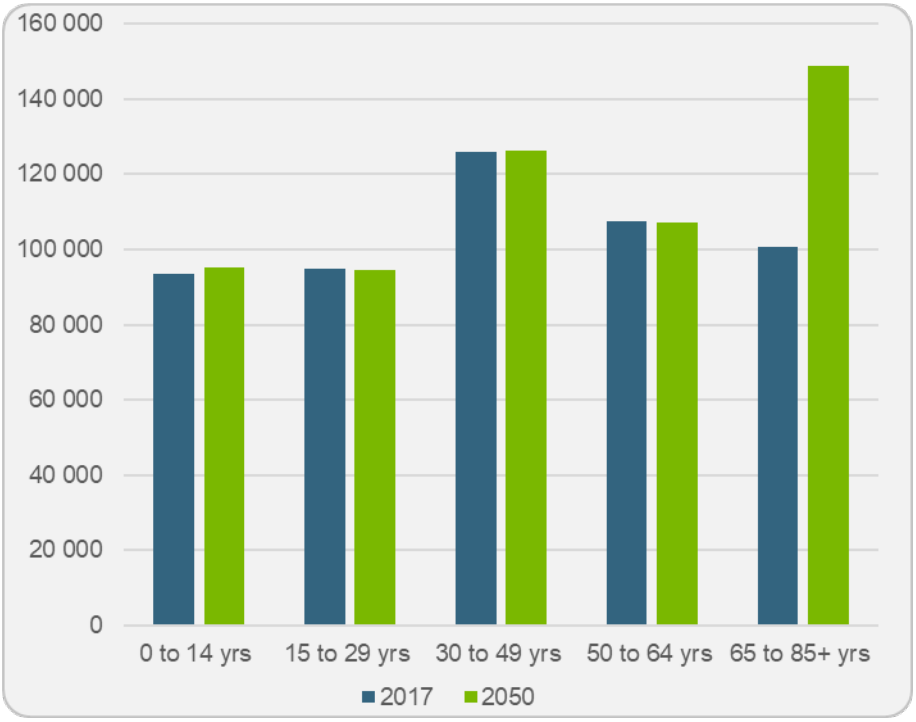


Tasmania's ageing population has significant implications for our aged care services. Compared with other Australian state and territories, we have the highest proportion of people aged 65+ (1 in 5 people) and the highest proportion of people aged 50+ (2 in 5 people).[5]

1.1.3 Our population is growing

Tasmania's population is predicted to grow to around 572,000 people by 2050. Most of this growth will occur in the south of the state, with little growth forecast for the north and north west regions.[6] Population growth is expected to be almost entirely in the 65+ age group (see Figure 6).

Figure 6. Projected population increase, Tasmania | 2017 and 2050



Source: Tasmanian Department of Treasury and Finance | 2019 Population

1.1.4 Many people in our community experience disability

Over 25% of Tasmanians have a disability,[7] a significantly higher proportion than the national average of 17.7%.[8] Disability can be described by degree of limitation. A person has a limitation if they have difficulty, need assistance from another person, or use an aid or other equipment to perform one or more core activities (communication, mobility, and self-care). Table 1 describes what different degrees of limitation mean for a person with a disability.

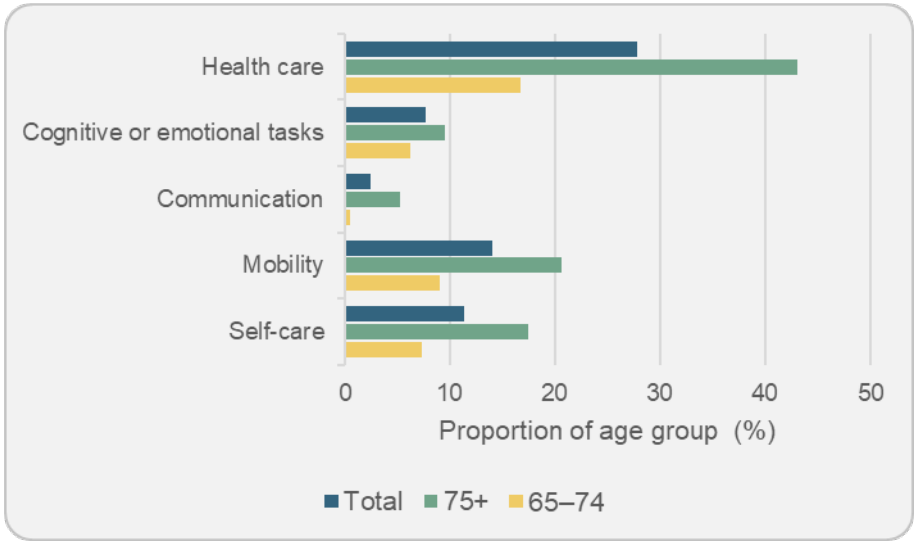
Table 1. Descriptions of disability by degree of limitation to perform core activities

Degree of limitation	What this means for people with a disability
Profound	greatest need for help; that is, always needs help with at least one core activity
Severe	needs help sometimes or has difficulty with a core activity
Moderate	no need for help but has difficulty
Mild	no need for help and no difficulty, but uses aids or has limitations

Source: ABS. Disability, Ageing and Carers, Australia. 2018

Rates of disability grow with increasing age, so much of the burden of disability is concentrated in older age groups (Figure 7).

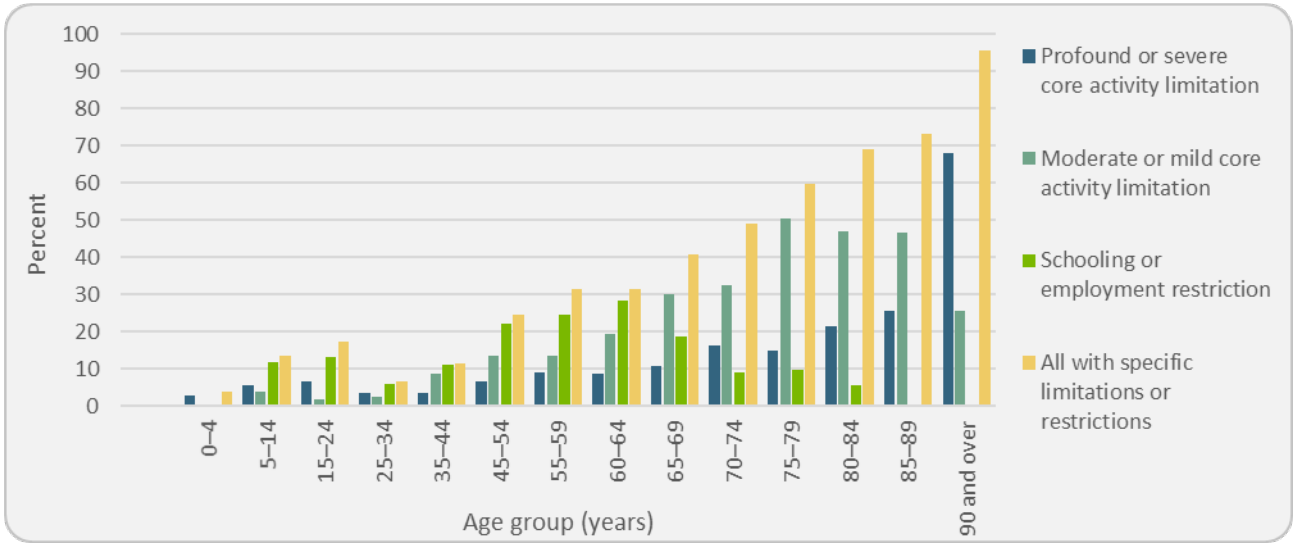
Figure 7. People aged 65+ who need assistance with personal activities, by age and activity type, proportion of age group | 2018



Source: ABS. Disability. Ageing and Carers, Australia | 2018

Everyday self-care activities become increasingly difficult to manage as we age and as our abilities decline. In 2018, 43% of all Tasmanians aged 65+ needed help with everyday activities.[9] This proportion increased to 56% in the 75+ age group (Figure 8).

Figure 8. Disability status by age group, Tasmania | 2018



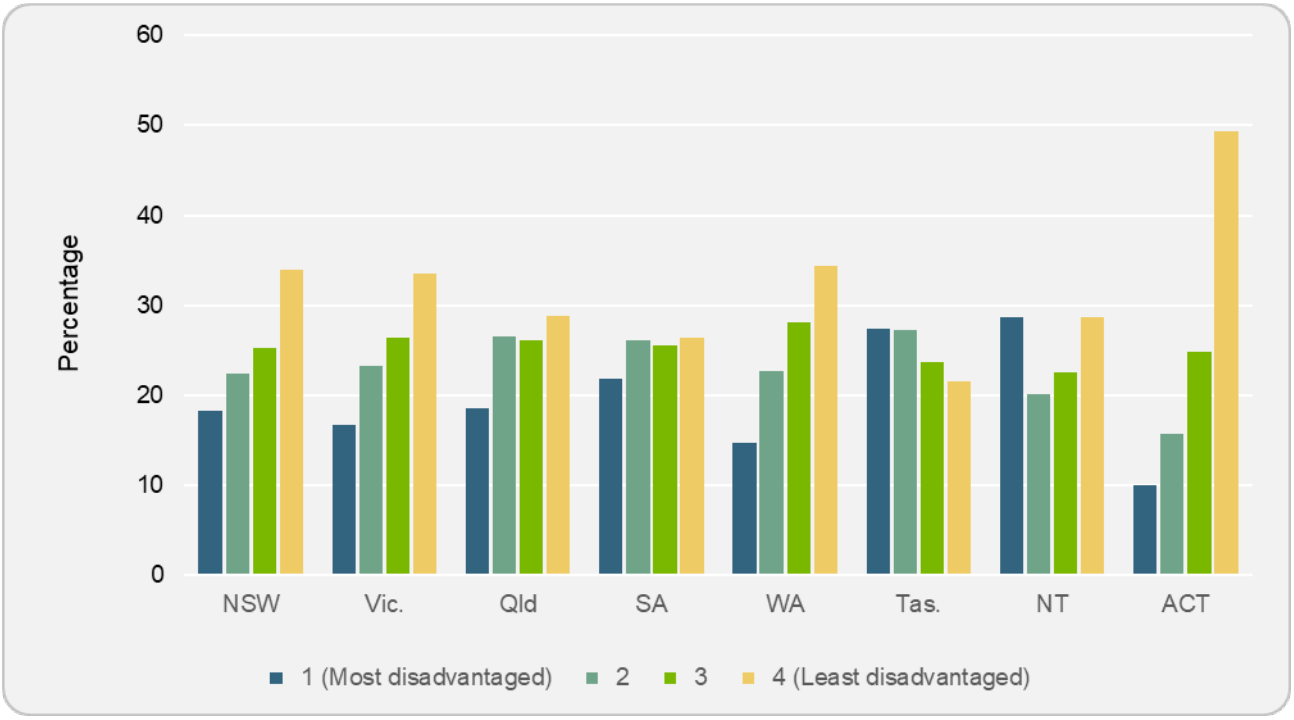
About 80% of disabled Tasmanians receive assistance from informal carers while 60% receive some assistance from formal providers, mostly private commercial organisations. This indicates that about 80,000 Tasmanians are unpaid carers. Most of these are family members, with a median age of 53 years.[8]

Over 15% of Tasmanians report that they experience discrimination due to their disability. Discrimination is more likely for females, younger people, and those with intellectual or psychosocial disabilities.[7,8,9]

1.1.5 Our community is socioeconomically diverse

Tasmania has high rates of socioeconomic disadvantage. When compared with the Australian population, 4.6% of Tasmanians are in the highest income quintile (the top 20% of Australians) and 37% are in the bottom income quintile (the bottom 20% of Australians). The percentage of Tasmania's population in the bottom two quintiles is the highest of all states and territories (Figure 9).[10]

Figure 9. Percentage of people experiencing socioeconomic advantage and disadvantage, by Australian states and territories | 2016



Our socioeconomic status is influenced by our income, education, employment and ability to participate in our community. Socioeconomic disadvantage is strongly associated with poorer health outcomes.

Transport disadvantage occurs where people are not able to access either public or private transport to get to where they need to go. People living in regional Tasmania experience greater difficulty in accessing transport than people living closer to the main population centres.[11]

Housing stress and homelessness contribute to poor health. People who experience homelessness also experience significantly higher rates of death, disability and chronic illness than the general population.[12] Tasmanians are experiencing high, and growing, rates of housing stress and homelessness. Chronic conditions are more common in areas with lower socioeconomic status.[13]

1.1.6 Health literacy influences health outcomes

Health literacy is the knowledge and skill people need to be able find, understand, and use information and services to make decisions about their health and health care.

Many factors influence people's health literacy including their educational attainment, the support available to them, their community and environment, and their access to services.

Tasmanians with low levels of health literacy find it hard to:

- access health information and services
- understand information
- use information to make informed choices.[14]

We need better data about health literacy in our population. There is a lack of up-to-date data that describe the health literacy of people living in our local government areas.

1.1.7 We have limited cultural diversity

Tasmania has a less culturally and linguistically diverse population than Australia as a whole. More than 80% of Tasmanians were born in Australia compared to Australia where 66% of Australians were born in Australia. Only 6.5% of households speak a language other than English, compared with 22% nationally.[3]

1.2 Health needs

1.2.1 Our health status

The health status of Tasmanians can be measured using a range of health indicators – qualities or features of our population that we can measure to describe our health.

Health indicators that are commonly used to measure the health of populations include:

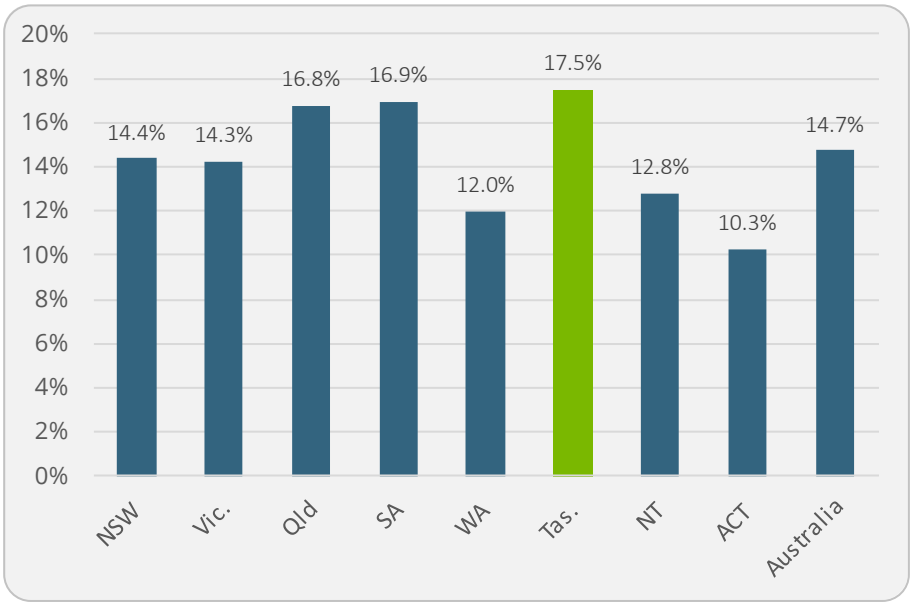
- self-assessed health
- life expectancy
- infant mortality
- causes of death.

1.2.2 Tasmanians report low levels of self-assessed health

Self-assessed health status is a commonly used measure of overall health which reflects a person's perception of his or her own health at a specific point in time.

The proportion of Tasmanians who describe their health as excellent, very good, or good is larger than the proportion of people who describe their health as fair or poor. However, the percentage of Tasmanians who rate their health as fair or poor is the highest of any state or territory in Australia (Figure 10).[15]

Figure 10. Self-assessed health as fair or poor in people aged 15+, percentage of population by Australian states and territories | 2017–18



1.2.3 Our immunisation coverage rates are high

Tasmania has high immunisation rates with nearly 95% of Tasmanian children being fully vaccinated by age 5.[16] However, this also means that 1 in 20 children are not appropriately vaccinated when they start school.

Aboriginal children in Tasmania have higher immunisation rates than other children and are above 95% at 1 year and 5 years of age.[17]

A national HPV (human papillomavirus) vaccination program was introduced for school-aged girls in 2007 and extended to boys in 2013. The vaccine provided protection against 4 types of HPV. A new vaccine was introduced in 2018, protecting against 9 types of HPV.

Tasmania's HPV vaccination rates are lower than the national average. In 2017, 74.6% of Tasmanian females and 64% of Tasmanian males were fully vaccinated for HPV, compared with 80.2% of females and 75.9% of males nationally.

There is currently no regular or nationally consistent source of data from which to estimate vaccination coverage in adults in Australia.[18] Population surveys are used to estimate vaccination coverage in the adult population or in selected population groups.[19]

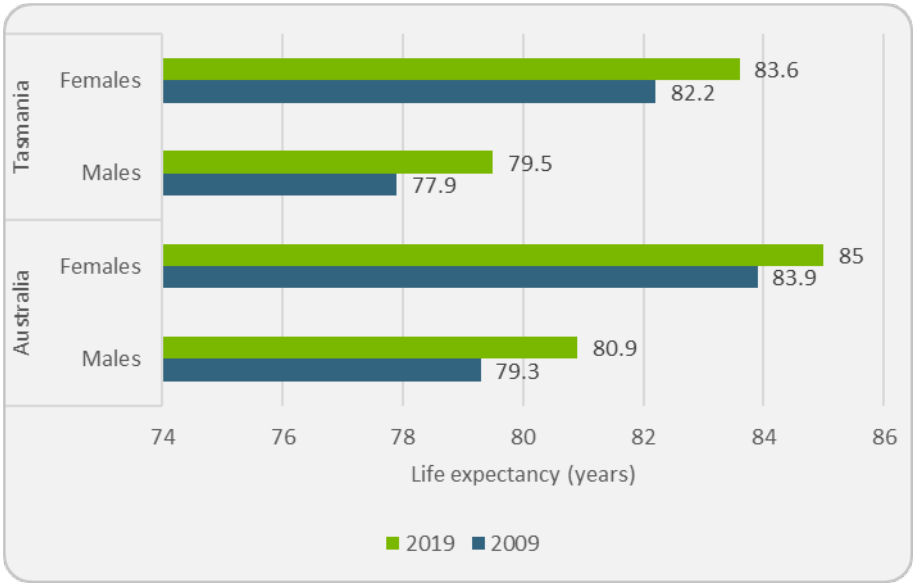
In 2009, the Adult Vaccination Survey estimated that almost 75% Australians aged 65+ were vaccinated against influenza. The same survey showed that pneumococcal vaccine coverage among the target population was 54%.[20]

1.2.4 Tasmanians have a lower life expectancy than Australians overall

Life expectancy is the number of years a person can expect to live, depending on the age they have already reached. Life expectancy in Australia has increased significantly over the past century, reflecting the considerable decline in mortality rates – initially from infectious diseases and, in later years, from cardiovascular disease.

Life expectancy for Tasmanians has increased by an average of 1.6 years for males and 1.4 years for females in the 10 years to 2019.[21] Tasmanian males born today can expect to live to 79.5 years (compared with 80.9 years for Australian males) and Tasmanian females born today can expect to live to 83.6 years (compared with 85 years for Australian females) (Figure 11).[21] However, Tasmania continues to have the second lowest life expectancy of any jurisdiction, after the Northern Territory (Figure 11).[22]

Figure 11. Life expectancy, Tasmanians compared to Australians | 2009 and 2019



1.2.5 Tasmania's infant mortality rates are higher than the Australian average

The infant mortality rate is the number of deaths of children under one year of age in a specified period per 1000 live births in the same period.

There are 4.5 deaths per 1000 live births on average in Tasmania, higher than the Australian rate of 3.8 deaths per 1000 live births.

1.2.6 Chronic conditions are the major causes of death

All diseases, conditions or injuries that either resulted in or contributed to death are recorded on a person's death certificate. Causes of death are commonly reported by the underlying cause of death.

The most common causes of death in Tasmania are related to chronic diseases. Cancer and cardiovascular diseases are responsible for most deaths, followed by dementia and chronic lung diseases (Table 2).[23] See Chapter 2 Chronic Conditions for detailed information about specific chronic conditions in Tasmania.

In Tasmania, many deaths occur prematurely and could potentially be avoided through improvement in lifestyle risk factors and better multidisciplinary management of chronic conditions.

Tasmania's age-standardised death rates are higher than for Australia overall.[24]

Table 2. Common causes of death, Tasmania | 2019

Cause of death	No. of deaths	% of all causes
Cancers	1,320	28.3
Cardiovascular disease (ischaemic/coronary and other)	1,144	24.5
Dementia and Alzheimer	367	7.9
Chronic lung disease	286	6.1
TOTAL (includes other less common causes of death not listed here)	4,663	100.0

Source: ABS, 3303.0 Causes of Death, Tasmania, 2019

Although Tasmania's rate of potentially avoidable deaths has been decreasing over time, we still have the second highest rate of any state or territory (133 deaths per 100,000 people) compared with the Australian average (104 deaths per 100,000 people).[25]

Aboriginal people have shorter life expectancy than the general population. This is discussed further in Chapter 3.

People aged 65+ experience higher rates of chronic conditions such as musculoskeletal diseases, cardiovascular disease, diabetes, and dementia. These contribute to potentially avoidable and potentially preventable deaths. Some are potentially treatable conditions. The likelihood of having at least one long-term health condition also increases with age. Around 81% of Australians aged 65–74 years have at least one long-term health condition and 98% of all Australians aged 85+ have at least one long-term health condition.[26]

Potentially avoidable deaths refer to death in people below the age of 75 years where death may have been avoided through effective interventions against specific diseases in a population.

Potentially preventable deaths are those where screening and primary prevention, such as immunisation or tobacco control measures, may have reduced the chances of premature death.

Deaths from potentially treatable conditions are those where access to safe, high-quality clinical care may have reduced the chances of premature death.

1.2.7 Priority populations have greater primary care needs

Some population groups have unmet primary care needs or have difficulty accessing appropriate primary care support. In Tasmania, our priority populations are:

- Aboriginal people
- people who receive aged care or disability services
- older people
- people with culturally and linguistically diverse backgrounds
- people with low socioeconomic status
- people living in rural and remote areas
- children and young people
- people who are homeless or at risk of becoming homeless
- people who identify as lesbian, gay, bisexual, transgender, intersex, queer and other sexuality and gender diverse (LGBTIQ+).

Comprehensive primary care, including immunisation, is needed by people in all priority population groups.

People from culturally and linguistically diverse backgrounds experience language and cultural barriers to accessing mainstream services.[27]

LGBTIQ+ people may experience stigma and discrimination when accessing primary care. They have a greater burden of chronic conditions and mental health problems.[28]

1.2.8 Homelessness contributes to health problems

People experiencing homelessness experience significantly higher rates of premature death, disability and chronic illness than the general population.[29] Homelessness and the disadvantages associated with it can contribute to premature ageing through early onset of health problems more commonly associated with later life.[30]

People experiencing homelessness have much higher rates of premature ageing, premature death, disability, and chronic illness than the general population.

Mental illness is one factor that contributes to the level of homelessness in Australia, with 27% of people who accessed specialist homelessness services in 2016–17 having a current mental health illness.[31] There is also a strong link between problematic alcohol or other drug use and experiences of homelessness.

1.2.9 There are barriers to accessing primary care in rural populations

People in regional and remote communities can experience barriers to accessing primary care services.[30] General practice, allied health and community nursing services are less accessible locally for people living outside urban population centres. Communities may rely on visiting services, which present challenges in delivering continuity of primary care to people locally.

Outreach to rural areas is offered through mental health services funded by Primary Health Tasmania and is a feature of the various service models. Outreach requires a higher financial investment which can lead to decreased service capacity particularly for clients in rural and remote areas.

Telehealth is a service modality that can improve primary care accessibility for people in rural areas. However, internet connectivity may limit the accessibility of telehealth services and low information technology literacy may be a barrier to accessing telehealth for some people.

1.2.10 Older people and their carers have greater primary care needs

Most older people have long-term health conditions. Older people in residential aged care have higher rates of multiple long-term health conditions or 'multimorbidity' than older people living in the community. Half of people living in residential aged care have 5–8 long-term health conditions.[32]

There is also a substantial mental and behavioural disease burden in older people living in residential aged care. Among people living in permanent residential aged care:

- about 87% have at least one diagnosed mental health or behavioural condition
- 49% have a diagnosis of depression
- 53% have a diagnosis of dementia.[33]

More older people in our community are living with dementia. Dementia is a broad term that refers to over 100 different diseases that impair brain function. The most common types of dementia are Alzheimer's disease and vascular dementia. Nearly 9000 people in Tasmania were estimated to have dementia in 2016.[34]

Dementia is a major health issue, causing substantial illness, high levels of disability, and premature mortality. In 2018, dementia was the second leading cause of death in Australia and the leading cause of death for women. Without a significant breakthrough in treatment, the number of people with dementia in Tasmania is expected to double by 2050, placing a greater demand on both the health and aged care systems in Tasmania.[35]

The needs of carers are an important part of primary care and aged care service provision. In 2015, around 11,000 Tasmanians aged 65+ received care from a primary carer (Table 3).[32] Carers experience a greater burden of poor health due to mental health problems and chronic conditions.

Table 3. Estimated number and proportion of Tasmanians who received care from a primary carer | 2015

Care recipients	Age of main recipient of care		
	0–64 years	**65+ years**	**All ages**
Estimated number	17,700	11,000	28,700
Estimated proportion	61.7%	38.3%	100%

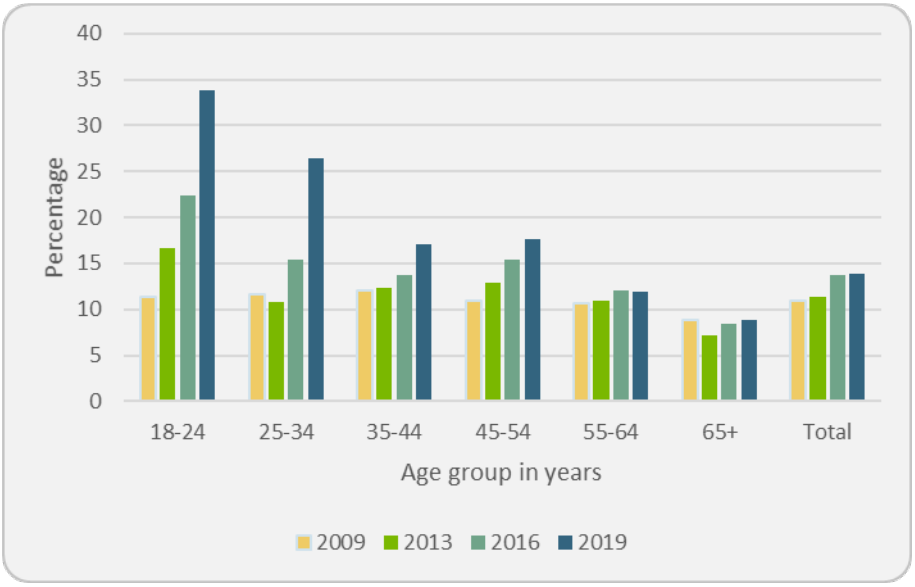
Half of primary carers provide care because they feel they could give better care than the available options. For Tasmanians aged 65+, 1 in 5 primary carers provide care because they feel they have no other choice, and 4 in 5 felt they had a family responsibility to provide care.[32]

1.2.11 Children and young people have diverse primary care needs

The major conditions for which children and adolescents seek health care vary by age group. Immunisations and respiratory tract infections are the most common reason for contact with primary health services in the under-5s, while injuries become more common in early and later childhood, and mental health conditions in adolescence.

The proportion of Tasmania's population under 19 years is projected to remain static over the next 3 decades.[36] However, Tasmania's young people are experiencing high and growing levels of high or very high psychological distress. Three times as many young people aged 18–24 years experienced psychological distress in 2019 compared with 2009 (Figure 12).[37]

Figure 12. High or very high psychological distress by age group, Tasmania | 2009–19



Health risk factors often become a concern during adolescence. Smoking, alcohol, and physical activity risk factors are more apparent in the over-12 age group when compared with the under-12 age group.[37]

Mental health conditions have a gendered distribution, with anxiety in adolescents being almost twice as likely to affect females than males.[38]

1.2.12 COVID-19

The coronavirus (COVID-19) pandemic has had a significant impact on the Tasmanian population, especially in March and April 2020 – the earlier months of the pandemic. An outbreak at a hospital in the north west of the state contributed to most of Tasmania's case numbers. Tasmania recorded 232 cases of COVID-19 to 5 February 2021, with 13 people dying as a result. Between February and October 2021 there have been very few cases of COVID-19 in Tasmania.

General practices began providing services via telehealth in response to COVID-19 and the introduction of telehealth item numbers by the Australian Government (Medicare). In July 2020, a survey of consumers conducted by Health Consumers Tasmania demonstrated most Tasmanians were satisfied with services delivered via telehealth and would continue to use telehealth to access their general practitioner (GP).[39] Some people with chronic conditions have delayed accessing primary care as a result of COVID-19.[39] The impacts of delayed treatment on health outcomes for these individuals are presently unable to be determined.

Evidence suggests that we can expect an increase in the burden of mental health-related disorders because of COVID-19. Anxiety, post-traumatic stress disorder (PTSD) and major depression are the major mental health disorders affecting survivors of severe COVID-19 illness and health workers. Children who are isolated or quarantined during a pandemic are more likely to develop acute stress disorder, mood disorders, adjustment disorder and experience grief reactions.[40]

1.3 Service needs

Tasmania experiences a greater disease burden and higher premature mortality than the national average, yet we claim fewer Medicare GP consultations and have higher use of emergency departments for less urgent care.

1.3.1 Most Tasmanians use general practice services

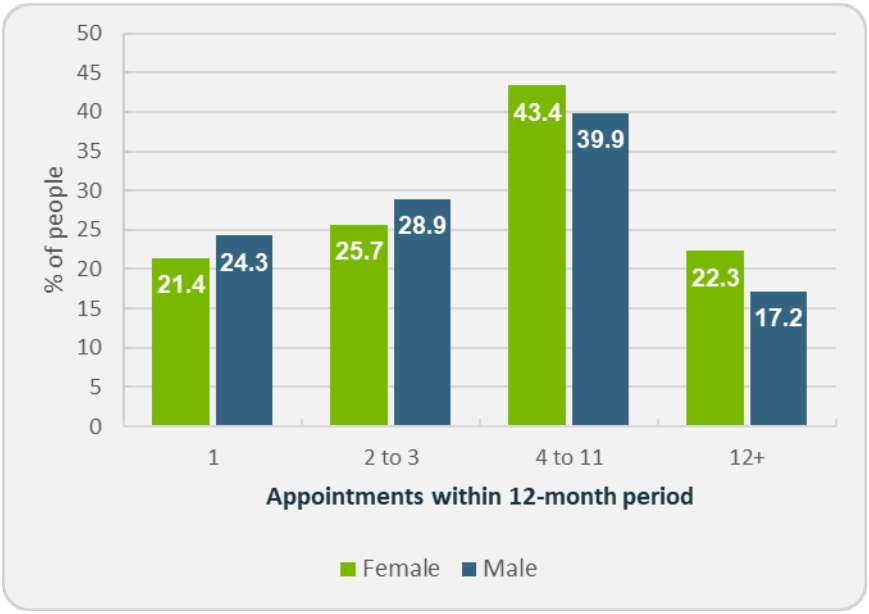
Primary care services include general practice, other medical, nursing, pharmaceutical, diagnostic, allied health, mental health, dental services, and home and community support services. Access to primary healthcare services helps reduce the number of avoidable hospital visits, improves population health, and improves health outcomes. It is important for the prevention and treatment of risk factors and chronic conditions as well as improving mental health outcomes.[41]

General practice is the point where most people enter the health system. GPs and practice nurses deliver health care and refer people who require other health services, helping people to navigate a complex healthcare system.[42]

Tasmanians saw their GP an average of 7 times in 2019. General practice is the point where most people enter the health system.

According to the Tasmanian Primary Health Information Network (PHIN) dataset, Tasmanians saw their GP 7 times a year on average in 2019. Most people booked an appointment to see a GP between 4 and 11 times a year. Analysis shows that males were more likely to book 1 to 3 appointments and females were more likely to book 4 or more appointments per year (see Figure 13).[43]

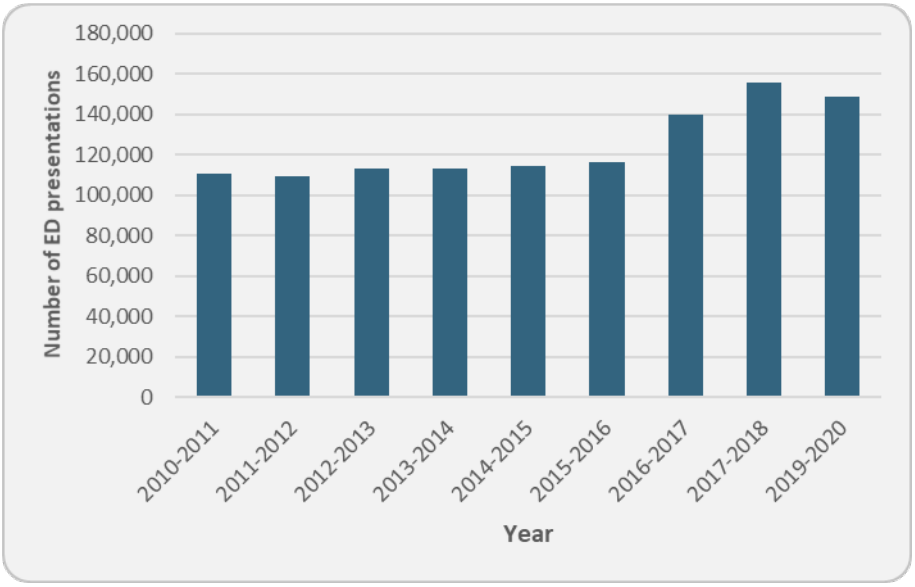
Figure 13. Percentage of males and females with multiple appointments over 12-month period, Tasmania | 2019



1.3.2 Public hospital service use is increasing in Tasmania

Presentations to public hospital emergency departments have been steadily increasing over the past 10 years in Tasmania (Figure 14). There was a decrease in public hospital emergency department presentations during the coronavirus pandemic in 2020.[44]

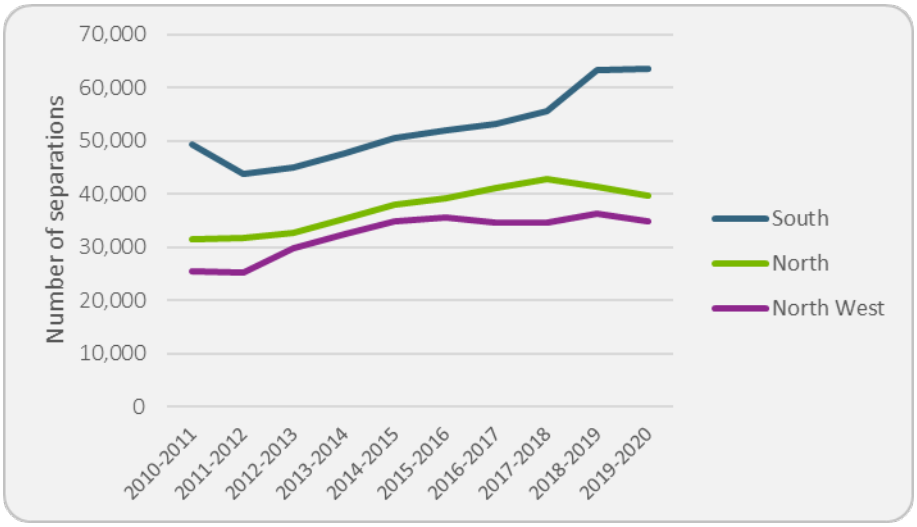
Figure 14. Public hospital emergency department presentations, Tasmania | 2010–11 to 2019–20



Public hospital inpatient care in Tasmania is also increasing over time. This rising demand for health services is due to our increasing burden of chronic disease.

Our overall hospital use in all regions has been increasing steadily over time with a decrease in the north and north west in 2020 during the COVID-19 pandemic (Figure 15).[45]

Figure 15. Public hospital separations by region, Tasmania | 2010–20



1.3.3 After-hours primary care services

Tasmanians outside the major centres of Hobart and Launceston have few options to access general practice in the after-hours period, especially in outer regional areas. The lack of face-to-face options contributes to people using ambulance services and emergency departments for less urgent care.

After hours primary health care is care that meets urgent needs that can't wait until the person's regular general practice is open.

In Hobart and Launceston there are private general practice services that deliver urgent care to patients. Consumers are also supported to receive care in the after-hours period through medical deputising services. Telephone-based services are provided by Medibank Health Solutions and GP Assist. Healthdirect provides a helpline for consumers requiring health advice after-hours, with calls responded to by a registered nurse.

For vulnerable Tasmanians, Moreton Group Medical Services provide a mobile health clinic to improve access to after-hours medical care for people with or at risk of homelessness and for clients of community service providers. It delivers scheduled, bulk-billed after hours health clinics at the location of partnered community service providers.

1.3.4 Palliative care service demand is increasing

Palliative care is care that improves the quality of life of people with life-limiting illness. Goals of palliative care include prevention and relief of suffering by early identification, assessment and treatment of pain and other physical, psychosocial and spiritual problems.[46]

Palliative care is provided in a range of settings, including in a person's home, residential aged care facilities, hospitals, hospices, respite care and after-hours services. Palliative care is not limited to specialist care services but includes primary and secondary level care and is provided at three different levels:[46]

- a 'palliative care approach', adopted by health professionals
- general palliative care provided by primary care professionals and those treating people with life threating illnesses
- specialist palliative care provided by specialist teams for people with complex conditions.[46]

In Tasmania it is estimated that 70% of palliative care is delivered outside the specialist hospital settings and is delivered by primary care providers such as GPs, health and community services, aged care services and community and volunteer organisations and groups.[47]

Most people would prefer to die at home but only about 14% do so, either because of lack of support, or they have not had a chance to express this choice.

In the next 25 years, the number of Australians who die each year will double.[48] More than 60% would prefer to die at home, yet currently only 14% do so.[47] Often people don't die at home either because support services are inadequate or because they have not had a chance to articulate and implement their choice through proper discussion and planning.[49]

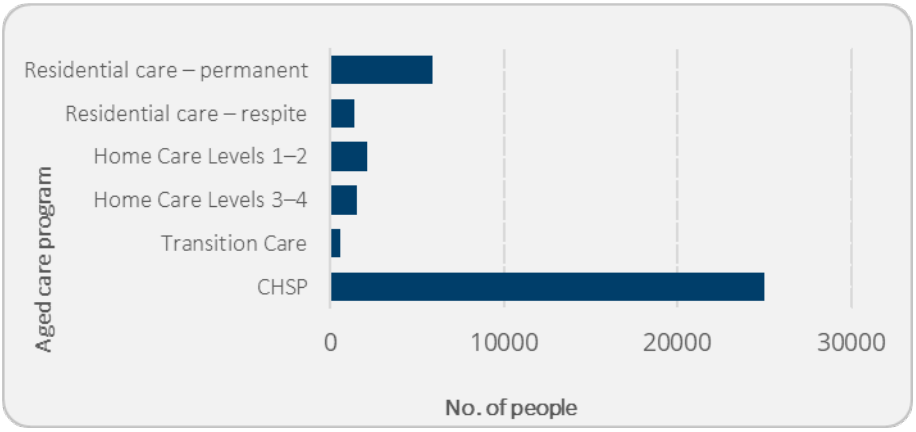
1.3.5 Aged care

1.3.6 Service demand is increasing

The aim of the aged care system is to promote the wellbeing and independence of older people (and their carers), by enabling them to stay in their own homes or by supporting their care needs in residential care.[50] The aged care focus population is all people aged 65+, and all Indigenous people aged 50+.

Most aged care services are provided to people in their home or in a community setting. In 2019 almost 25,000 Tasmanians aged 65+ accessed the Commonwealth Home Support Programme (CHSP), which helps older Australians with daily tasks, transport, social support and nursing care. Almost 6000 Tasmanians accessed permanent residential aged care in 2019 (Figure 16).[51]

Figure 16. People aged 65+ and Aboriginal people aged 50–64 years who received aged care services, by program type, Tasmania | 2018–19



Home Care Packages are available for people requiring more intensive levels of help to stay at home. There are four levels of care ranging from low to high care. Services are tailored to the individual and might include personal care (such as showering), support services (such as cleaning), and clinical care (such as nursing and allied health support).

Residential aged care is provided in aged care homes on a permanent or respite basis. Residents have accommodation, nursing care, support services (cleaning, laundry and meals) and personal care services.

The waiting time to receive aged care services in Tasmania is increasing. In June 2020, there were 79 aged care services in Tasmania that offered a total of 5194 residential places.[52] To receive a place in residential aged care, people must first be assessed by an aged care assessment team (ACAT) to determine the level of care they require. After an ACAT assessment, the average wait time to enter residential aged care was 148 days in 2019–20. This is up from 63 days in 2015–16.

Our aged care service needs are increasing. Demand for aged care services is driven by the size and health of our older population and Tasmania has one of the oldest, sickest populations in Australia. In particular, the need for home care is growing rapidly, reflecting consumers' preference for remaining at home for as long as possible.[53] As older people are generally higher users of health services than younger people, demand is expected to increase with our ageing population.[54]

The average wait time for a residential aged care place in 2019–20 was 148 days. In 2015–16, the wait was only 63 days.

GPs provide most of the care for people aged 65+ years

People who live in residential aged care often have more chronic diseases than the general population so they are likely to need more visits to their GP. GPs also play a central role in prescribing medicines for older people in residential aged care.[55]

GP attendances to residential aged care facilities in Tasmania are lower than for all of Australia. In 2016–17 the number of GP attendances in residential aged care facilities per patient was 14.3, lower than the Australian average of 16.6 attendances.

One in 10 hospitalisations are from residential aged care

Hospitals and RACFs experience frequent patient transfers between the two types of facilities for many clinical problems. In Australia, 1 in 4 residents of RACFs have at least one admission to hospital each year.[56]

Infections are among the most common causes of hospitalisation of residents of RACFs. Up to 25% of all hospitalisations from RACFs are for infections, most commonly respiratory, urinary tract, gastrointestinal and skin infections.[57] Older people who live in residential aged care experience more infections than people who live in other settings.[58] There are many reasons for the higher infection rate, including their generally advanced age, poorer health status, multiple comorbidities and compromised immune status, greater use of invasive devices such as urinary catheters, and close living environment.[59] Medical support and diagnostic capability can be limited in RACFs which can result in transfer of residents to hospitals for medical assessment and care.[60]

1.4 Stakeholder perspectives

The health system faces many pressures. There is a growing demand for services, contributed to by an ageing population with increasing chronic disease burden. Consultation with clinician, consumer and partner organisation stakeholders identifies many challenges to responding to Tasmania's large and growing primary care service needs.

1.4.1 Primary care services may not be accessible or affordable for Tasmanians

According to stakeholders, people want access to services in the community and as close to home as possible. There are a range of barriers that Tasmanians may experience in accessing primary care, including:

- out-of-pocket costs
- sometimes lengthy wait times to see a GP
- health literacy problems that are not addressed in current service delivery models
- difficulty accessing transport.

Tasmania is experiencing ongoing workforce recruitment and retention challenges in primary care. Rural areas have difficulty recruiting GPs and allied health professionals to work locally, resulting in the need for people to travel to these services. Low bulk-billing rates and out-of-pocket costs for radiology, pharmacy and pathology make general practice services unaffordable for priority populations in Tasmania.

1.4.2 People use hospital emergency departments inappropriately

People choose to go to an emergency department rather than a primary health service for many reasons, including:

- a lack of availability of local primary health services
- cost (no cost to attend emergency department)
- timeliness and convenience of having diagnostic and treatment services in one place (emergency department)
- a perception that there is greater clinical expertise available from emergency departments
- not having a regular GP
- not being able to access a GP in their desired timeframe
- a lack of consumer health literacy or knowledge or understanding of the health system and the purpose of emergency departments
- a lack of faith in GP skills.

People sometimes attend emergency departments for needs that could be met at a GP clinic.

Stakeholders report it will be difficult to divert patients away from emergency departments to other care settings whilst there are cost barriers and limited after-hours access to general practice.

1.4.3 Available health services are not well-promoted to consumers

Consumers lack awareness of the services available to them, the cost of services and how services can be accessed. This results in consumers receiving care from services that do not best meet their needs. For example, people attend emergency departments for after-hours care that could be delivered through telephone-based services or community clinics.

Stakeholders describe low health literacy, hospital-centric help-seeking behaviours. Consumer expectations also contribute to people using ambulance and emergency department services who could otherwise have their care needs met by community-based primary care services. Stakeholders describe opportunities for a greater role for nurses and allied health professionals in the after-hours period, especially to care for people with mental health, alcohol and other drug and palliative care needs.

1.4.4 Digital health, data and technology are under-used

Digital health, data and technologies can enable health information continuity between providers. Providers need to be appropriately funded and technologies need to integrate with practice software if providers are to adopt them. Technologies may include:

- shared health records
- eReferral systems
- telehealth
- online health analytic applications to support continuous quality improvement.

Stakeholders describe opportunities to better embed the use of digital technologies in the healthcare system to improve communication and information-sharing between providers.

1.4.5 Primary care services for end-of-life care and aged care can be improved

Stakeholders report some groups have more difficulty accessing palliative care that is appropriate for their needs. These groups include:

- people who are lesbian, gay, bisexual, transgender, intersex, queer and other sexuality and gender diverse (LGBTIQ+)
- people from culturally and linguistically diverse backgrounds
- Aboriginal people
- people with a disability
- people experiencing homelessness
- veterans
- refugees
- prisoners
- care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations) and people affected by forced adoption or removal.

Most palliative care needs are for personal care, respite and equipment, rather than specialist services, so these can be met in the community.

Recent findings from the Tasmanian palliative care system show that in most instances, people's palliative care needs relate to personal care, respite services and equipment rather than clinical or specialist services. Many of these care needs can be met in the community by primary care providers.

People receiving aged care services, particularly residential aged care, also report experiencing difficulty accessing timely general practice care. Some residential aged care facilities are unable to attract medical practitioners to care for their residents. Gaps in visiting allied health services are widespread across allied health disciplines. GP stakeholders report complex systems in many aged care facilities for documenting visits in patient records, difficulty locating nursing staff to support the visiting GP, and electronic systems for documentation in resident records that are not integrated with GP record keeping, make delivering general practice services time-consuming and unrewarding both professionally and financially.

Consumers and carers remain confused about the palliative care and aged care services that are available to them. They report confusion with different services delivering care at one time, and seek greater clarity and coordination of these services, and greater understanding of the available education and training resources.

1.5 Priority actions

Accessible, comprehensive primary care will result in better health outcomes for our community.

1.5.1 Evidence-based care

Our priority is to build on practice-based evidence.

Care for chronic conditions should be based on evidence and coordinated primarily within general practice. General practice brings:

- strengthened knowledge of the needs of individuals and local communities
- a focus on improving the quality of primary medical care as a key part of a clinically led practice-based innovation.

Evidence-based decision-making by general practice team members can be facilitated by a range of practice supports. Clinical pathways are one important tool to enable evidence-based decisions to be made by healthcare professionals during a consultation.

We will continue to work with primary care providers to implement Tasmanian HealthPathways. Through this work, providers are supported to deliver evidence-based care.

We will continue to provide general practice with access to timely practice reports. Our practice reports deliver participating GPs with advice regarding their performance against evidence-based standards of care.

1.5.2 Health information continuity

Our priority is to enable health information continuity between providers. Information and data continuity between providers is essential for the delivery of coordinated care for chronic conditions.

Using technology, particularly electronic communication and information-sharing, will reduce the administrative burden on clinicians and increase the availability of information for clinical decision support, and contributing to improving the patient experience of care.

We will continue to work with providers to increase eReferral and shared electronic health record adoption to enable delivery of better care for chronic conditions.

Robust data is needed to inform and measure health outcomes. Through enhancement of PHN Exchange and analysis and reporting of general practice data provided to the Primary Health Tasmania Primary Health Information Network (PHIN), we will support practices to use computer-based technology to track clinical, operational and patient experience metrics to monitor progress towards our goals and objectives.

1.5.3 Managing factors that contribute to poor chronic disease outcomes

People can reduce their chances of developing a chronic condition by reducing risk factors that are in their control to change. This includes smoking, drinking, being overweight, not being physically active, and consuming too much alcohol. Supporting people to manage their own health can improve health status and symptom management and reduce health service use.

GPs play a key role in the screening, detection, and management of chronic conditions. Our work to improve data-driven continuous quality improvement in general practice will incorporate initiatives to improve health risk factor assessment and management within general practice.

Supporting GPs to identify target groups that are not immunised and create opportunities to improve immunisation rates is a priority. Comprehensive roll-out of COVID-19 immunisation in Tasmania is an ongoing priority. Through provider support, we will support general practice reporting to the Australian Immunisation Register.

Improving participation by Tasmanians in national cancer screening programs will deliver improved cancer outcomes for our community. We will continue to work with GPs to improve cancer screening rates in Tasmania.

Primary Health Tasmania will leverage existing outreach services to provide immunisation to people experiencing homelessness. Leveraging existing services to reach homeless people for vaccination programs can also provide a trusted access point to provide the other necessary health and social services.

1.5.4 Supporting community palliative care

People receive end-of-life care from a range of community providers. It is important that community providers are resourced and supported to deliver this care. Primary Health Tasmania's priority is to provide education and support to primary care medical, nursing and allied health providers involved in delivering care at end-of-life.

We will work with community aged care providers to commission workforce skills development and increased community service options in end-of-life care to ensure people receive timely, appropriate palliative care.

1.5.5 Supporting primary care delivery for people in residential aged care

Primary Health Tasmania's priority is to support the delivery of primary care to residents of residential aged care. Diabetes is a priority chronic condition that contributes to preventable emergency department presentations and hospital admissions for people in residential aged care. Diabetes also contributes to the infectious disease burden in residential aged care. Primary Health Tasmania's priority is to support the delivery of diabetes educator services to people in residential aged care.

High rates of depression affect residents of aged care facilities. Primary Health Tasmania's priority is to support the delivery of comprehensive mental health care within residential aged care, improve access to multidisciplinary mental health care, and build the skills of the generalist workforce in identifying and managing mental health problems. This involves:

- providing resources and supports to care staff to improve detection of mental health problems, including routine screening for suicidal ideation[61]
- supporting GPs in assessing, screening, managing and referring those who have mental health problems[62]
- providing access to alternatives to medication to manage mental health problems.

2

Chronic conditions

2 Chronic conditions

2.1 Overview

2.1.1 Chronic conditions are Tasmania's leading cause of illness, disability and death

Addressing chronic conditions is the biggest challenge facing Tasmania's health system. Chronic conditions are putting unprecedented strain upon individuals, communities and the health system. Our ageing population contributes to increasing chronic disease burden and rising healthcare costs.

2.1.2 What are chronic conditions?

The National Strategic Framework for Chronic Conditions describes chronic conditions as a broad range of health conditions, including chronic and complex health conditions, mental illness, trauma, disability, and genetic disorders. [63]

Chronic conditions have complex and multiple causes and usually progress gradually. They may occur as a single condition in a person, or alongside other diseases. Chronic conditions can occur at any age, although they are more common as people get older.

Chronic conditions are a range of health conditions, including chronic and complex health conditions, mental illness, trauma, disability, and genetic disorders.

The most common chronic conditions are: arthritis, asthma, back pain, cancer, cardiovascular disease, COPD, diabetes and mental health conditions.

2.1.3 Most Australians have a chronic condition

Chronic conditions are very common. Half of all Australians have at least 1 of the 8 major chronic conditions that are reported on regularly by the Australian Institute of Health and Welfare. These are arthritis, asthma, back pain, cancer, cardiovascular disease, COPD, diabetes and mental health conditions. [64] These 8 common conditions have a big impact on Australians, as:

- 1 in 2 Australians (50%) have at least one chronic condition
- 3 in 5 Australians (60%) aged over 65 years have more than one chronic condition
- around 9 in every 10 deaths are associated with a chronic condition.

Many chronic conditions are not life-threatening in the short term. However, they can worsen over time and become more serious. Chronic conditions can lower quality of life and may affect a person's independence, cause disability, and shorten life expectancy.

2.2 Health needs

2.2.1 Many Tasmanians have chronic conditions

Around half of all Tasmanian adults report having a chronic condition – the highest proportion of all jurisdictions in Australia.[65] The major chronic conditions in Tasmania are musculoskeletal conditions, cancer, mental health problems, cardiovascular disease and diabetes. As people age, their likelihood of having chronic conditions increases.[66]

Many conditions are avoidable through prevention or can be detected early and are amenable to management in primary care. Most conditions are managed in primary care by proactive healthcare professionals who work as a team and focus on outcomes. People can self-manage with limited healthcare support, especially during the early stages of their illness. However, as chronic conditions become more complex, more intensive team care may be needed.

2.2.2 Cancer affects a significant proportion of Tasmanians

Tasmanians experience higher rates of cancer than the national average, contributing to our overall burden of chronic disease. The most common forms of cancer in Tasmania are prostate, bowel, breast, skin, and lung cancers.[67] Many of these cancers can be identified and treated early through increased participation in cancer screening programs.

Tasmanians' participation in cancer screening can be improved

Cancer screening programs aim to reduce illness and death from cancer through early detection. Cancers detected through screening are less likely to cause death than those diagnosed in people who have never participated in a screening program.[68]

Australia has three population-level cancer screening programs. They are for:

- breast cancer
- bowel cancer
- cervical cancer.

About half of all Tasmanians are not participating in the national cancer screening programs. Many cancers can be treated successfully if they are found early.

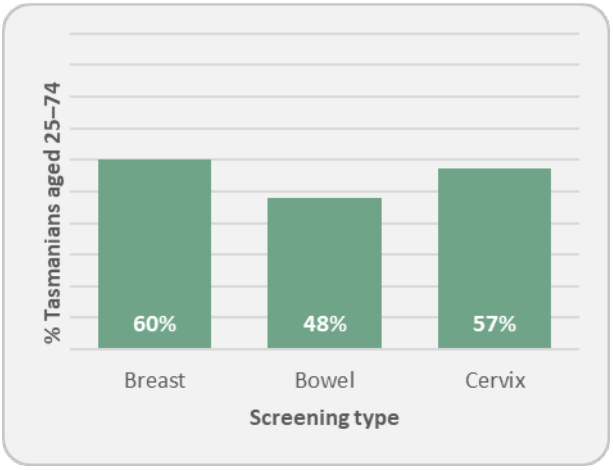
BreastScreen Australia was established in 1991. It provides free screening mammograms to women aged 40 and over every two years, and actively targets women aged 50–74.

The *National Cervical Screening Program*, established in 1991, targeted women aged 20–69 for a Papanicolaou smear, or 'Pap test,' every two years. In December 2017, the Cervical Screening Test replaced the Pap test in Australia. The Cervical Screening Test is more effective than the Pap test because it detects the human papillomavirus, a common infection that can cause cervical cell changes that may lead to cervical cancer. Women aged 25–74 years are invited to have a Cervical Screening Test every five years.

The *National Bowel Cancer Screening Program*, established in 2006, targets men and women between the ages of 50 and 74, inviting them to screen for bowel cancer using a free faecal occult blood test. Since 2020, all eligible Australians between the ages of 50 and 74 are invited to do the screening test every two years.

About half of all Tasmanians are not participating in our national cancer screening programs (see Figure 17).[69]

Figure 17. Participation rates in cancer screening by type, Tasmanians aged 25–74 | 2017–18



Surveys report that the following population groups either avoid, or have difficulty in accessing or understanding cancer screening:

- Aboriginal people
- culturally and linguistically diverse people, refugees and asylum seekers
- the aged, especially those who are homebound or have dementia
- low socioeconomic groups
- people residing in areas with lack of transport or poor access to health services
- women who have experienced sexual abuse
- men.

2.2.3 Our health risk factors increase our risk of chronic disease

Health risk factors are characteristics associated with an increased risk of developing an illness or health condition. They are the lifestyle factors that we can influence and can work to change, with the right supports.

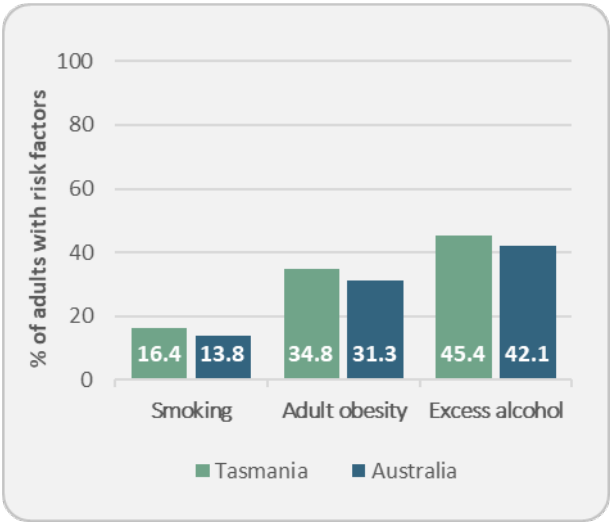
The major preventable behavioural risk factors for disease are tobacco smoking, excess alcohol consumption, physical inactivity, poor diet and nutrition and overweight and obesity.

Many risk factors are less favourable in Tasmania compared with Australia overall. Smoking and adult obesity rates are higher, more adults exceed the single-occasion alcohol consumption risk guideline, physical activity levels are low, and nutritional intake is poor (see Figure 18). [70]

People with these risk factors are likely to experience chronic disease. Many of these risk factors can be mitigated through targeted health promotion and anticipatory care – a population approach to health care that identifies and supports people who are at greatest risk of developing chronic conditions with the least capacity to address risk.

Health risk factors are lifestyle behaviours that contribute to a higher risk of developing an illness or chronic condition.

Figure 18. Percentage of adults with lifestyle risk factors, Tasmania compared to Australia | 2018



Rates of tobacco smoking are high in Tasmania

Tobacco smoking is a leading cause of preventable disease and death in Australia. More than three-quarters of this disease burden is accounted for by lung cancer, COPD, and ischaemic heart disease.

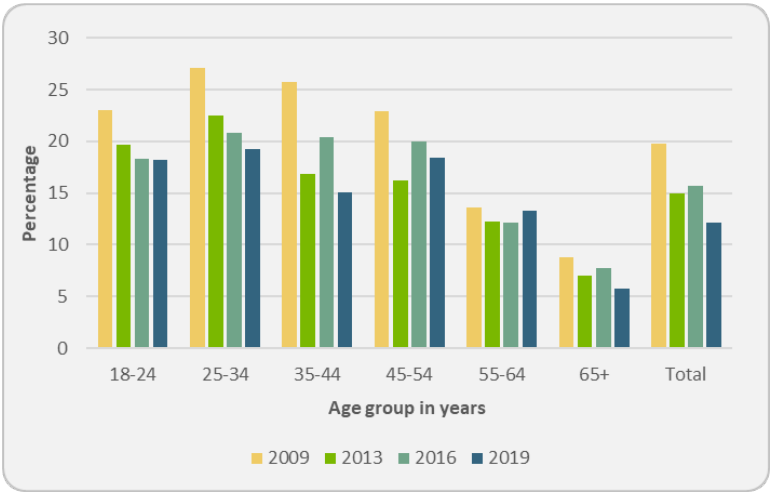
The average number of Tasmanians who died each year from tobacco use increased from 502 per year between 2008 and 2012, to 559 per year between 2013 and 2017.[71]

Many other diseases are also associated with smoking, including:

- other cancers
- respiratory and cardiovascular diseases
- pregnancy complications
- hip fractures and low bone density
- peptic ulcers
- dental problems.

Smoking rates in Tasmania have declined in recent years but are still high compared with the rest of Australia. Around 12.8% of Tasmanians smoke daily compared to the national figure of 11.0% (Figure 19).[72]

Figure 19. Current smokers by age group, Tasmania | 2009–19



Smoking continues to be more common in lower socioeconomic areas. The LGAs with the highest proportions of reported current smokers are the West Coast, Southern Midlands and Brighton.[37]

Excess alcohol consumption

Excess alcohol consumption falls into two main categories – single-occasion risk and lifetime risk.

Single-occasion risk is the risk of alcohol-related harm from drinking more than four standard drinks on a single occasion.

Lifetime risk is the accumulated risk from either drinking on many drinking occasions, or drinking on a regular basis (for example, daily) over a lifetime.

Drinking too much alcohol is directly associated with a range of harm including road injuries, suicide, violence, as well as longer-term health problems such as:

- liver cirrhosis
- mental health problems
- pancreatitis
- foetal growth restriction
- several types of cancer.[37]

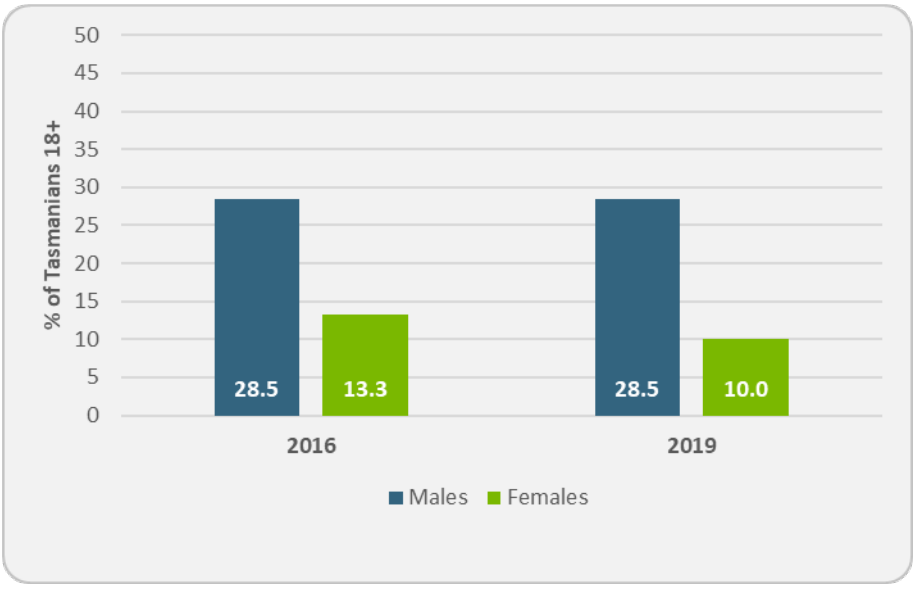
Males are at significantly greater risk of lifetime harm from alcohol, compared with females. The proportion of Tasmanians at lifetime risk of harm from alcohol use has declined since 2016 for females but has remained the same for males (Figure 20).[37]

In 2019:

1 in 3 Tasmanians were at risk of single-occasion harm from alcohol use

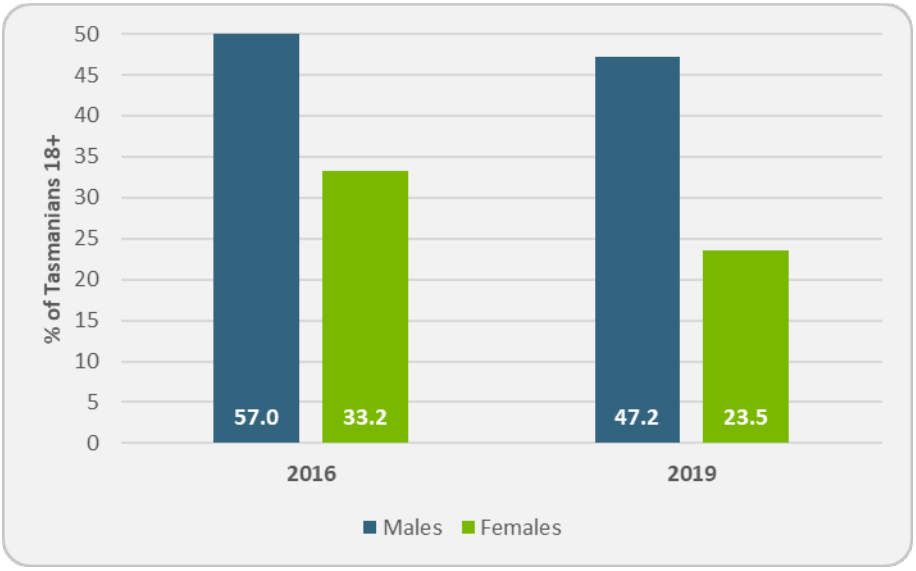
1 in 5 Tasmanians were at risk of lifetime harm from alcohol use

Figure 20. Alcohol causing lifetime harm, Tasmanians aged 18+ | 2016 and 2019



Males are also at significantly greater risk of harm from single-occasion alcohol use, compared with females. However, harm from single-occasion alcohol use is decreasing over time for both males and females (Figure 21).[37]

Figure 21. Alcohol causing harm on a single occasion, males and females aged 18+, Tasmania | 2016 and 2019



Approximately 8.9 deaths per 10,000 population are alcohol-induced in Tasmania, compared to 5.1 deaths per 10,000 population in Australia as a whole.[73] Around 1 in 5 Tasmanians with dependent children drank more than the recommended amounts.

One-third of Tasmanians do not get enough physical activity

Being physically inactive is bad for our health, and contributes to cardiovascular disease, mental health problems, type 2 diabetes, and some cancers.

Nearly one-third of Tasmanian adults did not meet physical activity guidelines in 2019, a slight increase since 2016. Two-thirds of people reported insufficient muscle strengthening activity. Physical inactivity was most pronounced in north western LGAs compared to the rest of Tasmania.

More than 40% of Tasmanian adults reported being mostly sedentary at work, and the proportion of people using active transport like walking and cycling has declined significantly over time.[37]

One-half of Tasmanians have a poor diet

In 2019, less than half of Tasmanian adults reported adequate dietary intake of two serves of fruit a day, and only 1 in 20 reported consuming five serves of vegetables a day. This was similar across socioeconomic levels but was lowest amongst those who reported fair or poor self-assessed health.

Poor diet, such as low consumption of fruit and vegetables and high intake of salt, saturated fats and sugar, is linked to poor health and disease, especially cardiovascular diseases, type 2 diabetes, and some cancers. People who are overweight or obese are more likely to consume sugar-sweetened drinks.[37]

When asked about their dissatisfaction with available food, 2019 survey respondents said the most common concerns were the cost, quality and variety of available food.[37]

3 in 5 Tasmanian adults are overweight or obese

Nearly 60% of adult Tasmanians reported being overweight or obese in 2019. The data suggests a decline in overweight adults but an increase in obese adults. More men reported an overweight BMI than women, however slightly more women reported an obese BMI.[37] There is a shift in the distribution of obese BMI towards the middle socioeconomic group in Tasmania.

Unfortunately, self-reported estimates often underestimate the magnitude of the problem, so it is likely that the obesity problem is greater than reported in the Tasmanian Population Health Survey 2019. Without reliable data, it is difficult to know the extent of the problem in our state.

Implementing health programs to address the health issues of physical inactivity and obesity will directly contribute to lessening the impact of chronic conditions on our health system.

2.2.4 Many Tasmanians have chronic conditions

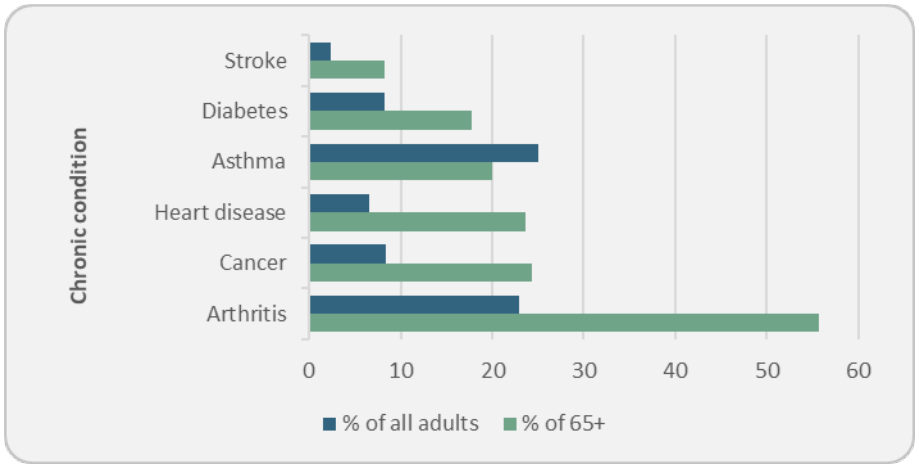
In Tasmania, 1 in 2 people has at least one chronic condition, and 1 in 10 Tasmanians has three or more.[37] Rates of chronic conditions in Tasmania are generally higher than Australia as a whole, in part because our population is older and chronic conditions are more common as we age.

In Tasmanians aged 65+, self-reported rates of most chronic diseases are higher than in the younger population (Figure 22).

The increasing prevalence of chronic conditions … is placing unprecedented pressure on individuals, families, our communities, and the health system.

Council of Australian Governments, Health Council

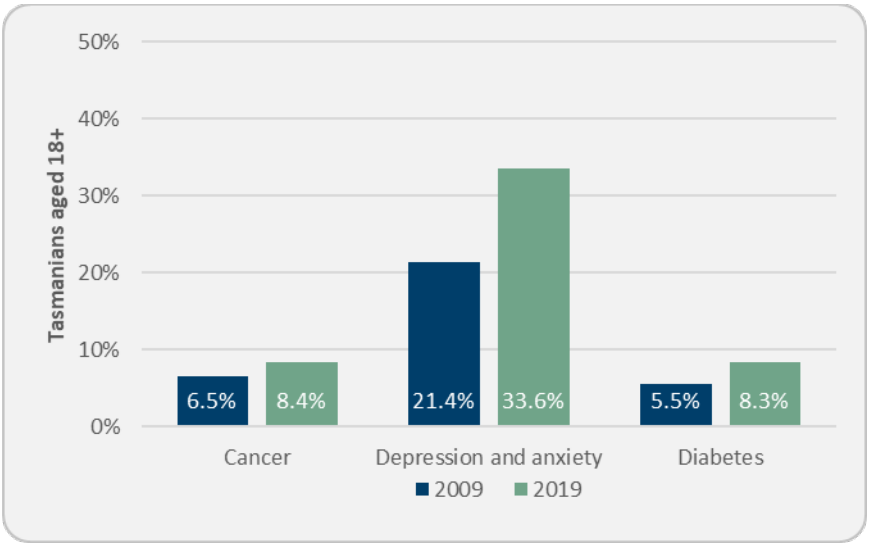
Figure 22. Self-reported chronic disease prevalence by disease type: all adults vs adults aged 65+, Tasmania | 2019



The burden of chronic conditions is increasing over time in Tasmania

Rates of specific chronic conditions are increasing over time in Tasmania. For example, self-reported rates of cancer, depression and anxiety, and diabetes increased between 2009 and 2019 (Figure 23).[74]

Figure 23. Self-reported ever-diagnosed chronic conditions (age standardised) in people aged 18+, Tasmania | 2009 and 2019



2.2.5 Risk factors for chronic diseases can be addressed

Lifestyle risk factors of smoking, alcohol consumption, physical inactivity, overweight and obesity, and poor nutrition contribute to our chronic disease burden. Primary care can support individuals to address risk factors for chronic disease.[37,66,75]

Many chronic conditions are made worse by mental health problems. Compared with the general population, people with severe mental health problems experience nearly twice the rate of cardiovascular disease (27% vs 16%), three times the rate of diabetes (21% vs 6%) and die 12–15 years earlier.[76]

The health needs and service priorities for people with mental health problems is discussed in detail at Chapter 4 Mental Health.

2.3 Service needs

Health services play a crucial role in helping people with chronic conditions to improve their health outcomes and to maximise their quality of life. However, our health system is a complex mix of programs and services delivered by a range of health and other professionals and can be difficult to navigate.

Many chronic diseases can be self-managed with limited healthcare support, especially in the early stages. However, as conditions become more serious and disabling, more intensive team care is often required, and hospital care may be needed for acute episodes.

As our rates of chronic conditions increase, so do our healthcare costs and demand for services.

2.3.1 Most of Tasmania's chronic disease burden is managed in general practice

We have an estimated 165 general practices in Tasmania and 918 GPs.[70] Many GPs work part-time. The full-time equivalent number of GPs in Tasmania is 560. Although Tasmanians have a higher chronic disease burden than Australians as a whole, we have fewer full-time equivalent GPs per 100,000 population — 105 per 100,000 in Tasmania compared with 113 in 100,000 for Australia.

Tasmanians have a higher chronic disease burden than Australians as a whole, but we have fewer GPs per head of population.

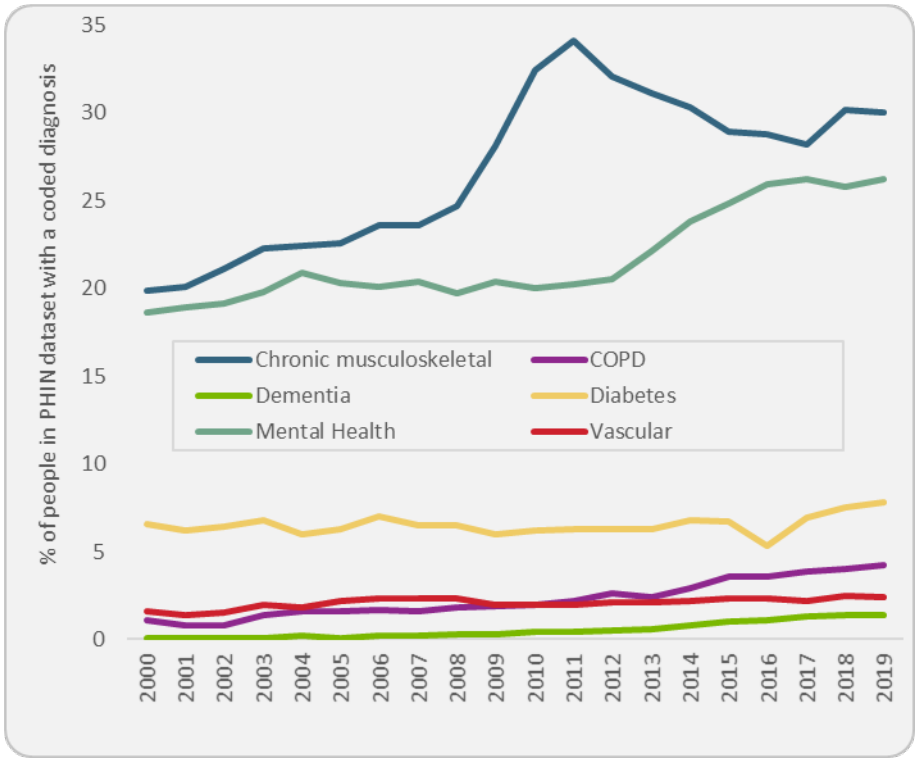
Nationally, the most frequent chronic problems managed in general practice are hypertension, mental health problems, musculoskeletal problems, diabetes and lipid disorders.[77]

In Tasmania, most general practices contribute data to Primary Health Tasmania to inform our understanding of care delivered to people in general practice. These data show the percentage of people who visited their GP for selected chronic conditions were:

- musculoskeletal conditions (44%)
- hypertension (35%)
- mental health conditions (38%)
- asthma (23%)
- diabetes (13%)
- cardiac diseases (11%).

The rate of people with chronic conditions being cared for in general practice, in particular musculoskeletal conditions and mental health problems, is increasing over time (Figure 24).

Figure 24. Trends in population prevalence estimates from active and inactive patients in general practice with a coded diagnosis, Tasmania | 2000–19



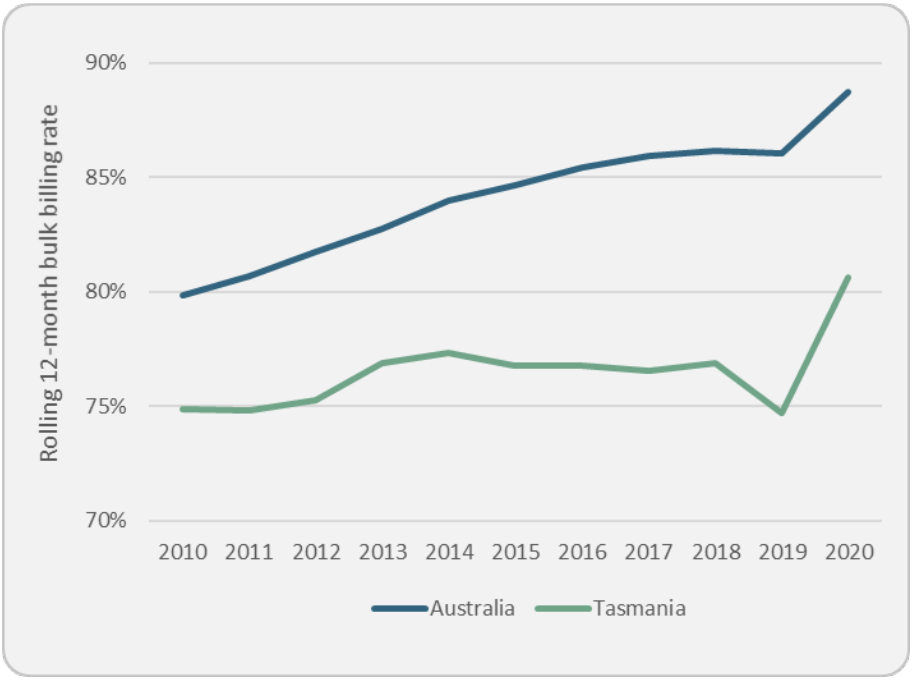
GPs care for most Tasmanians receiving health care for mental health problems. In 2019 there were approximately 80,000 people who saw their GP for a mental health problem.[70] The most common problem was depression, followed by anxiety. Local government areas with the highest rates of GP attendance for mental health problems were Devonport and the Huon Valley.

2.3.2 Tasmanians visit their GP less often than other Australians

Medicare data shows that Tasmanians have 5.6% fewer routine GP consultations and 19% fewer after-hours urgent consultations each year compared to Australia as a whole.[78]

Tasmania has the second-lowest bulk-billing rate in the nation for GP services and is consistently below the national average (Figure 25).[79]

Figure 25. GP non-referred attendances, rolling 12-month bulk-billing rate, Tasmania and Australia | 2010–20

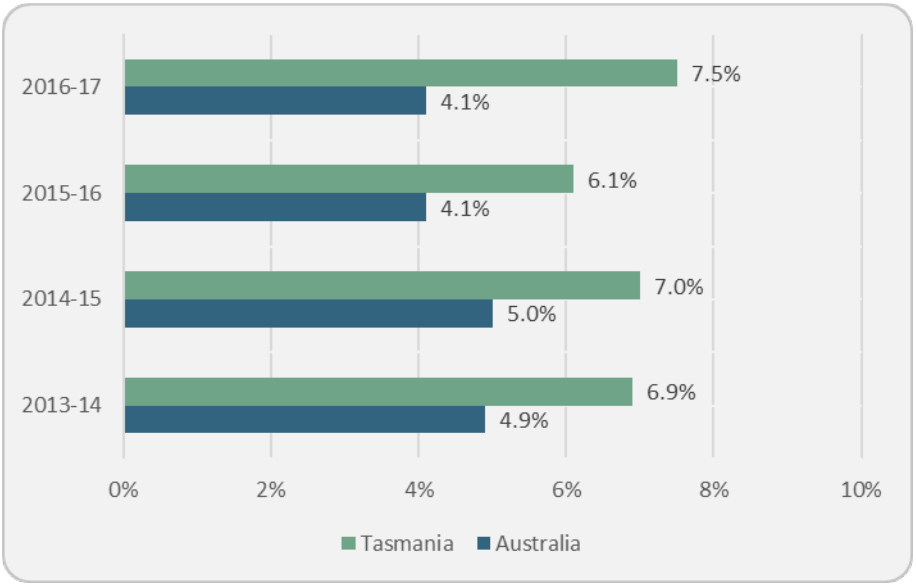


The Medicare Benefits Scheme (MBS) pays a rebate on GP consultation fees according to standard fees set by the Australian Government. The difference between the consultation fee and the Medicare rebate is an out-of-pocket expense.

Many Tasmanians cannot afford the out-of-pocket expense of a medical visit. Tasmania has the highest reported percentage of all 31 Primary Health Networks of adults reporting they did not see or delayed seeing a GP due to cost (Figure 26).[80]

Bulk billing refers to GPs choosing to accept Medicare benefit as full payment for a consultation, with no out-of-pocket cost to the patient.

Figure 26. Percentage of adults who did not see or delayed seeing a GP due to cost in the preceding 12 months, Tasmania and Australia | 2013–17



2.3.3 Some people with chronic conditions may be missing out on allied health care

GP Management Plans (MBS Item 721) and Team Care Arrangements (MBS Item 723) can be completed by GPs to plan chronic conditions management for patients and facilitate subsidised access to allied health professionals. This reduces out-of-pocket costs for allied health care.[81]

In 2019, fewer than 20% of patients with chronic conditions had a 721 and 723 item recorded. Rates of 721 items were highest for patients with diabetes mellitus (19.4%), followed by chronic obstructive pulmonary disease (COPD) (18.3%) and cardiovascular disease (17.5%). Rates of 723 were highest for diabetes mellitus (17.5%), COPD (15.2%) and cardiovascular disease (14.8%).

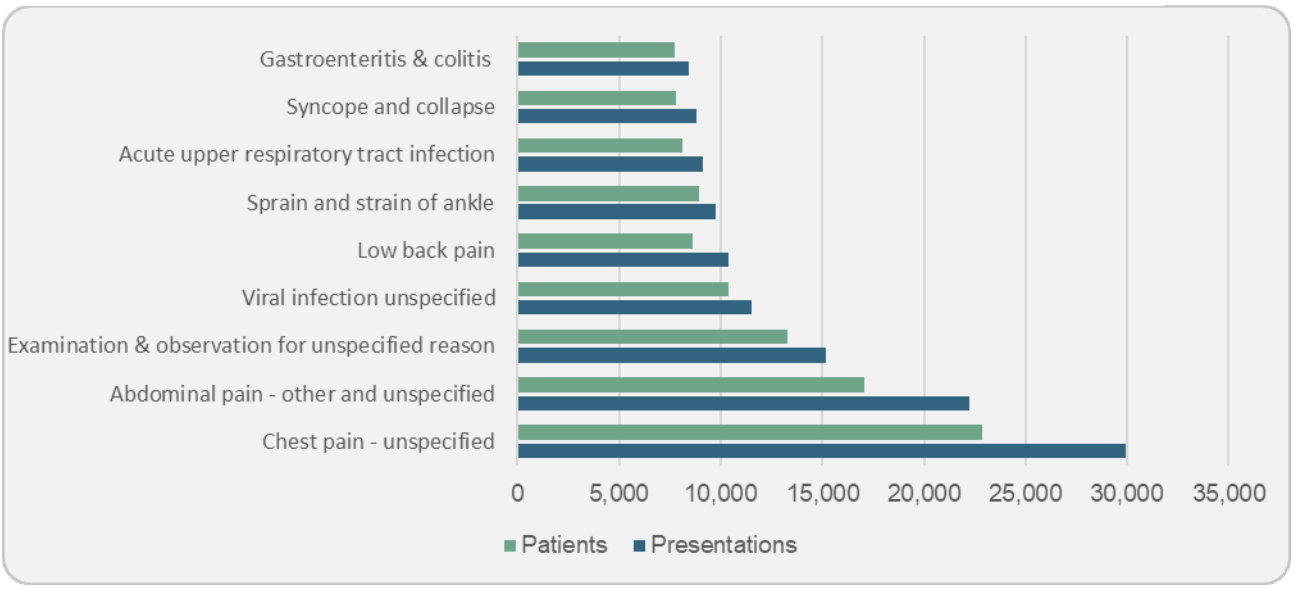
There is currently inadequate data to assess whether this is for reasons of lower allied health professional availability across Tasmania, or other reasons.

2.3.4 Many Tasmanians with chronic conditions need hospital care

Rates of public hospital emergency department presentation and inpatient admission are increasing over time in Tasmania. We are not alone in this growing need for hospital care. The same trend is observed nationally and internationally.[82]

The main reasons Tasmanians access public hospital emergency departments are for treatment of pain in the throat, chest, abdomen, pelvis and back (Figure 27).

Figure 27. Emergency department presentations, Tasmanian public hospitals | 2014–15 to 2019–20



2.3.5 Half of avoidable hospital admissions in Tasmania are due to chronic conditions

The term ‘avoidable admissions’ is also known as potentially preventable hospitalisations and refers to hospital admissions for conditions that are considered manageable through timely and effective primary care. The concept of avoidable admissions is used as an indicator of health system performance, both in Australia and internationally.[83]

Separation rates for avoidable admissions are used as indicators for monitoring the quality or effectiveness of non-hospital (primary) care in the community.

Avoidable admissions are grouped into three broad categories:

- vaccine-preventable
- acute conditions
- chronic conditions.

Diabetes is a priority chronic condition that contributes to preventable emergency department presentations and hospital admissions for people in residential aged care.

In Tasmania, approximately 50% of avoidable admissions are for chronic conditions and 47% are for acute conditions. The largest chronic disease avoidable admission burden is from COPD, heart failure and diabetes, and the largest acute disease burden is from urinary tract infections and cellulitis.

Between 2014–15 and 2019–20 there were 51,863 potentially preventable hospital admissions to Tasmania's four largest public hospitals — Royal Hobart Hospital, Launceston General Hospital, North West Regional Hospital and Mersey Community Hospital. The largest number of potentially preventable hospitalisations overall were for COPD (Table 4).[84,85]

Table 4. Potentially preventable hospitalisations by condition, 4 major public hospitals, Tasmania | 2014–15 to 2019–20

Condition	Separations	Patients	Bed days
COPD	7,288	3,327	29,196
Cellulitis	4,724	3,293	13,124
Heart failure	4,706	3,134	27,513
Urinary tract infections, incl. pyelonephritis	4,611	3,644	13,809
Diabetes complications	4,480	1,899	16,793
Asthma	4,237	1,284	2,865
Convulsions and epilepsy	3,616	2,152	8,469
Dental conditions	3,030	2,745	2,038
Influenza and pneumonia, vaccine-preventable	2,918	2,578	21,351
Iron deficiency anaemia	2,880	2,399	2,148
Ear, nose and throat conditions	2,877	2,663	3,388
Angina	2,482	1,947	4,288
Gangrene	884	598	9,887
Other vaccine-preventable conditions	817	531	4,853
Bronchiectasis	567	262	2,250
Perforated bleeding ulcer	542	494	4,270
Hypertension	516	450	968
Pneumonia (not vaccine-preventable)	276	264	2,164
Pelvic inflammatory disease	241	223	480
Rheumatic heart disease	120	105	910
Nutritional deficiencies	44	40	719
Eclampsia	7	7	25

People from our most disadvantaged communities are over-represented in our preventable hospitalisations. Low income, combined with a lack of access to affordable primary health care, increases rates of preventable hospitalisations.[75]

2.3.6 A small number of Tasmanians use a large percentage of hospital resources

A small number of Tasmanians require a large number of hospital bed days. With the right primary health care and support, many of these people can be managed in the community and would have better health outcomes, avoiding the need to be hospitalised.

Between 2017 and 2020 there were 832 Tasmanians admitted to hospital 10 or more times for acute public hospital management of their chronic conditions (excluding people who come to hospital for dialysis or chemotherapy). This comprises 7% of all public hospital bed days. These people spent an average of 120 days in hospital each.[85]

These people had multiple chronic conditions, including chronic lung and lung disease, diabetes and chronic kidney disease, as well as musculoskeletal problems such as back pain and osteoarthritis. Many needed rehabilitation and other non-acute types of care, which can be delivered in the community if services are available.

2.4 Stakeholder perspectives

According to consumers and clinicians, people with chronic conditions often find it difficult to navigate our complex health system. Stakeholders report that communication and information-sharing between providers can be improved. Consumers report Tasmanians with chronic conditions may be unable to afford the care they need.

2.4.1 People with chronic conditions experience fragmented health services

Consumers with chronic conditions report:

- poor coordination of care between service providers, both in community and acute hospital settings
- a lack of communication and information-sharing between GPs, community allied health services, acute hospitals and residential aged care facilities.

This results in consumers having to tell their story multiple times to different providers. When information is not shared between providers, consumers can experience gaps in their care, delays to starting or changing treatments and poorer health outcomes.

2.4.2 Management of people with complex chronic conditions can improve

Some people with complex chronic conditions have complex care needs and the available community supports are insufficient to meet their needs. These people require access to comprehensive, multidisciplinary chronic conditions management that is integrated with acute hospital services and their usual general practice.

According to stakeholders, we lack an integrated, comprehensive system of care for people with complex and chronic care needs who have frequent hospitalisations. We need complex care that is accessible, affordable and that works with the person's usual general practice and hospital service providers.

2.4.3 Many people with chronic conditions need support to self-manage

People with chronic conditions need to self-manage their conditions to achieve good health and wellbeing outcomes. For many people, poor health literacy and a lack of available self-management support limits their ability to navigate the health system and to receive care from the right providers.

Stakeholders report some consumers need extra help to navigate the health system and extra support to manage their chronic conditions. It is generally not clear to consumers or their general practice providers where this additional support can be obtained, or if it is available.

2.4.4 People with chronic conditions need access to affordable care

People with chronic conditions may experience financial disadvantage because their health problems decrease their participation in employment, and because of substantial and ongoing out-of-pocket costs associated with their chronic conditions. Tasmanians experience greater socioeconomic disadvantage than Australians overall, impacted further because general practice bulk-billing rates in Tasmania are lower than the Australian average.[79]

People with chronic health conditions who experience social and economic disadvantage report difficulty accessing affordable primary care in Tasmania and will avoid seeing health professionals or filling prescriptions due to cost.

Some consumers need extra support to navigate health systems and to manage their chronic conditions, but they often don't know that this support is available or where to find it.

2.5 Priority actions

Primary Health Tasmania has an important role to play in transforming the management of chronic conditions in our community. We need to support the delivery of proactive, planned, and comprehensive primary care to keep people well and out of hospitals. We need to support our approach by measuring meaningful outcomes.

2.5.1 Improve the health and wellbeing of people with chronic conditions

A priority for Primary Health Tasmania is to improve the health and wellbeing outcomes of people with chronic conditions. Our goal is to increase the efficiency and effectiveness of primary care for these people, particularly those at highest risk of the poorest health outcomes.

Some chronic conditions disproportionately impact Tasmanians. These include cardiovascular disease, respiratory disease, diabetes, arthritis and musculoskeletal conditions, cancer and mental and behavioural problems. These priority chronic conditions cause increased sickness and death, reduce quality of life, and consume a large and growing proportion of healthcare resources. To improve the health and wellbeing of Tasmanians with chronic conditions, our goals are to enable:

- provision of evidence-based care
- primary care as close to home as possible
- comprehensive team-based primary care for those with high levels of hospital service use
- improved access to after-hours primary care
- culturally appropriate care
- timely, appropriate palliative care for those with life-limiting conditions
- best-practice performance by primary care providers that is data-driven.

2.5.2 Increase support for priority populations

There is an inequitable burden of chronic conditions and higher prevalence of risk factors in our priority populations. Greater emphasis towards identifying and supporting priority populations is needed to reduce the impact of chronic conditions. In Tasmania, our priority populations for management of chronic conditions in primary care are:

- older people
- people living in rural and remote areas
- Aboriginal people
- people who receive aged care or disability services
- people with low socioeconomic status.

Primary Health Tasmania's priority is to support priority populations to reduce the impact of chronic conditions on health outcomes.

2.5.3 Facilitate comprehensive care for people with chronic conditions

Primary Health Tasmania's priority is to implement comprehensive approaches to chronic conditions management that respond to consumer needs and provide proactive, planned care for people with chronic conditions.

We will prioritise the following areas of action:

Stepped-care model

- Implement a stepped-care model based on guidelines for evidence-based management of chronic conditions. As people's care needs increase, a person in a stepped-care model is supported to move from lower to higher levels of care and back again as their care needs stabilise. The result is people receive more effective, efficient, person-centred care.

Health pathways

- Implement health pathways within general practice through our Tasmanian HealthPathways program. These pathways enable providers to deliver evidence-based care appropriate to the patient's care needs. They also support providers to escalate people to higher levels of care as the need arises.

Education and training

- Deliver education and training for primary care providers to improve evidence-based management of chronic conditions.

Digital health program

- Improve the use of effective and accessible technology by health professionals and consumers to improve chronic conditions management through better communication and information-sharing.
- Data collection.
- Improve the use of high-quality data for primary care service quality monitoring and chronic conditions improvement.
- Work with general practices to collect, analyse and report general practice data to undertake activities that will improve quality of care for people with chronic conditions.

New models of care

- In partnership with Tasmanian public hospital partners, implement innovative models of primary care for people with chronic, complex conditions who are high users of inpatient hospital services. The Chronic Complex Care Service, targeting northern Tasmania in the first instance, will reduce preventable hospitalisations for frequently hospital patients most at risk of poor health outcomes.

2.5.4 Support and encourage team-based, person-centred primary care

Effective models of chronic disease management require a team-based approach to care where people take a more active role in the day-to-day decisions about the management of their illness. Partnership between the patient and health professionals is essential for effective chronic conditions management. This empowers people to become more active in managing their health. When people are more informed, involved, and empowered, they interact more effectively with healthcare providers and take actions that will promote healthier outcomes.

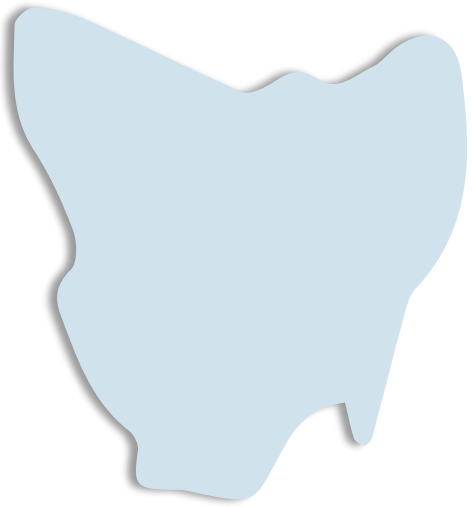
Primary Health Tasmania will prioritise commissioning and supporting the delivery of team-based models of primary care that are comprehensive and meet the primary care needs of priority populations and for priority chronic conditions.

Primary Health Tasmania will:

- partner with consumers to design, implement and evaluate innovative primary care services, programs and activities for people with chronic conditions, particularly those who are frequently admitted to Tasmanian public hospitals
- integrate a team-based approach to delivery of care through our commissioned services
- support delivery of multidisciplinary primary care to people as close to home as possible through our Rural Primary Health Services commissioning
- support Aboriginal Community Controlled Health Organisations to care for community members with chronic health conditions through our ITC program
- focus on diabetes support, particularly for Tasmanians in residential aged care
- work with community aged care providers to commission workforce skills development and increased community service options in end-of-life care. This will improve outcomes for Tasmanians with life-limiting chronic conditions and ensure they receive timely, appropriate palliative care.

2.5.5 New workforce roles

Tasmania has many workforce challenges and lacks the allied health workforce required to meet all the population's needs. Primary Health Tasmania is working with hospital and community health professionals to introduce new workforce roles that can support allied health professionals to deliver community-based allied health care.



3

Aboriginal people

3 Aboriginal people

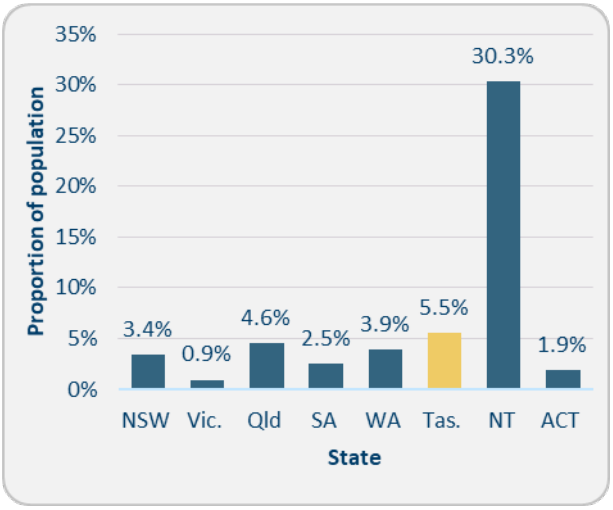
3.1 Overview

Aboriginal and Torres Strait Islander Australians are descended from the people who lived in Australia and surrounding islands prior to European colonisation.[86] In this report, we respectfully use the term 'Indigenous' to refer to Aboriginal and Torres Strait Islander peoples nationally. We use 'Aboriginal Tasmanians' to refer to the Tasmanian Aboriginal community, respecting their preference.[87]

3.1.1 Tasmania has the second highest proportion of Aboriginal people in Australia

In 2016, Tasmania was home to more than 28,500 Aboriginal people.[88] At 5.5% of the population, this is the second highest proportion of Aboriginal people of any other state or territory (Figure 28). About one-quarter of Tasmanian Aboriginal people lives in the greater Hobart region.[89]

Figure 28. Estimated resident population by Indigenous status, Australia | June 2016



3.1.2 Indigenous people experience health inequities

Indigenous people face significant health inequities, compared with other Australians. They have lower life expectancy, higher chronic disease and mental health disease burden, poorer self-reported health, and higher rates of smoking and obesity.[90]

Indigenous people also face ongoing challenges associated with racism, stigma, environmental adversity and social disadvantage.[91]

3.1.3 Indigenous people need access to culturally appropriate health care

Indigenous people have poorer health than non-Indigenous Australians, and they do not always have the same level of access to health care.[92] Improving the health and wellbeing of Tasmanian Aboriginals includes ensuring access to culturally appropriate healthcare services that practice clear and respectful communication, respectful treatment, inclusion of family members, and empowering Aboriginal people to make their own decisions about care.

Improving the health and wellbeing of Aboriginal Tasmanians is a priority for Primary Health Tasmania.

3.2 Health needs

Providing a clear health profile of Aboriginal people in Tasmania and Australia is challenging due to limited data being available. In this report, if local data are not available, we present data for Australia as a whole, recognising the situation for Tasmanian Aboriginals may not be the same as their mainland counterparts.

In general, compared with non-Indigenous Australians, Indigenous people in Australia have:

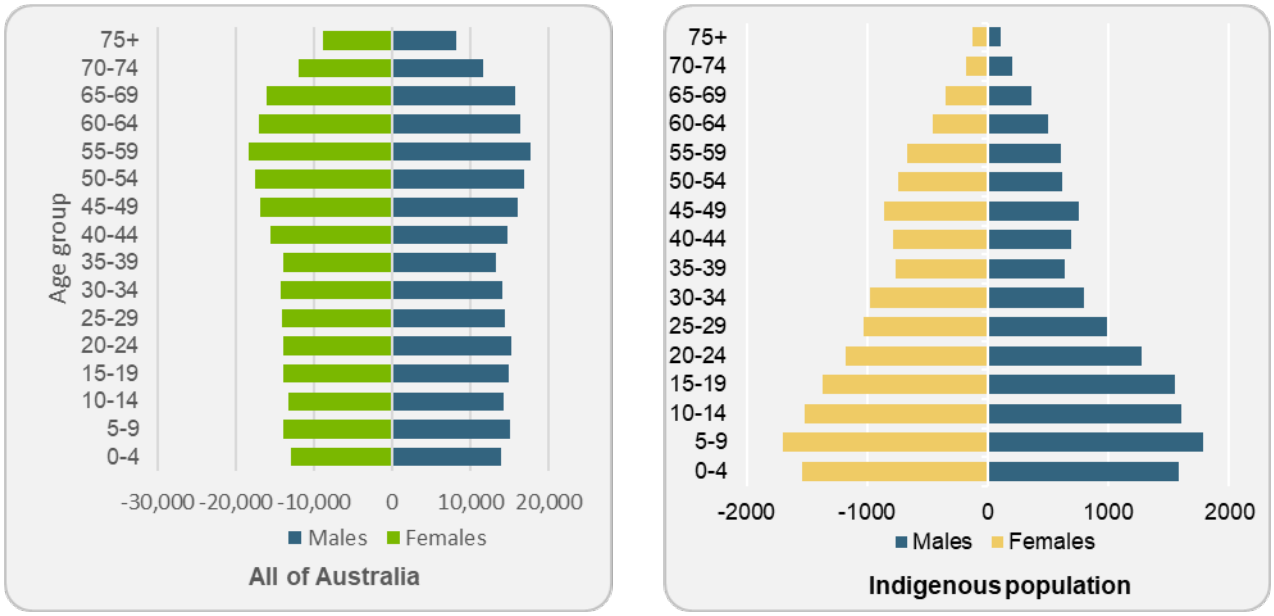
- a younger age structure
- a higher chronic disease burden
- a higher mental health disease burden
- higher rates of health risk factors.

Additionally, Indigenous people experience higher rates of racism and stigma, and have unmet needs for culturally appropriate care.[91]

3.2.1 Australia's Indigenous population is younger than the non-Indigenous population

The median age of Australia's Indigenous population is 23 years compared with 43 years for the non-Indigenous population.[93] Figure 29 illustrates the estimated resident population in 2016 with a higher proportion of young people and lower proper proportion of older people. This reflects the higher fertility rates and higher death rates compared with the non-Indigenous population.[93]

Figure 29. Estimated population distribution by Indigenous status and age group, proportion of Australian population | 2016

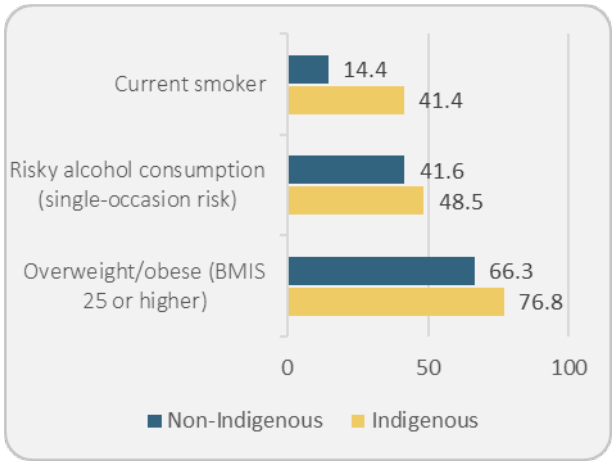


3.2.2 Indigenous people have poorer health status and higher health risk factors

Indigenous Australians experience poorer health than non-Indigenous Australians. This is due to both social determinants and health risk factors. Indigenous Australians generally have lower levels of education, employment, and income, and poorer quality housing than non-Indigenous Australians.[90]

They also may have higher rates of risk factors such as tobacco smoking, risky alcohol consumption and insufficient physical activity in some geographical areas. Nationally, the Indigenous smoking rate is 2.7 times higher than that for non-Indigenous Australians (Figure 30).[94]

Figure 30. Age-standardised prevalence of selected health risk factors by Indigenous status, Australia | 2018–19

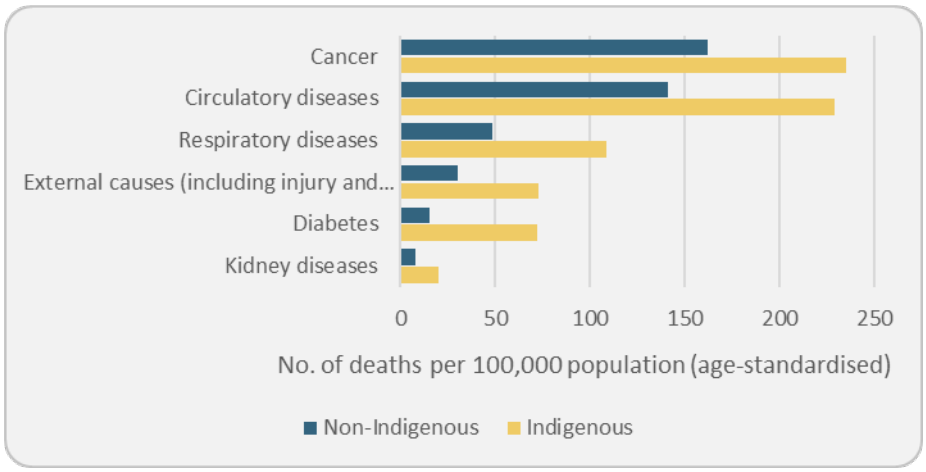


Notes: 1. For non-Indigenous rates, 2017–18 was used.
2. The rate ratio is calculated by dividing the age standardised rate for Indigenous people by the comparable age standardised rate for non-Indigenous people.

3.2.3 Indigenous Australians have a higher chronic disease burden

Two-thirds of the disease burden of Indigenous people is caused by chronic diseases.[95] In 2018, the national age-standardised death rate for diabetes was nearly five times as high as for Indigenous people (72 deaths per 100,000 compared with 15 deaths per 100,000).[96] Chronic diseases are their single biggest killers[97] with cancer, circulatory diseases, and respiratory diseases among the leading causes of death in 2018 (Figure 31).[98]

Figure 31. Leading broad causes of death by Indigenous status, selected Australian jurisdictions* | 2018



*Data are for New South Wales, Queensland, Western Australia, South and Australia and the Northern Territory combined.

3.2.4 Aboriginal Tasmanians have a high mental health disease burden

In 2019 about 25% of Tasmanian Aboriginal adults reported high or very high levels of psychological distress.[37] This compares to 14% of Tasmanian adults overall.

In Australia generally, the rate of Indigenous Australians reporting high or very high levels of psychological distress was 2.3 times the rate for non-Indigenous Australians, based on age-standardised rates.[99]

Age-standardised rates of Indigenous deaths by suicide have increased nationally from 20.2 per 100,000 persons in 2009–13 to 23.7 per 100,000 persons in 2014–18, almost double that of non-Indigenous Australians (12.3 per 100,000 persons in 2014–18). Suicide rates were highest in Indigenous youth at 47.1 per 100,000 for the 25- to 34-year age group and 40.5 per 100,000 for the 15- to 24-year age group.[100]

Indigenous deaths by suicide have increased significantly in recent years. They are almost double the rate of non-Indigenous Australians. Suicide rates are highest in the younger age groups.

3.2.5 Culturally safe health care is important for Indigenous Australians

Indigenous Australians experience poorer health than non-Indigenous Australians, and they may also experience disparities in access due to factors such as remoteness, affordability and a lack of cultural safety.[92] Indigenous people also experience discrimination accessing services[91] and may avoid seeking care.

Improving the cultural competency of healthcare services can increase Indigenous Australians' access to health care, increase the effectiveness of care that is received, and improve the disparities in health outcomes.[101]

3.3 Service needs

This section describes available information about Aboriginal people's use of health services.

3.3.1 Avoidable hospitalisations for Tasmanian Aboriginals

Indigenous people nationally have higher rates of avoidable hospital admissions – or potentially preventable hospitalisations (PPHs) – for chronic conditions than non-Indigenous people. In Tasmania it is estimated that the rate of potentially preventable hospitalisations is 17 per 1000 Tasmanian Aboriginal residents, lower than national rates of 70.4 potentially preventable hospitalisations per 1000 Indigenous residents.[102] The top five potentially preventable conditions in people who were hospitalised in Tasmania were dental conditions; COPD; ear, nose and throat conditions; cellulitis; and urinary tract infections.

3.3.2 Emergency department use

In 2017–18, Indigenous Australians accounted for 6.7% of total public hospital emergency department presentations.[103] In the two-year period from July 2015 to June 2017, the hospitalisation rate for Indigenous Australians was 2.3 times the rate for non-Indigenous Australians (based on age-standardised rates). A large part of this difference was due to substantially higher rates of dialysis. Among all five leading causes of hospitalisations for Indigenous Australians, the age-standardised hospitalisation rate per 1000 population was higher than the corresponding non-Indigenous rate in four causes, with the exception being for diseases of the digestive system (Table 5).[104]

Table 5. Age-standardised rates of the leading causes of Indigenous hospitalisations per 100,000 population, by Indigenous status, Australia | July 2015 – June 2017

	Indigenous	Non-Indigenous
Circulatory diseases	32	19.9
Digestive diseases	38.8	40.5
Genitourinary diseases	22.8	19.1
Respiratory diseases	40.6	18.2
Injury and poisoning conditions	50.1	29.1

3.3.3 Primary care service use

In 2019, more than 12,000 Aboriginal people accessed GP services across Tasmania, about 3.2% of all people who saw a GP that year.[105] The five most frequent diagnoses GPs recorded were depression, asthma, hypertension, hyperlipidaemia, and anxiety.

3.3.4 Indigenous-specific healthcare services

The Australian Government provides funding through its Indigenous Australians' Health Programme (IAHP) to organisations delivering Indigenous-specific primary healthcare services, designed to be accessible to Indigenous clients.

There are seven Indigenous-specific primary healthcare organisations in Tasmania, five of which report having fewer than 500 clients.[106] In 2018–19 they reported seeing more than 6000 clients, mostly Aboriginal. These clients received a total of 67,483 episodes of care, approximately 11 per person.

The most reported service activities were for immunisation, mental health and healthy lifestyle-related reasons. The major challenges reported are staffing and coordination of care, and service gaps identified are dental and youth services.[107]

Access to effective and culturally competent primary health care is vital for meeting the health needs of Indigenous Australians, particularly for detecting and managing health conditions so as to prevent hospitalisation and death.

National Indigenous Australians Agency

Influenza immunisation

In 2019, around 6 in 10 Indigenous people aged 50+ did not have a flu vaccination in the previous 12 months.[108,109] Indigenous Australians have a higher chance of serious illness, such as pneumonia or death if they get influenza (the flu). Influenza vaccination substantially reduces the risk of hospitalisation and death from influenza and pneumonia, especially for older Indigenous Australians.[110]

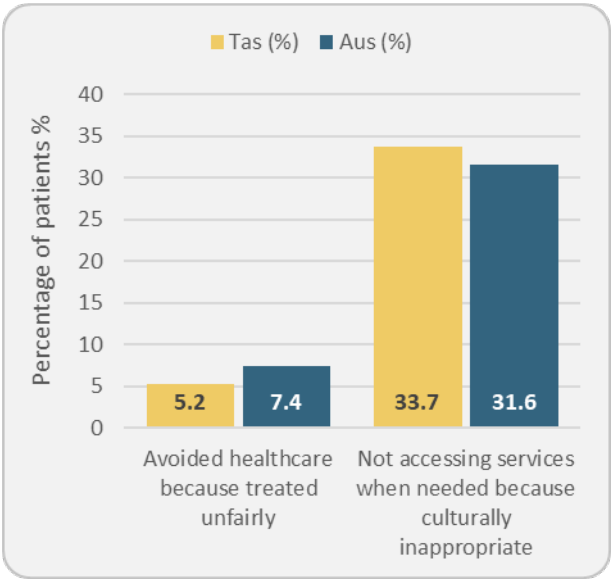
Some Indigenous people avoid healthcare services due to culturally inappropriate treatment

The available evidence suggests that in 2018–19, 30% of Indigenous Australians did not access health care when they needed to. There is a range of reasons for non-access, however lack of cultural appropriateness of the service was the reason why about one-third of people did not go to hospital or a counsellor, and why about one-quarter did not see a dentist or doctor.[111]

In Tasmania, cultural appropriateness of most health services remains an issue for about one-third- of Aboriginal people (Figure 32).[112] This is higher than the Australian average.

Culturally appropriate primary health care is needed to improve the health and wellbeing of Indigenous Australians. The roles of effective primary care include prevention, early intervention, health education, and the timely identification and management of physical and psychological issues.[113]

Figure 32. Indigenous patient experiences of health care, Tasmania and Australia | 2018–19



3.4 Stakeholder perspectives

We received feedback about primary care experiences of Aboriginal people in Tasmania from Aboriginal Community Controlled Health Organisations (ACCHOs), commissioned Aboriginal-specific health service providers, consumers and clinicians.

3.4.1 Cultural insensitivity is common within mainstream services

Tasmanian Aboriginals report regular experiences of cultural insensitivity from mainstream health providers, including GPs, practice nurses and specialists. Aboriginal people have experienced inappropriate language, judgmental attitudes and inappropriate behaviours by health professionals within clinics. Stakeholders shared experiences of:

- mainstream service providers not maintaining the confidentiality of patients
- derogatory language regarding the entitlement of Aboriginal people to health services and supports that non-Indigenous people are not entitled to
- GPs refusing to complete Indigenous Health Assessments or work with Aboriginal Community Controlled Organisations to support comprehensive management of patients with chronic conditions.

Some stakeholders expressed that attendance at cultural awareness training alone does not lead to changes in behaviour of clinicians. They report clinician bias regarding Aboriginal people can be unconscious and clinicians may unknowingly shame people or make assumptions about health literacy and socioeconomic disadvantage.

3.4.2 Aboriginal people have difficulty accessing primary care services

Stakeholders report Aboriginal people have trouble accessing primary care for many reasons. A lack of availability of care, inability to obtain an appointment, inability to afford the cost of care, and culturally insensitive care are all reasons people may not seek care.

Cultural awareness training alone does not necessarily lead to behaviour change in clinicians. Bias can be unconscious.

According to stakeholders, the delivery of holistic, comprehensive, and appropriate health care by local Aboriginal communities is important to improving health outcomes for Tasmanian Aboriginals.

ACCHOs are an important source of culturally safe, tailored primary care for many Indigenous Tasmanians. Stakeholders report that access to ACCHOs varies across Tasmania. Some Aboriginal people may not live near an ACCHO or may prefer to access a mainstream primary care provider instead of an ACCHO.

Low health literacy can be an issue experienced by Aboriginal Tasmanians, making it difficult to navigate the health system or to self-manage their chronic conditions.

Affordability of primary care is also a barrier to accessing primary care. Most mainstream GPs do not bulk-bill patients. Fees to attend specialist appointments may make specialist care unaffordable.

Transport is an issue affecting access to primary care, especially for Aboriginal people in rural communities. The Integrated Team Care (ITC) program commissioned by Primary Health Tasmania provides support to some of these people. For patients who are not linked with their ACCHO, access to transport is more limited.

3.4.3 Mainstream primary care and ACCHOs can work together

People accessing health services report difficulties navigating the health service system. It is sometimes unclear to patients and their families and caregivers which services they should use for specific health problems.

According to stakeholders, communication and information-sharing between different professionals and settings and ACCHOs can be improved.

Stakeholders report that Aboriginal people need better access to care for mental health and issues related to alcohol and other drug use. They need better access to support that meets their cultural care needs and that promotes social and emotional wellbeing. Mainstream services working with Tasmanian Aboriginal communities could provide better culturally tailored support for people.

3.4.4 There are gaps in the Aboriginal health professional workforce

Stakeholders report more needs to be done to increase participation of Aboriginal people in the health workforce. There are not enough paid positions in the health workforce for Aboriginal doctors, nurses, midwives, allied health professionals and ancillary workforce (including managers and administrative roles).

According to stakeholders, more identified positions are needed in mental health and alcohol and other drug services to better meet people's cultural care needs.

Aboriginal health workers provide specialised service delivery and fulfil a wide range of mainstream healthcare roles. They enhance the amount and quality of clinical services provided to Aboriginal and Torres Strait Islander people. According to stakeholders, this workforce needs to be expanded to meet the primary healthcare needs of people in our community.

3.5 Priority actions

Primary Health Tasmania is prioritising health outcomes of Tasmanian Aboriginal people. The goals and corresponding actions for 2021–25 are described below.

3.5.1 Improved access to culturally safe, person-centred primary care for Tasmanian Aboriginals

Improving the cultural safety of primary care services is a priority for Primary Health Tasmania. Primary Health Tasmania will work with Aboriginal stakeholders to:

- support initiatives to improve cultural safety of mainstream primary care services offered across the state; this includes offering training programs to practices as well as measuring and monitoring Tasmanian Aboriginals' patient experiences at these services
- increase capacity of ACCHOs to delivery primary care to meet the needs of their local communities
- support ACCHOs to respond to primary care needs within their communities, with a focus on social and emotional wellbeing, mental health, alcohol and other drug services, and comprehensive chronic conditions management.

3.5.2 Improve the management of chronic conditions

Many Indigenous people with chronic conditions experience worse health outcomes than their non-Indigenous peers. Primary Health Tasmania's priority is to improve the management of chronic conditions. Primary Health Tasmania will work with Aboriginal stakeholders to:

- increase uptake of Medicare Benefits Scheme Item 715 (and associated items) Indigenous Health Assessments
- build the capacity of ITC services to help people with chronic conditions access comprehensive chronic conditions management support, and improve chronic conditions outcomes
- support ITC services to collect, analyse, monitor and report on measures that are useful to demonstrate program outcomes and efficiency
- build relationships between ACCHOs and mainstream service providers to facilitate communication, information-sharing and collaborative primary care service delivery.

3.5.3 Build the Aboriginal and Torres Strait Islander health workforce

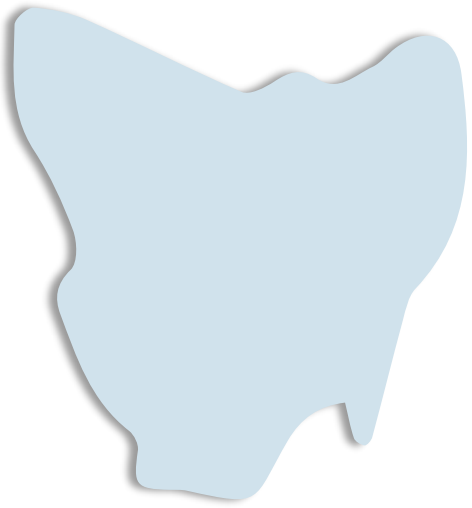
A priority for Primary Health Tasmania is to build workforce capacity and capability of Aboriginal health professionals. We will support ACCHOs to identify gaps in Aboriginal health workforce and support model of care development to address gaps.

Through our commissioning of services and partnership approach, we will support ACCHOs to:

- increase availability of Aboriginal health workforce within their own organisations
- increase availability of Aboriginal health workers within mainstream commissioned services
- facilitate partnerships between Aboriginal health workers in ACCHOs and commissioned mainstream services to foster collaborative primary care management of people where appropriate.

3.5.4 Capture meaningful data

A priority for Primary Health Tasmania is to support current commissioned services to collect, analyse, monitor and report on health measures. Meaningful data are needed to demonstrate program outcomes and efficiency to external funding sources including the Australian Government. Primary Health Tasmania will respectfully work with Aboriginal partner organisations to improve their ability to demonstrate the effectiveness of their services and the outcomes they achieve.



4

Mental health

4 Mental health

This chapter contains reference to suicide, which some people might find distressing. If you need help or would like to talk to someone, please call Lifeline on 13 11 14 or the Suicide Call Back Service on 1300 659 467.

4.1 Overview

Mental health problems and mental illness are one of the greatest causes of disability, reduced quality of life, and impaired productivity in our community.

4.1.1 Impact of mental illness

Mental and substance use disorders contributed 12% of Australia's total burden of disease in 2015, making it the fourth highest disease group contributing to the total burden.[114]

Mental health problems and mental illness are a significant health issue in Tasmania that have a substantial social and economic impact on our community. The burden of mental illness makes it harder for people to live fulfilling lives. It also has an economic impact on the state through increased use of health and other services, as well as indirect costs due to lost productivity when people are unable to work.[115]

Promoting good mental health, preventing mental health problems and mental illness, and reducing stigma and discrimination associated with mental illness are a shared responsibility between our government, service providers, individuals and communities.

In 2020, Primary Health Tasmania and the Tasmanian Department of Health released *Rethink 2020: A state plan for mental health in Tasmania 2020–2025*, a platform for service integration and planning in Tasmania.[116] This chapter draws substantially from the knowledge in that report.

A **mental illness** is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised criteria. The term mental disorder is also used to refer to these health problems.

A **mental health problem** also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness.

Australian Government, Department of Health

4.2 Health needs

4.2.1 Mental health problems are a major part of our burden of disease

About 1 in 5 people in our community will experience mental health problems in any year.

Most Tasmanians with mental health problems are living with a mild mental health disorder. Primary care services are the main group of health professionals that deliver care for mild mental health disorders.

Mental health problems are a major part of the Tasmanian burden of disease.

14,860 people are living with a severe mental health disorder

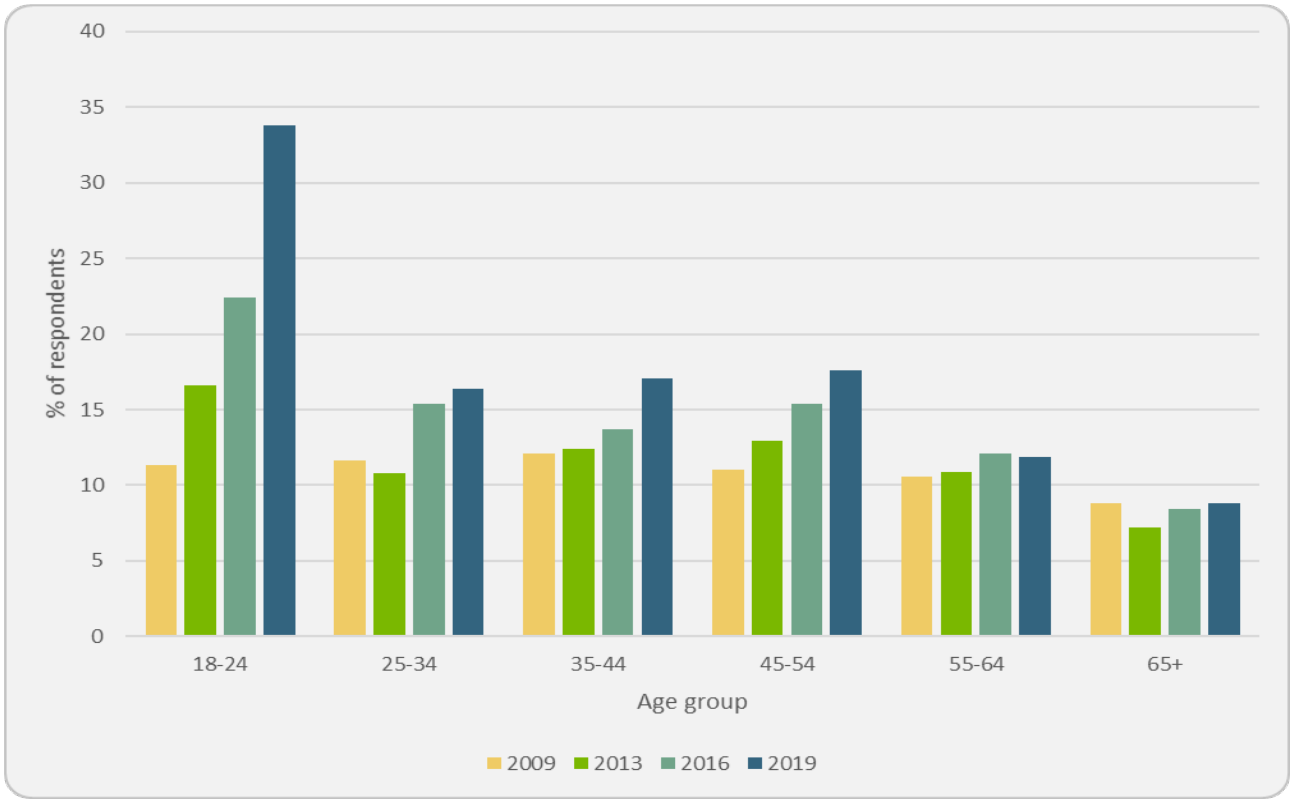
29,721 people are living with a moderate mental health disorder

59,442 people are living with a mild mental health disorder

Self-reported psychological distress is a measure of the burden of diagnosed and undiagnosed mental health problems affecting the Tasmanian population. Of all adults, just under 14% reported very high or high levels of psychological distress in 2019 (Figure 33).[37]

Levels of psychological distress are particularly high among younger Tasmanians aged 18–34 years and have increased substantially in the past decade. One-third of the 18–24 age group and more than one-quarter of the 25–34 age group reported very high or high levels of psychological distress in 2019.

Figure 33. Self-reported psychological distress, Tasmanian Population Health Survey: 2009–19



Mental health problems include mood disorders such as depression, anxiety disorders, psychotic disorders, eating disorders, trauma-related disorders, and substance abuse disorders.

Between 2009 and 2019 the percentage of Tasmanian adults reporting ever being diagnosed with anxiety or depression increased from 21.4% in 2009 to 33.6% in 2019.[37]

The burden of mental health problems and mental illness is concentrated in people who are most socioeconomically disadvantaged.[70]

4.2.2 People with mental illness often have additional physical health issues

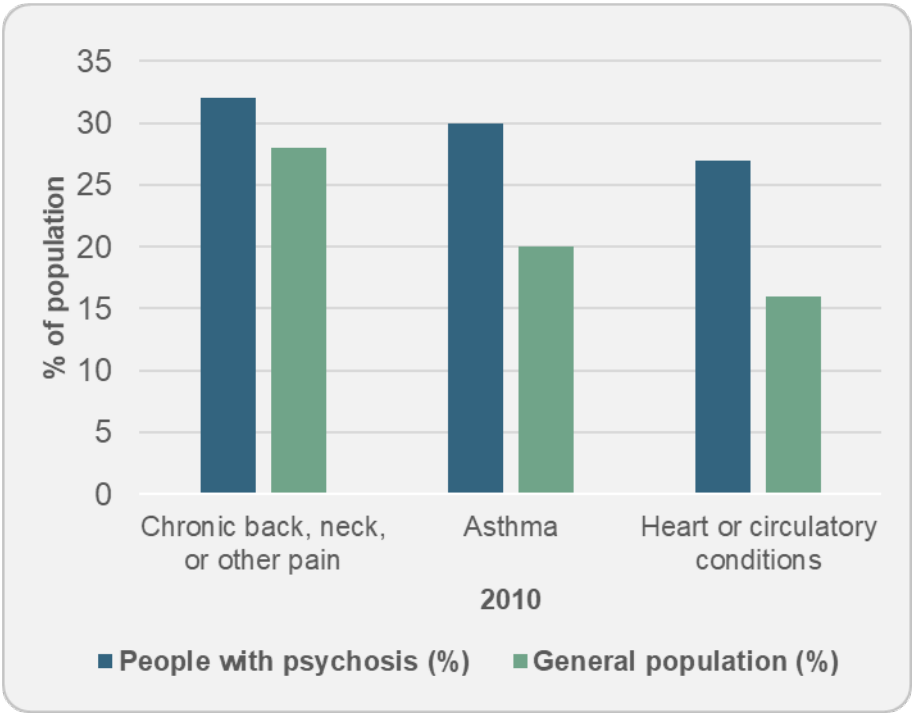
Most people with mental illness also have chronic disease.

People living with mental illness have poorer physical health than other Australians, as their physical health needs are often overshadowed by their mental illness. According to results of the 2017–18 Australian Health Survey, for people who reporting having a mental illness:

- the most common additional health conditions that people living with mental illness experience are arthritis (including back problems), asthma, and heart and vascular disease
- people with self-reported mental illness experience significantly more heart/stroke/vascular disease (7% vs 4%), arthritis (23% vs 13%), and diabetes (7% vs 4%) compared with the general population.

People living with severe mental illness have a reduced life expectancy of 15–20 years compared with people without severe mental illness.[117] The second national survey of People Living with Psychotic Illness[118] also provides estimates on the physical health of Australians living with psychosis. Chronic back, neck or other pain were the most common chronic physical conditions (32% compared with 28% for the general population) identified among people with psychosis in 2010. Other common conditions included asthma (30% compared with 20% for the general population) and heart or circulatory conditions (27% compared with 16%).

Figure 34. Physical health of people living with psychosis compared with the general population, Australia | 2010



Physical health treatment rates for people living with mental illness are reported to be around 50% lower than for people with only a physical illness. This leads to physical conditions being undiagnosed and untreated, which can prove fatal.[119]

About 67% of people who die by suicide in Tasmania have a reported physical illness and 46% experience acute, chronic or cancer-related pain in the period leading up to death.[120]

People with severe and enduring mental illness die 15–20 years earlier than the general population. Eating disorders are also associated with high mortality rates.[121]

4.2.3 Psychosocial needs of people with mental health disorder are substantial

The psychosocial support needs of people with psychotic illnesses are substantial and largely unmet.[118]

- Nearly one-quarter of people with psychotic illness report feeling socially isolated and lonely.
- Two-thirds say their illness makes it difficult to maintain close relationships.
- Almost one-third live alone; however, 40.6% of reported they would prefer to be living with someone else.
- The majority of people had at least one friend (86.5%), however, 13.3% had no friends at all, 14.1% had no one they could rely on, and 15.4% had never had a confiding relationship.
- Two-thirds (68.6%) had not attended any social programs and a similar proportion (69.4%) had not attended any recreational activities.
- More than one-half (56.4%) of people with psychotic illness reported receiving no or minimal support from any source.

4.2.4 More than one-half of people who died by suicide in Tasmania had a previous mental illness diagnosis

Suicide was the leading cause of death among Tasmanians aged 15–44 years in 2019 and accounted for the highest number of years of life lost. Tasmania has a higher rate of suicide than the rest of Australia. The age-standardised suicide rate in Tasmania in 2018 was 15 per 100,000 people, compared with 12.1 per 100,000 nationally.[119] Suicide rates are higher among males than females in all age groups, and are highest among men aged 35–64.[120]

The reasons for suicide are complex and multifaceted. Suicide is not always connected to mental illness. Suicide attempts are often linked to feelings of helplessness or being overwhelmed by a situation. These stressful life events can include relationship difficulties, social isolation, loss of a job or income, and financial or housing stress. However, more than one-half (60%) of people who died by suicide in Tasmania in 2012–16 had at least one previous diagnosis of a mental illness. A similar proportion (64%) of people who died by suicide had received mental health treatment in the 12 months leading to death, and nearly half (47%) received treatment in the 6 weeks leading to death, most commonly from a GP.[120] For people with available toxicology reports, pharmaceutical drugs had been consumed before death by 72%, alcohol by 35%, and illicit drugs by 13%.

Suicide prevention has been identified as a national priority and in December 2018, it was elevated to a whole-of-government issue. The *Fifth national mental health and suicide prevention plan (Fifth plan)* commits all governments to work together to achieve better mental health and suicide prevention outcomes, including through integration in planning and service delivery at a regional level. Improvements in mental health services are imperative, however an effective suicide prevention response may require concerted action by law enforcement agencies, planning and infrastructure developers, transport providers, social support agencies, housing providers and health agencies.[119]

4.3 Service needs

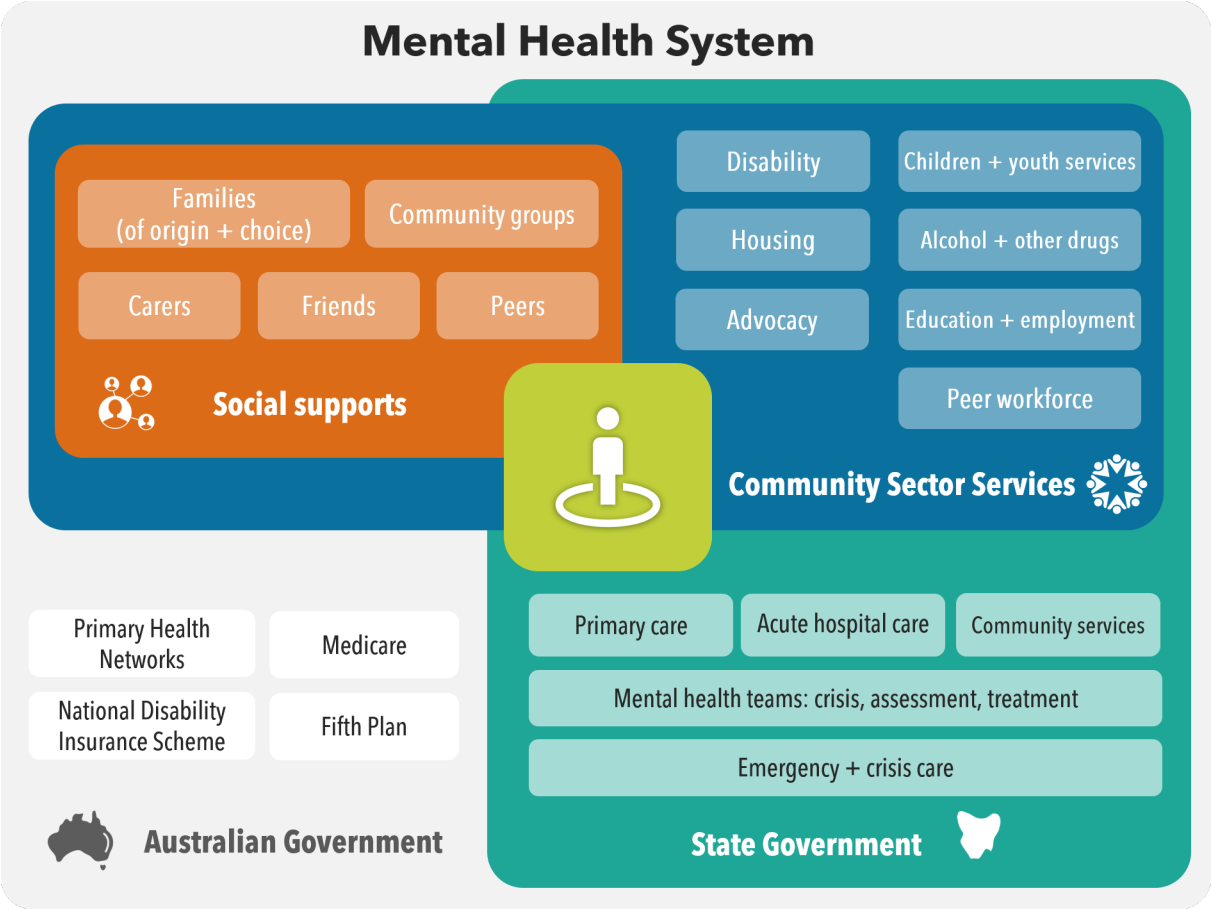
4.3.1 Tasmania's mental health system is complex

A range of mental health-related services are provided in Tasmania by various levels of government. The Tasmanian Government provides mental health care through public hospitals, including emergency departments, residential mental healthcare services and community mental healthcare services. The Australian Government funds consultations with specialist medical practitioners, GPs, psychologists and other allied health practitioners through the Medicare Benefits Scheme and other primary mental health services through the Primary Health Networks.

Access to psychologists may be subsidised through Medicare with the preparation of a Mental Health Treatment Plan by a GP, depending on eligibility. Mental health care is also provided in private hospitals.

In addition to specialised services, both levels of government provide support to population mental health crisis and support services, such as Lifeline and Beyond Blue. Support for psychosocial disability is also provided through the National Disability Insurance Scheme and by the non-government mental health sector.

Figure 35. Tasmania's mental health system



The *Fifth national mental health and suicide prevention plan* and Tasmania's *Rethink 2020* mental health strategy describe the mental health system as complex, fragmented, and difficult to navigate. Both the national strategy and *Rethink 2020* commit Primary Health Tasmania and the Tasmanian Government to develop an integrated mental health system in Tasmania.

Developing an integrated mental health system that supports better outcomes for consumers and their families and carers is important. Progress has been made since the original *Rethink mental health* report was released in 2015. *Rethink 2020* describes ten Reform Directions for mental health care in Tasmania.

Integration means bringing together services and systems that are aiming for the same outcome. Integration can provide more flexible and responsive services for people and aims to make system navigation easier.

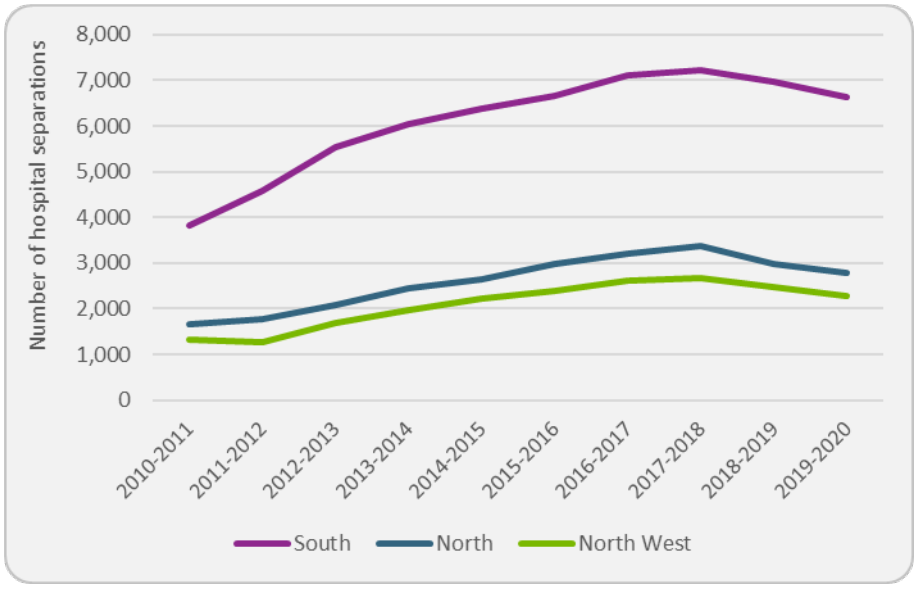
Rethink 2020: Key Reform Directions

	Empowering Tasmanians to maximise their mental health and wellbeing.
	A greater emphasis on promotion of positive mental health, prevention of mental health problems and early intervention.
	Reducing stigma.
	An integrated Tasmanian mental health system.
	Shifting the focus from hospital-based care to support in the community.
	Getting in early and improving timely access to support (early in life and early in illness).
	Responding to the needs of specific population groups.
	Improving safety and quality.
	Supporting and developing our workforce.
	Monitoring and evaluating our action to improve mental health and wellbeing.

4.3.2 Hospital service use for mental health problems is increasing over time

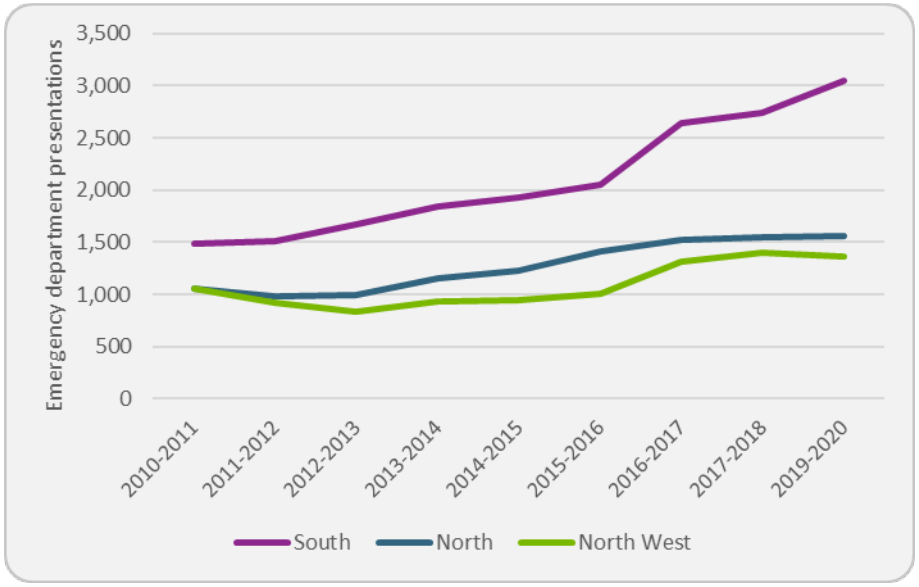
The number of hospital separations in people with mental and behavioural disorders has increased in Tasmania since 2010–11 (Figure 36).

Figure 36. Public hospital separations, mental and behavioural disorders, Tasmania | 2010–11 to 2019–20



Emergency department presentations in people with mental and behavioural disorders have also increased in Tasmania since 2010–11 (Figure 37).

Figure 37. Public hospital emergency department presentations, mental and behavioural disorders, Tasmania | 2010–11 to 2019–20

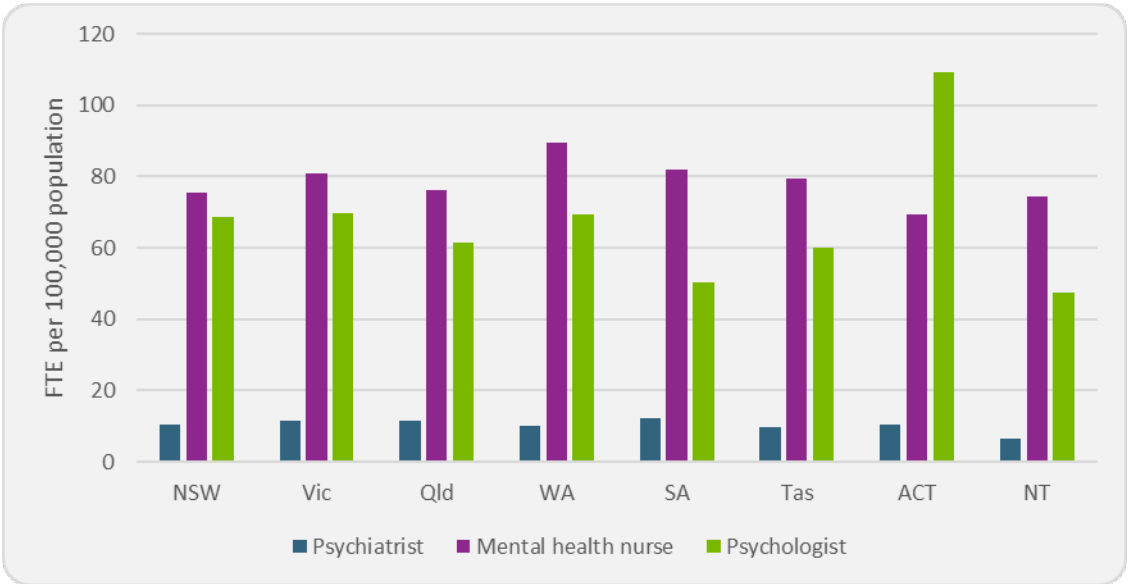


4.3.3 Tasmania has a smaller mental health workforce compared with other jurisdictions

Tasmania provides clinical community-based mental services through 17 specialist, multidisciplinary teams which are located across the state, operating on a regional basis. Each team has a designated area of responsibility. These teams operate over extended hours in the community to provide triage, crisis support, assessment, and treatment. In addition, teams located in general hospitals provide specialist consultation liaison services. The only exception is the Mental Health Service Helpline located in Hobart which provides a statewide service.

However, the number (full-time equivalent) of psychiatrists and psychologists per 100,000 population is smaller in Tasmania than many other jurisdictions (Figure 38).[122]

Figure 38. Clinical full-time equivalent mental health disciplines per 100,000 population, Australian states and territories | 2017



4.3.4 GPs provide most of the care for people with mental illness

The 2007 National Survey of Mental Health and Wellbeing (the most recent survey) collected data on mental health service access in the preceding 12 months. From this survey, it was estimated that about one-third (35%) of people with symptoms of a mental health problem in the previous 12 months made use of mental health services.[123] Of these:

- 71% consulted a GP
- 38% consulted a psychologist
- 23% consulted a psychiatrist.

More recent estimates suggest that the treatment rates identified in 2007 have increased (to 46% in 2009–10), influenced by the introduction of government-subsidised mental health treatment items to Medicare.[124]

In 2018–19, 9% of the Australian population received clinical mental health services through a GP, 2% from a private psychiatrist, and 2% received clinical mental health services through a public specialised service (for example, hospital or community care).[125]

In Tasmania, GPs provide most of care for people who have mental health problems, with psychologists the second-most common community level service provider. In 2019, about 3 out of 4 Tasmanians visited a GP and 1 in 5 of them had a diagnosed mental health condition.[105]

COVID-19 has further influenced treatment patterns. During the course of the COVID-19 pandemic in 2019–20, 45% of MBS mental health-specific services were provided by psychologists (including clinical psychologists), 31% were provided by GPs and 20% were provided by psychiatrists.[125]

Medicare data show that Tasmanians use Medicare-subsidised mental health specific services such as GPs and psychologists at a lower rate than the national average. However, data from the Pharmaceutical Benefits Scheme reveals that prescription rates for mental health issues are significantly higher than the national average.[105,126]

This may reflect issues such as:

- GPs not being aware of the mental health Medicare item numbers
- people having difficulty getting in to see a psychologist
- affordability or out-of-pocket cost of seeing a psychologist.

Expanding access to mental health-specific services is necessary to enable better management of mental health problems at a primary care level.

4.3.5 Commissioned mental health services are improving outcomes

Funding by the Australian Government Department of Health has been provided to PHNs nationally through a Primary Mental Health Care flexible funding pool to support commissioning of mental health and suicide prevention services. Key service delivery areas include:

- low-intensity psychological interventions for people with, or at risk of, mild mental illness
- short-term psychological therapies delivered by mental health professionals
- psychological interventions for youth with severe mental health problems
- early intervention services for children and young people with, or at risk of mental illness
- services for adults with severe and complex mental illness who are being managed in a primary care setting
- psychosocial support for people with severe mental health problems.

Primary Health Tasmania also commissions psychological services for people in residential aged care and for people who are experiencing mental health impacts from bushfires. Most commissioned services are for delivery of short-term interventions to people with mild to moderate mental illness (Table 6).

Table 6. Profile of Primary Health Tasmania commissioned mental health programs | 2018–19 to 2020–21

Program	Clients	Episodes	Services
Low-intensity	1,426	1,458	10,547
Short-term	4,688	5,868	35,873
Youth severe	288	313	15,931
ASC	554	573	18,280
Psychosocial	315	336	9,834
Aged	354	366	2,617
Bushfires	109	136	1,129

Funded providers are required to collect information from their clients about their illness severity at entry to the service, and outcomes achieved over the course of the episode of care. The Kessler 10 (K10) measure is used as a proxy for illness severity and outcomes. K10 is an evidence-based measure of psychological distress that has been shown to correlate with the presence of underlying mental health problems. People with a K10 measure of less than 20 are considered to have no psychological distress, those with a measure of 20–24 have mild psychological distress, a measure of 25–29 indicates moderate psychological distress and >29 indicates severe psychological distress.

At baseline, the mean psychological distress levels of people accessing commissioned residential aged care mental health services is mild, those accessing bushfire recovery services and low-intensity services is moderate and all other programs is severe psychological distress. A statistically significant improvement in psychological distress was observed across all commissioned mental health services (Table 7).

Table 7. Mean pre- (entry or review) and post- (review or exit) K10 score, clients of commissioned health services, Primary Health Tasmania | 2018–19 to 2020–21

Program	Pre-K10 score (n)	Post-K10 score (n)
Low-intensity	25.7±7.7 (351)	17.6±5.0 (189)
Short-term	30.1±8.1 (1,617)	25.8±8.7 (746)
Youth severe	33.1±8.5 (87)	29.3±10.2 (38)
ASC	33.8±8.6 (302)	27.4± 9.3 (247)
Psychosocial	x	x
Aged	24.4±6.2 (303)	19.9±5.2 (186)
Bushfires	28.7±8.7 (22)	24.9±7.5 (10)

*p<0.001 pair test, x=data not available.

Primary Health Tasmania also commissions mental health services for young people through headspace centres in Tasmania's three regions. Over 6000 young people received services in the last three-year period (Table 8).

Table 8. Profile of the headspace program in Tasmania | 2018–19 to 2020–21

Region	Clients (no.)	Episodes (no.)	Services (no.)
South	3,806	5,947	20,867
North	2,609	4,023	15,054
North West	687	855	3,106

Outcomes achieved by services are measured using K10. The majority of young people for whom K10 measures are available at service commencement and at follow-up, experience either stable levels of psychological distress over time or an improvement in their psychological distress (Table 9).

Table 9. Outcome of services by K10 score, people who received services from headspace, Tasmania | 2018–19 to 2020–21

Region	Outcome group (%)		
	Significant improvement	No significant change	Significant deterioration
South (n=438)	28.1	58.0	13.9
North (n=174)	27.6	60.9	11.5
North West (n=41)	26.8	65.9	7.3

4.4 Stakeholder perspectives

Consultation with stakeholders indicates Tasmania is experiencing many challenges in meeting the care and support needs of people with mental health problems, their carers and their families.

4.4.1 People want an integrated mental health service experience with streamlined intake assessment

People accessing mental health services report difficulties navigating the mental health service system. It is unclear to patients and their families and caregivers which services they should access for specific mental health problems.

When services are accessed, people report service providers do not always communicate and share relevant information with each other, which results in people having to tell their story multiple times and contributes to gaps in continuity of mental health care.

People with severe mental health problems are increasingly accessing disability services through the National Disability Insurance Scheme (NDIS) to meet their care needs. People accessing NDIS services report limited information-sharing and communication between disability and health providers, which contributes to gaps in coordination of care.

People with mental health problems, their families and caregivers, and their primary care providers advocate for greater integration of the mental health service system for a seamless patient experience. This will require better communication and information-sharing between providers. Additionally, an intake assessment process is recommended that will standardise the process of assessing people's care needs and directing them to the most appropriate service to meet these needs.

4.4.2 We need to address gaps in mental health services

People report it is difficult to access urgent mental health care outside working hours, particularly after-hours or on weekends. This is a problem for people in crisis, who present to emergency departments for care during these periods. Limited options for mental health care during after-hours and weekends periods are also a problem for people with mental health problems who are at working during normal working hours and for those with carer responsibilities.

People living in rural and remote areas of Tasmania experience difficulties accessing mental health services compared with Tasmanians living in more regional areas. Internet connectivity in rural and remote areas of Tasmania is limited and is a barrier in accessing online modality of mental health services. Many mental health services are brokered from private providers by funders, which can increase the overall cost of delivering mental health services.

Service provision is heavily weighted towards the south of the state, where most of the population lives, but also where most of the specialist mental health workforce lives. This has implications for those living in regional areas who find it difficult to access local mental health support. This occurs due to transport disadvantage, long waiting lists and large out-of-pocket expenses to see private psychiatrists.

Children with mental and behavioural problems are experiencing long delays in accessing clinical paediatric clinical psychologists, in the north and north west of the state.

4.4.3 Workforce issues are ongoing in Tasmania

Tasmania continues to experience difficulties recruiting and retaining a mental health workforce that is sufficient to meet people's mental health care needs. Demand for services is high and clients experience difficulties in accessing services with wait lists a common feature. Limited capacity across the whole mental health sector is also commonly reported.

Children with mental and behavioural problems need access to a multidisciplinary paediatric care team that can assess their physical, mental and developmental care needs. People report long delays in accessing paediatric clinical psychologists, particularly for psychometric assessment and behavioural management. Delays are very long in the north and north west of Tasmania. Most services are delivered in the private sector as public health services have experienced ongoing issues recruiting to paediatric psychology positions.

In youth services, recruiting appropriately qualified mental health workers also remains a challenge. Providers report access to specialist psychiatric services as challenging. Providers struggle to find suitably skilled and experienced staff to work in the youth mental health sector.

Tasmania has limited availability of psychiatrists and psychologists compared with other jurisdictions. The availability and recruitment of credentialled mental health nurses continues to be problematic and challenging for adult service providers.

Tasmania has very limited psychogeriatric service availability and a limited psychogeriatrics workforce. As a result, other clinical disciplines care for people with psychogeriatric care needs, which is not ideal.

Staff turnover is reported as problematic in this very mobile workforce.

GPs provide the majority of mental health services for people with mental health problems. Tasmania is experiencing ongoing shortages of GPs, particularly in rural areas.

4.4.4 There are significant data gaps

There is a need to address the significant lack of data about who, how and when people with mental health issues access services. There is a lack of information about which acuity of patients accesses which levels of the service system, or about the appropriateness of movement of people between different levels of the service system.

Addressing this data gap will provide valuable information about how best to target services to people with mental health problems.

4.5 Priority actions

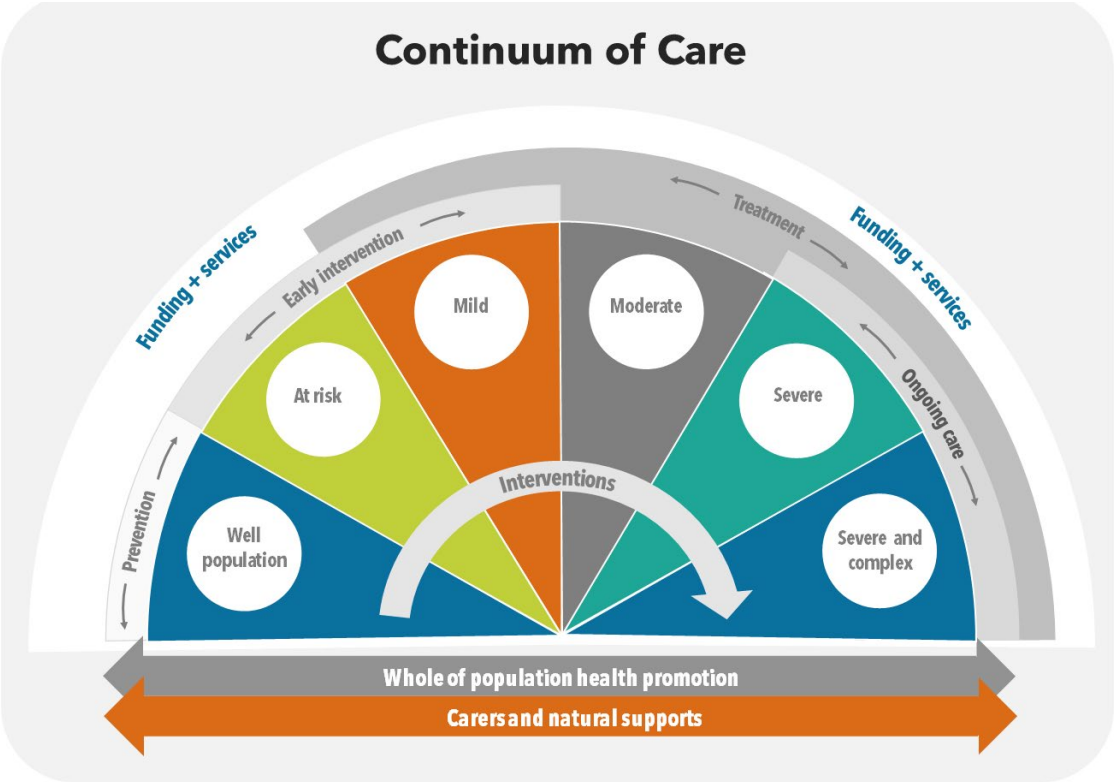
4.5.1 Commission across spectrum of need and continuum of care

Primary Health Tasmania will continue to commission services that support and feed into a stepped-care approach or continuum of care. This is an evidence-based, staged system with different levels of interventions from the least to the most intensive that is best suited to each person's needs. Within this approach, people are supported to transition up to higher intensity services or transition down to lower intensity services as their needs change.

In Tasmania, this is reflected in the Tasmanian Mental Health Continuum of Care Model, which is based on feedback from consumers and their families and friends across Tasmania (Figure 39).

4.5.2 Establish a primary mental health service gateway in North Tasmania

Figure 39. Tasmanian Mental Health Continuum of Care Model



People in the north and north west of Tasmania have less availability of primary mental health services than people in the south.

Primary Health Tasmania will establish a primary mental health service gateway in the north. This service will enable adults with mild to moderate complexity mental health problems to access comprehensive assessment, multidisciplinary management and coordinated referral to higher level mental health services where required.

4.5.3 Address gaps in mental health services

Primary Health Tasmania commissions services to address gaps in primary care. Currently most of Primary Health Tasmania's commissioned mental health services are for youth mental health, with headspace services receiving the largest proportion of commissioning resources.

Primary Health Tasmania will continue to commission to address gaps in primary mental health care, providing commissioned:

- low-intensity services
- short-term psychological interventions
- youth mental health services, including youth severe services
- primary mental health care and psychosocial support for adults with severe and complex mental health problems
- mental health care for older people living in residential aged care.

We will commission primary mental health services for rural Tasmanians to address gaps in the delivery of mental health care in rural areas.

4.5.4 Strengthen suicide prevention and early intervention

Primary Health Tasmania will continue to work with the Tasmanian Department of Health and other stakeholders to renew the Tasmanian Suicide Prevention Plan, deliver community-based suicide prevention activity against evidence-based best practice, and support the development and delivery of the Way Back Support Service for people who have attempted suicide.

Primary Health Tasmania is a National Suicide Prevention Trial site. We are focussing on the delivery of activities to prevent suicide in men aged 40–64 years and in both men and women aged 65+. The trial is being conducted in three locations in the north and north west.

4.5.5 Improve data analysis

Primary Health Tasmania will work with the University of Tasmania's Tasmanian Data Linkage Unit to collate, analyse and share results from a mental health linked data set. The analysis will inform the sector's understanding of people's touchpoints across the mental health service system, identify service gaps and highlight opportunities for mental health service improvement.

5

Alcohol and other drugs

5 Alcohol and other drugs

5.1 Overview

Alcohol and other drug (AOD) use is a major cause of preventable disease, illness, and death in our community. Alcohol is the drug most used by people and is associated with chronic disease and injury. It is also the most common drug for which people seek treatment.[127]

'Other drug use' or 'illicit drug use' (used interchangeably) can include:[128]

- illegal drugs – drugs that are prohibited from manufacture, sale or possession in Australia; for example, cannabis and heroin
- pharmaceuticals – drugs that are available from a pharmacy, over the counter or by prescription, which may be subject to misuse; for example, prescription painkillers
- other psychoactive substances – legal or illegal, potentially used in a harmful way; for example, inhalants such as petrol.

AOD use is associated with a health, social and economic burden.

Health burden

AOD use is associated with increased rates of mental illness, infectious disease, injuries, and death. It can contribute to pregnancy complications, cancer, cerebrovascular, cardiovascular, liver and digestive diseases.

Social burden

Misuse of alcohol and drugs contributes to domestic and sexual violence, crime, road accidents, work-related harm, and community safety issues.

Economic burden

Economically, AOD use places strain on individual household expenditure and contributes to lost productivity. The cost to our community support systems includes health care, hospitals, law enforcement and justice.

People affected by alcohol and other drugs need access to quality treatment and support services. A priority for Primary Health Tasmania is achieving an integrated system where people receive appropriate services along the continuum of care.

Primary Health Tasmania’s priority actions in alcohol and other drugs treatment are to:

- provide commissioned community-based services for AOD treatment
- address data gaps in commissioned services
- build the capacity of the AOD treatment sector.

Alcohol is the most used drug and is also the most common drug for which people seek treatment.

5.2 Health needs

The consumption of alcohol and other drugs is a major cause of preventable disease, illness and death in Tasmania.

5.2.1 Alcohol and other drug use in Tasmania

The National Drug Strategy Household Survey collects information on alcohol and other drug use in Australia and gives us a snapshot of alcohol and other drug use by state.

According to the most recent survey results in Tasmania in 2019 among people aged 14 and over:

- 1 in 4 people consumed 5 or more drinks in one sitting (at least monthly)
- 1 in 6 people used an illicit drug in the past 12 months.

Rates of alcohol consumption are higher in Tasmania than Australia as a whole, whereas rates of illicit drug use are similar in Tasmania compared with Australia (Table 10).

To reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day.

NHMRC. Australian guidelines to reduce health risks from drinking alcohol. December 2020

Table 10. Selected statistics on AOD use in Tasmania compared to Australia | 2019

	Tasmania (%)	Australia (%)
Drank alcohol in the previous 12 months	83.2	71.2
Consume 5 or more drinks in one sitting (at least monthly)	26.3	24.8
Used an illicit drug in the past 12 months	16.5	16.4

5.2.2 Alcohol consumption is a problem in Tasmania

Alcohol is the most widely used drug in Tasmania. An estimated 83% of Tasmanians consume alcohol each year. The proportion of Tasmanians drinking daily, weekly, monthly or less than monthly, or who are ex-drinkers, has not changed significantly between 2016 and 2019.

Many of us consume alcohol responsibly for social or cultural reasons. However, some people misuse alcohol with resulting health, social and economic impacts. In Tasmania, 1 in 4 people drink alcohol at levels that exceed single-occasion risk (consume 5 or more drinks in one sitting at least monthly) and 16.6% drink alcohol at levels that exceed the lifetime risk for alcohol-related harm. Rates of lifetime risk and single-occasion risk have decreased since 2007.

Alcohol misuse has health, social and economic impacts on individuals and communities. In 2019, 1 in 5 Tasmanians were victims of an alcohol-related incident, including experiencing:

- verbal abuse (16.9% of people)
- physical abuse (5.1% of people)
- put in fear (10.2% of people).

Single-occasion risk is drinking more than 4 standard drinks on any one occasion.

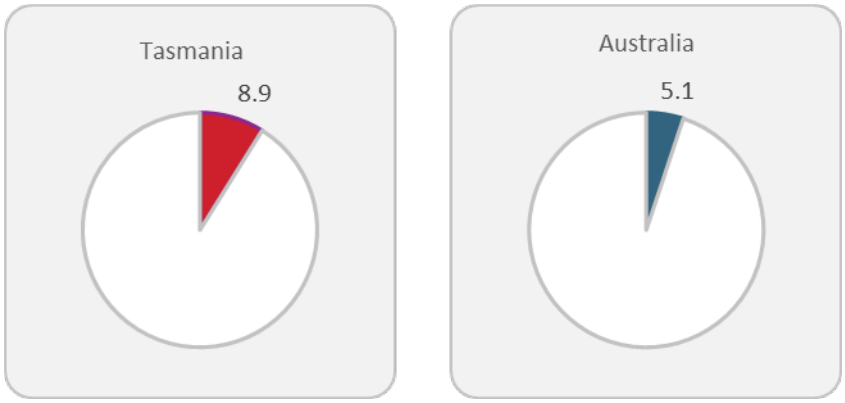
Lifetime risk is drinking more than 2 standard drinks a day.

Alcohol consumption contributes to preventable death in Tasmania

Deaths that are directly attributable to harmful alcohol consumption occur due to liver disease, mental and behavioural disorders, cardiomyopathy and other chronic conditions (for example, pancreatitis). Two-thirds of alcohol-induced deaths are due to liver disease. Deaths directly attributable to alcohol have declined nationally since the late 1990s to 5.1 per 100,000 persons in 2017, compared with 6.6 per 100,000 persons in 1997. People most likely to die from a cause directly attributable to alcohol are males aged 60–64 years, people with chronic alcoholic liver disease, and people living outside of a capital city.

Death rates from harmful alcohol consumption are higher in Tasmania than Australia as a whole. In 2017, there were 8.9 deaths per 10,000 population compared to 5.1 deaths per 10,000 population in Australia (Figure 40).[129]

Figure 40. Alcohol-induced deaths, rate per 100,000 population, Tasmania and Australia | 2017



Alcohol-related deaths extend beyond those deaths which are directly attributable to alcohol. In 2017 there were 4186 deaths nationally where alcohol was mentioned as being a contributing factor. Deaths due to injury, including suicide, transport accidents and falls were the most common causes of death to have alcohol mentioned as a contributory factor. Younger Australians are more likely to have alcohol as an associated factor to death, often as a result of single-occasion risky drinking (for example, acute alcohol intoxication and impaired judgement that influenced the death event). The older population are more likely to have a chronic condition related to long-term harmful alcohol consumption.

5.2.3 Illicit drug use contributes to preventable harm in Tasmania

Illicit drug use and prescription drug misuse is associated with death, illness, injury, social and family disruption, lost opportunities for education and employment, and increases in crime.[130]

Rates of illicit drug use in Tasmania are stable over time

Illicit use of drugs includes use of illegal drugs, and misuse or non-medical use of some pharmaceuticals.

In 2019, about 1 in 6 Tasmanians had used an illicit drug in the previous 12 months which is similar to the national average.[131] Rates of illicit drug use in 2019 were similar to 2016 (17.4%) and 2001 (14.4%). However, the type of illicit drug used has changed over time (Table 11). In 2019, painkillers and opioids used for non-medical purposes were the second most commonly used illicit drug in the previous 12 months after cannabis (Table 11).

Table 11. Top 5 illicit drugs used in the previous 12 months, people aged 14+, Tasmania | 2001, 2016 and 2019

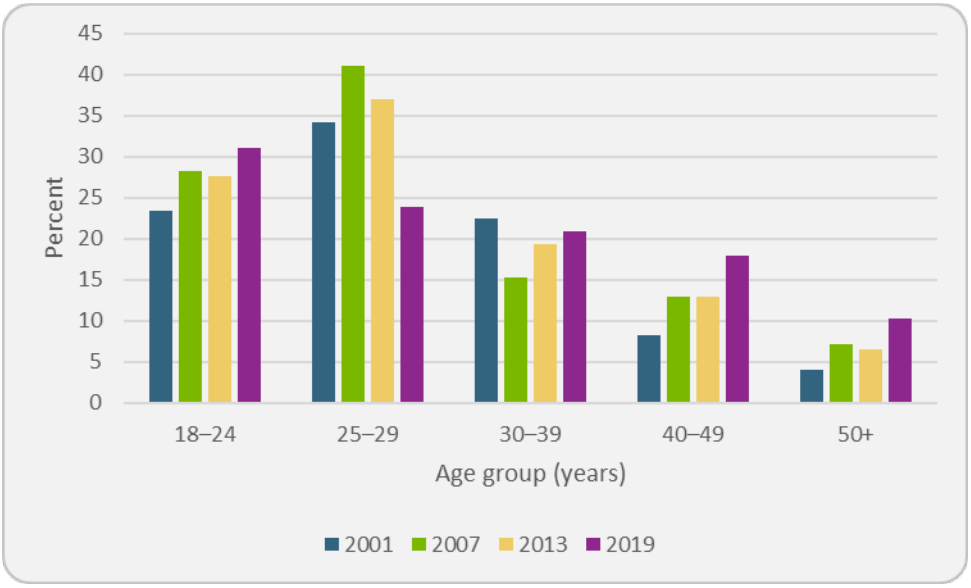
Rank	2001		2016		2019	
	Drug	%	Drug	%	Drug	%
1	Cannabis	11.9	Cannabis	12.4	Cannabis	12.6
2	Meth/amphetamine	2.1	Tranquillisers/sleeping pills	2.9	Ecstasy	*2.4
3	Hallucinogens	*1.0	Hallucinogens	*2.2	Cocaine	*1.6
4	Injected drugs	*1.0	Meth/amphetamine	*2.1	Tranquillisers/sleeping pills	*1.3
5	Tranquillisers/sleeping pills	*1.0	Ecstasy	*2.0	Methadone/buprenorphine	*0.9

*Estimate has a relative standard error of 25% to 50% and should be used with caution.

Rates of illicit drug use vary according to age group

In 2019, rates of illicit drug use were highest in Tasmanians aged 18–24 years. Between 2001 and 2013, rates of illicit drug use were highest in Tasmanians aged 25–29 years (Figure 41).

Figure 41. Illicit drugs used in the previous 12 months, according to age category, age 18+, Tasmania | 2001, 2016, 2013 and 2019



Illicit drug use impacts individuals and communities

Similar to alcohol misuse, illicit drug use has health, social and economic impacts on individuals and communities. In 2019, 1 in 5 Tasmanians were victims of an illicit drug-related incident, including experiencing:

- verbal abuse (7.6% of people)
- physical abuse (2.2% of people)
- put in fear (6.3% of people).

5.3 Service needs

AOD treatment services assist people to address their drug use. The goals of treatment can include reducing or stopping drug use as well as improvements to social and personal functioning. Assistance may also be provided to support the family and friends of people using drugs.

In 2019–20, publicly funded AOD treatment agencies provided treatment to an estimated 139,000 clients nationally. The four most common drugs that led clients to seek treatment for their own drug use were alcohol (34% of all treatment episodes), amphetamines (28%), cannabis (18%) and heroin (5%). Almost two-thirds of all clients receiving treatment were male, and the median age of clients was 35 years.[132]

5.3.1 Tasmania's specialist alcohol and other drug treatment services

In 2019–20 there were 23 specialist alcohol and other drug treatment agencies in Tasmania, 15 were non-government agencies and 8 were government treatment agencies.

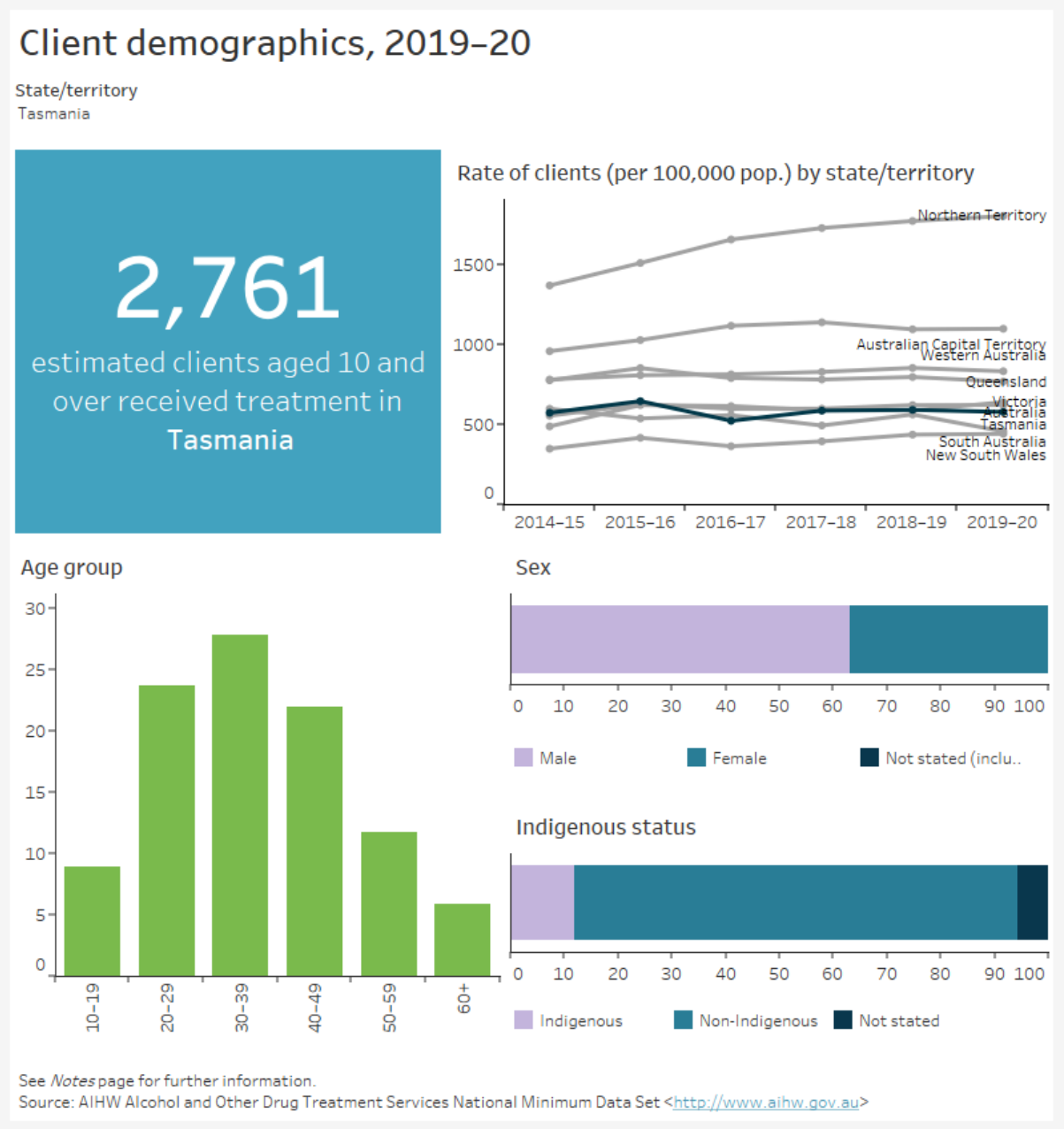
There were 2761 Tasmanians aged 10 years and over who received treatment from specialist alcohol and other drugs services in 2019–20. Our rate of treatment is 580 people per 100,000 population, which is lower than the national treatment rate of 624 people per 100,000 population.[133]

Approximately 63% of Tasmanians who received specialist treatment were male and 11.9% identified as Aboriginal. Tasmanians aged 30–39 years were most likely to receive specialist services (Figure 42).

Access to evidence-based, quality alcohol and other drug information and treatment services should be seen as a basic right of all Tasmanians.

Alcohol, Tobacco and other Drugs Council Tasmania

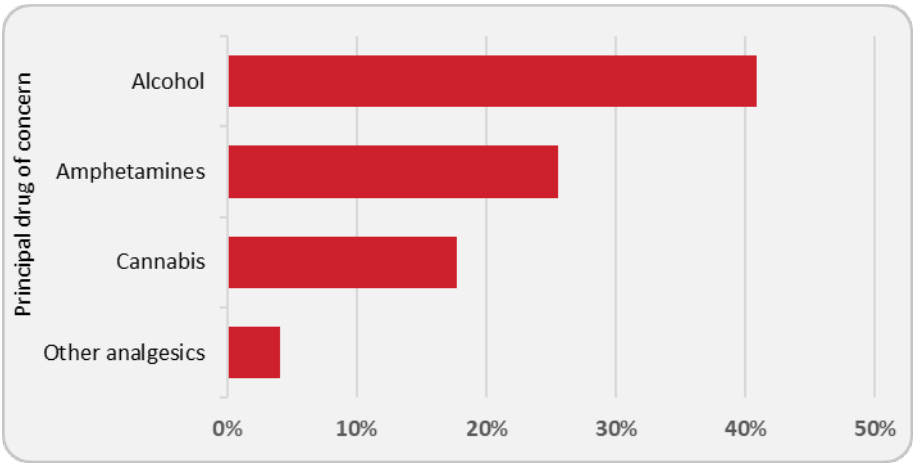
Figure 42. Alcohol and other drug treatment services, client demographics, Tasmania | 2019–20



Most specialist treatment is provided for alcohol-related concerns

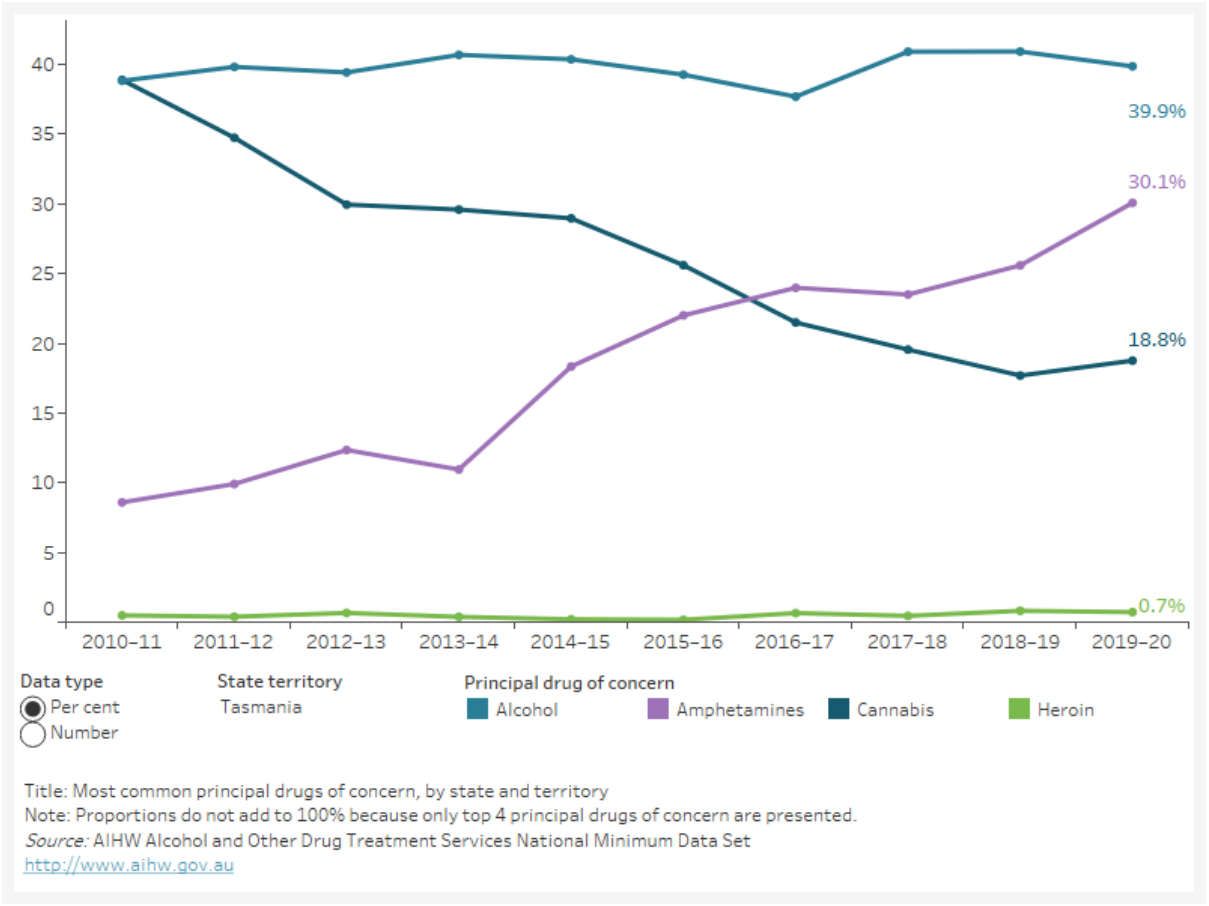
Alcohol is the most common drug of concern for Tasmanians who attended specialist alcohol and other drugs treatment services, followed by amphetamines and then cannabis (Figure 43).

Figure 43. Proportion of closed treatment episodes for own drug use by drug of concern, Tasmania | 2019–20



Rates of people seeking treatment for alcohol as a principal drug of concern have been stable in Tasmania since 2010–11 whereas rates of people seeking treatment for amphetamines have increased (Figure 44).[132]

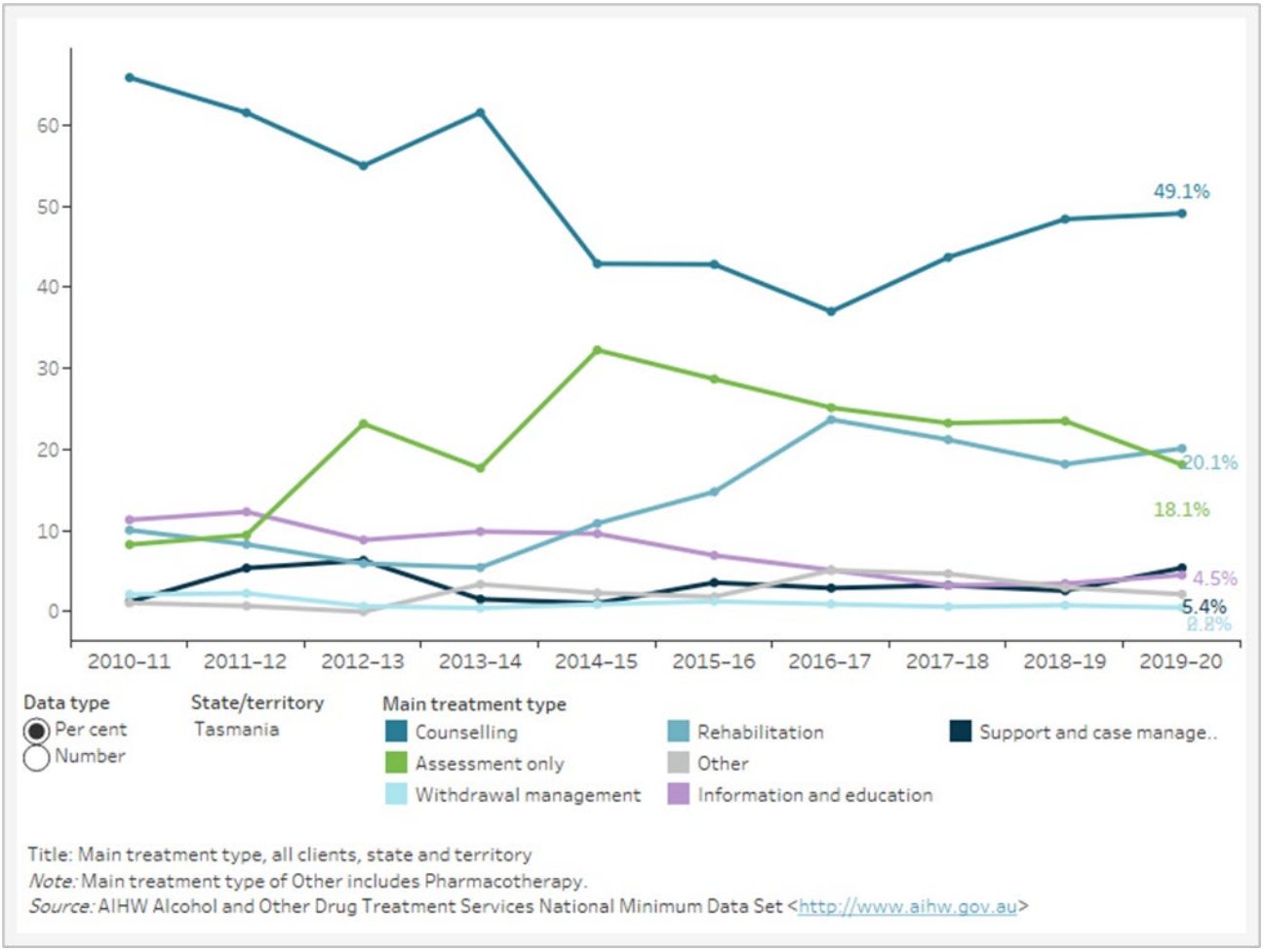
Figure 44. Presentation rates for principal drugs of concern, Tasmania | 2010–20



The main treatment provided by specialist alcohol and other drugs services is counselling

Counselling is the most common treatment received by Tasmanians accessing specialist alcohol and other drugs treatment services. Rates of counselling as the main treatment type have decreased since 2010–11 and rates of rehabilitation as the main treatment type have increased (Figure 45).

Figure 45. Main treatment type provided by specialist AOD services, Tasmania | 2010–20



5.3.2 Other services that provide care and support

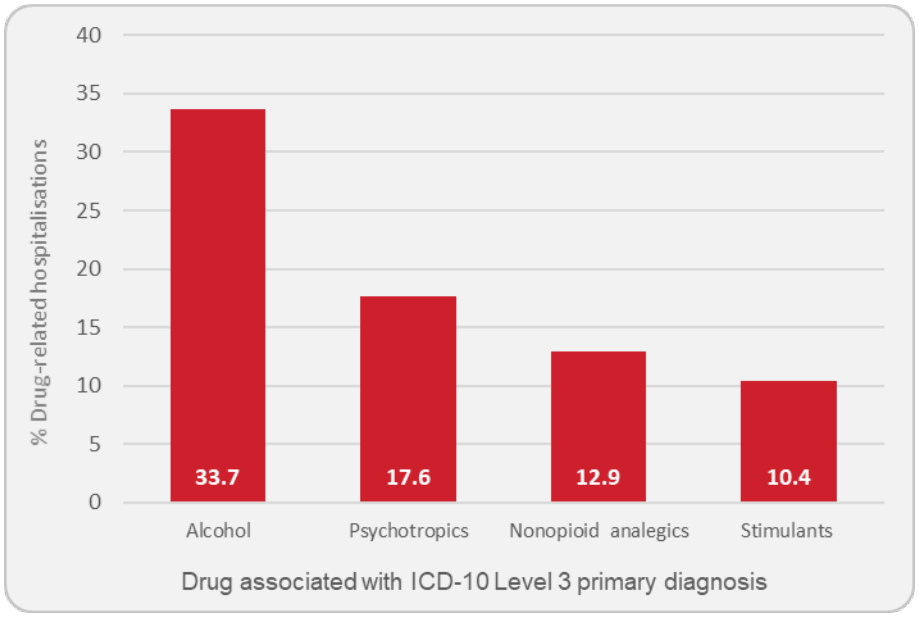
Specialist alcohol and other drugs treatment services are one part of a larger health system providing care to Tasmanians with alcohol and other drug treatment needs. Services span hospitals and acute services, mental health, disability, emergency services, children and youth services, and even housing, justice, education and employment providers.[134]

Hospitalisations

In 2017–18, approximately 1.2% of all hospitalisations in Tasmania (1545 out of 134,055) had a drug-related principal diagnosis. Figure 46 illustrates the following top four reasons for hospital separations with a drug-related principal diagnosis:

- alcohol-related
- psychotropic drug-related
- non-opioid analgesic-related
- mental and behavioural disorders due to stimulants.

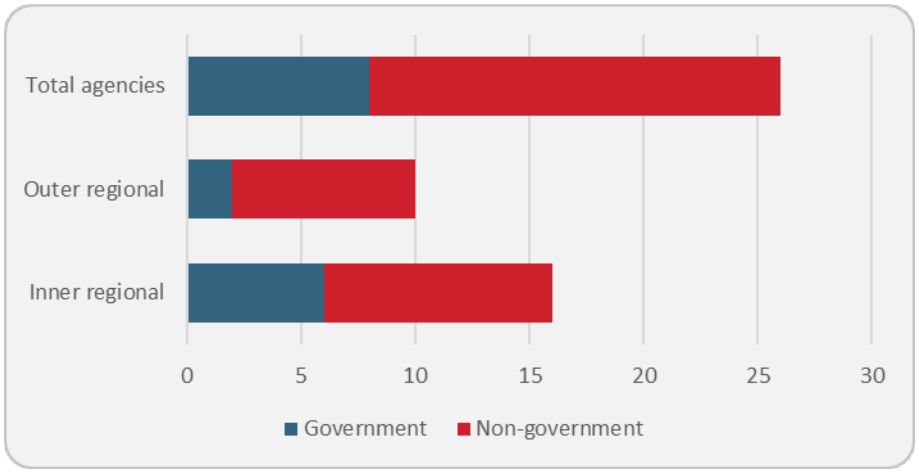
Figure 46. Top four reasons for hospital separations with a drug-related principal diagnosis, Tasmania | 2017–18



5.3.3 Available AOD treatment services in Tasmania

Figure 47 illustrates the proportion of government and non-government AOD treatment agencies in Tasmania. In 2018–19, 8 of the 26 AOD agencies in Tasmania were non-government treatment agencies that receive public funding; 16 agencies were located in inner regional areas, the remaining 10 were in outer regional areas. Non-government organisations had a notably higher presence in outer regional areas.[135]

Figure 47. Number of AOD treatment agencies by remoteness area and sector, Tasmania | 2018–19



5.4 Stakeholder perspectives

Feedback about service needs and priorities from clinicians, alcohol and other drugs service providers and consumers highlights the opportunities to better support people with AOD primary care needs.

5.4.1 Main care need is for managing alcohol-related problems

The most common substance use disorders managed by primary care relate to alcohol use, according to consultation with primary care stakeholder groups.

Stakeholders report people experiencing alcohol use issues may also experience homelessness, mental ill-health, physical health problems, and involvement with child protection and police services. As a result, primary care needs may be complex and primary care solutions need to be holistic and able to respond to a broad range of health and social issues.

Stakeholders report low availability of alcohol and other drugs counsellors to support other primary care providers in the management of alcohol misuse issues. Aboriginal stakeholders report difficulties accessing culturally tailored AOD treatment services. Building the Aboriginal health workforce to deliver alcohol and other drugs treatment and support is a priority for Aboriginal stakeholder organisations who participated in consultations.

People with alcohol problems present to emergency departments with intoxication, trauma and self-harm. Links between emergency departments and AOD primary care service providers could be strengthened to improve continuity of care.

5.4.2 Improved referral pathways to specialist services for other drug-related problems

Stakeholders identified a need for improved service coordination between primary care and specialist AOD services. Managing complex drug issues, particularly methamphetamine use, requires ready access to specialist alcohol and other drugs services and mental health services by primary care providers.

Stakeholders report gaps in specialist services in Tasmania in addiction psychiatry. There is fragmentation of specialist AOD and mental health services. Referral pathways are important for primary care providers, but it is unclear whether to refer patients to AOD specialist services, mental health services or both.

Wait times for accessing specialist support are often prolonged. Stakeholders advocate for improved triage and assessment to expedite intake of people with time-critical alcohol and other drugs issues.

Stakeholders also described:

- long wait times and sometimes restrictive criteria to access services
- lengthy distances to travel to services, particularly for consumers from rural areas
- a lack of integration and communication between different services, including lack of communication between government and non-government services.

It is often unclear to primary care providers whether to refer patients to specialist AOD services, mental health services or both.

5.4.3 The impact of COVID-19 on AOD use is uncertain

In response to the COVID-19 pandemic, a range of public health measures have been periodically in place, including the order that all non-essential services close temporarily. This included licensed liquor outlets such as pubs and clubs (excluding bottle shops attached to these venues), and gyms. Borders have been closed and movement across borders has been restricted.

Stakeholders report access to illicit drugs has not been demonstrably reduced during COVID-19 lock-downs, except for steroids for injection, which were more difficult to acquire for people who use them. Many stakeholders report unchanged levels of consumption and use of alcohol. Some stakeholders report people may have initially increased or decreased alcohol use, but then reverted to their usual patterns.

The Australian Government announced in April 2020 that an additional $6 million would be allocated to online and phone support services for people experiencing drug and alcohol problems.[136] Primary care providers report that uptake of these services has been low to date.

5.5 Priority actions

5.5.1 Better integration of care across the AOD service system

Primary Health Tasmania's priority is to further develop our commissioning approach to encourage integration across the boundaries of primary, community and acute services.

Most alcohol-related treatments can be delivered in the community. Through our commissioning activities, Primary Health Tasmania will increase the availability of community AOD information and treatment services for all Tasmanians.

Comorbidity of mental health and AOD issues is a significant challenge facing service providers. Primary Health Tasmania will commission primary mental health services that support AOD service providers to deliver integrated treatment to people with AOD and mental health comorbidities.

Through our Tasmanian HealthPathways and partnerships with Tasmanian Government stakeholders, Primary Health Tasmania will improve streamlined referral pathways into specialist services for people with complex AOD issues.

5.5.2 Build the capacity of the AOD treatment sector

Primary Health Tasmania's priority is to build the capacity of the primary care service system to increase the availability of AOD treatment.

Through our Practice Incentives Program Quality Improvement Incentive Program, Primary Health Tasmania will work with general practices to improve identification of people with AOD use issues.

Through Tasmanian HealthPathways and provider support, Primary Health Tasmania will support GPs to strengthen evidence-based management of AOD problems.

Primary Health Tasmania is working with participating Aboriginal organisations to deliver AOD treatment and support to Aboriginal people in Tasmania. We are supporting organisations to develop their Aboriginal health workforce to respond to AOD issues in their communities.

5.5.3 Improve AOD data collection

Primary Health Tasmania is working with commissioned AOD services to improve data collection and reporting.

Collecting high-quality data allows us to monitor and understand client outcomes. In Tasmania, data on drug and alcohol use, and client treatment and outcomes are collected in a range of different ways. This makes transfer of consistent, complete information between services difficult and compromises the quality of treatment provided to clients.

Government-funded organisations are required to provide data to the Alcohol and Other Drug Treatment Services National Minimum Data Set. However, the current minimum data set is focused on episodes of care and does not provide sufficient information about client outcomes.[137]

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