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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 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

1.1 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.

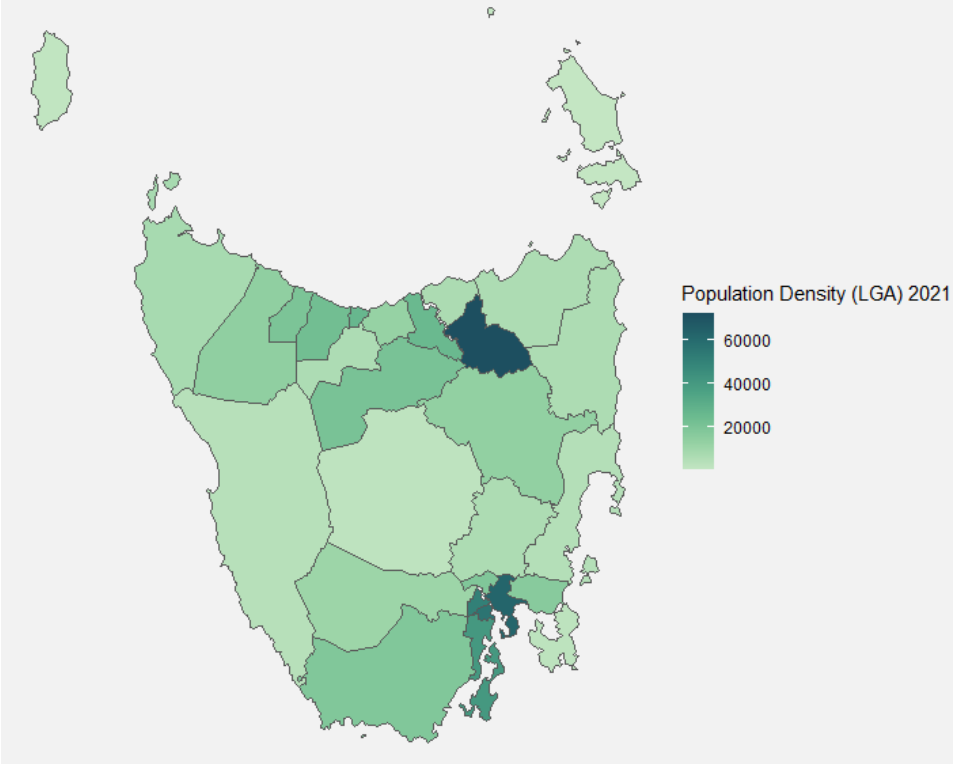
Access to health care is problematic for many Tasmanians, particularly for people living in rural areas, for those experiencing socioeconomic disadvantage, for Aboriginal and Torres Strait Islander people, and for people who are from culturally and linguistically diverse backgrounds.

Tasmania is home to a regionally dispersed population of just over 557,000 people[1]. 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

There were 557,571 people who were residents of Tasmania on 28 June 2021, approximately 2.2% of Australia's total population[1]. Most of our population lives in or around the Hobart, Launceston, Devonport, and Burnie localities[2] (Figure 2). Among the population centres in Tasmania, Hobart has the highest proportion of the population (40.5%), followed by Launceston where 16.4% of Tasmania's population reside[3] (Figure 3).

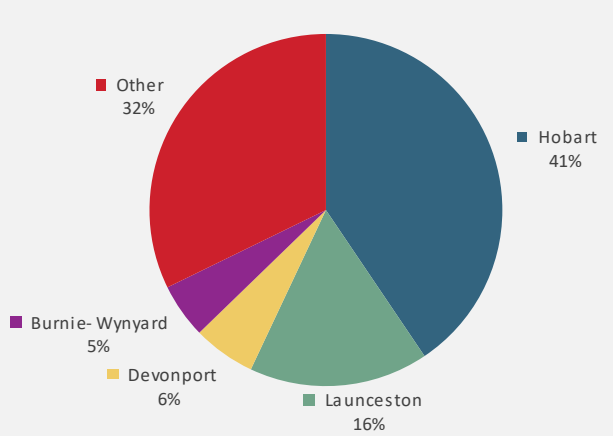
Figure 2. Tasmanian population density by local government area | 2021



Tasmania's Aboriginal people account for 6% of Tasmania's population, higher than the national average of 3.8%, and second only to the Northern Territory[4].

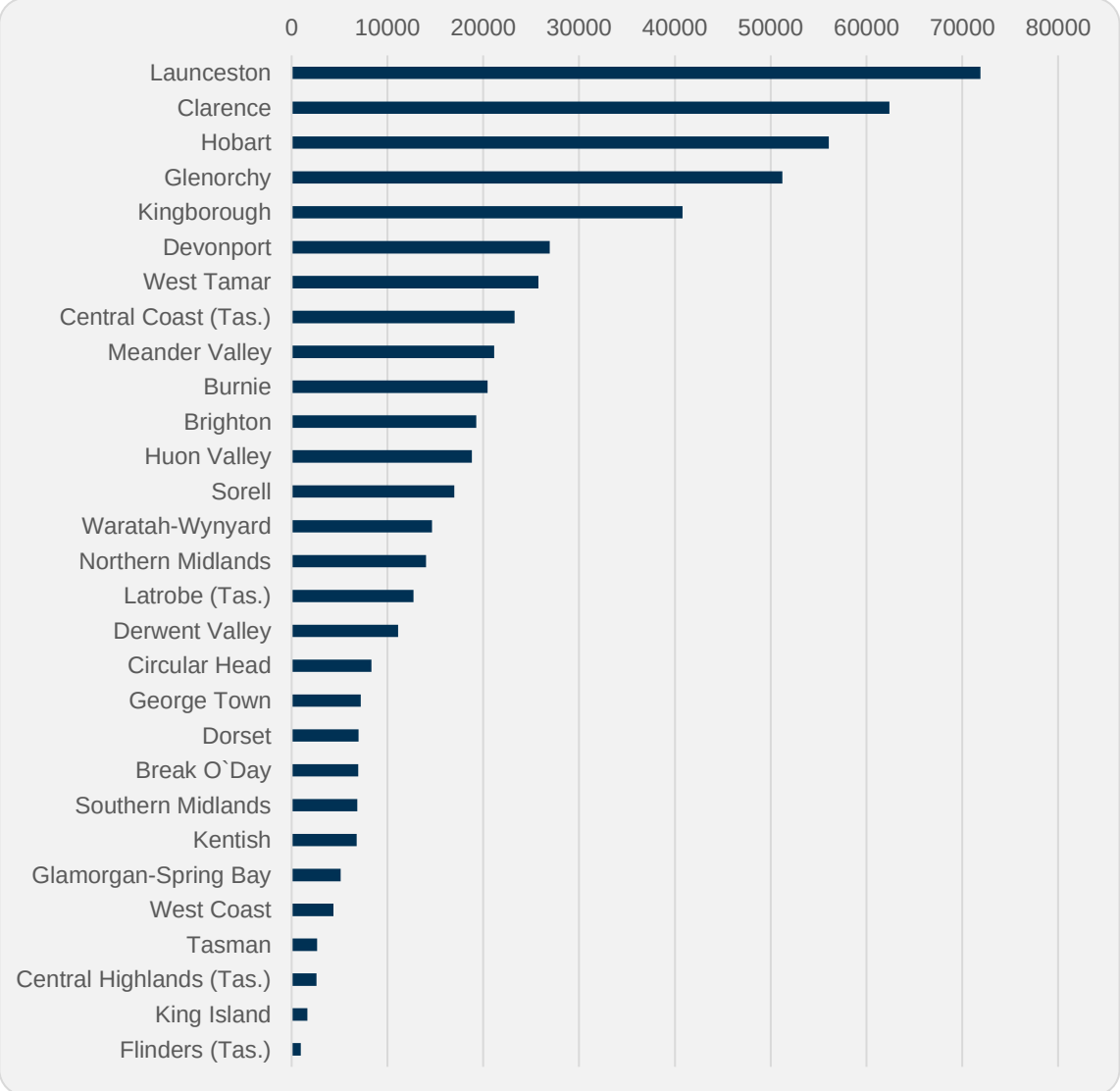
In Tasmania, 86.1% of people only spoke English at home. Other languages spoken at home include Mandarin (1.5%), Nepali (1.3%) and Punjabi (0.5%)[5].

Figure 3. Proportion of population distribution by population centre, Tasmania 2021



There are 29 local government areas (LGAs) in Tasmania. Of our 29 LGAs, 21 are classified as outer regional or remote. The population for each LGA is shown in Figure 4[3].

Figure 4. Population by local government area, Tasmania 2021



1.1.2 We have an ageing population

Figure 5 shows the proportion of population by age group for Tasmania and Australia. Compared with the Australian population, Tasmanians aged 60 years and over are more strongly represented than younger age groups in the population[6].

Figure 5. Population age distribution, Tasmania and Australia 2022

Tasmania's ageing population has significant implications for our aged care services. Compared with other Australian states 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)[7]. Most Tasmanians aged 65 and over live in and around the major population centres of Hobart and Launceston, but the rural and remote areas along the East Coast and Flinders Island have the highest proportions of their population aged 65 or over (around one third of the population)[8].

1.1.3 Our population is growing

The Tasmanian Department of Treasury and Finance published population projections in April 2019 based on the estimated resident population as of 30 June 2017. These predicted that Tasmania's population would grow to around 572,000 people by 2050. However, the Tasmanian population has grown much faster than expected, and projections are currently being recalculated. In 2015, the Tasmanian Department of State Growth set a target to grow the population to 650,000 people by 2050 to create jobs and drive economic growth[9].

1.1.4 Many people in our community experience disability

Over 25% of Tasmanians have a disability, a significantly higher proportion than the national average of 17.7%[10]. 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

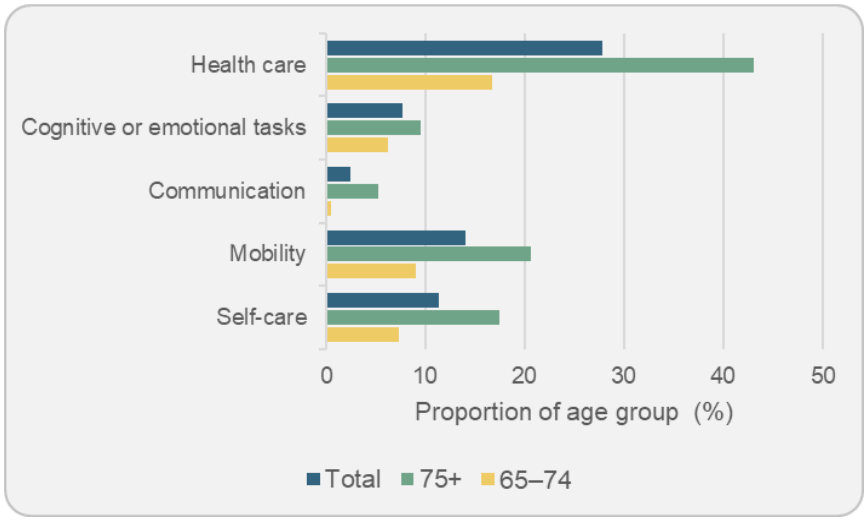
Degree of limitation	What this means for people with a disability
Profound	greatest need for help; that is, always needs help with at least one core activity
Severe	needs help sometimes or has difficulty with a core activity
Moderate	no need for help but has difficulty
Mild	no need for help and no difficulty, 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 6).

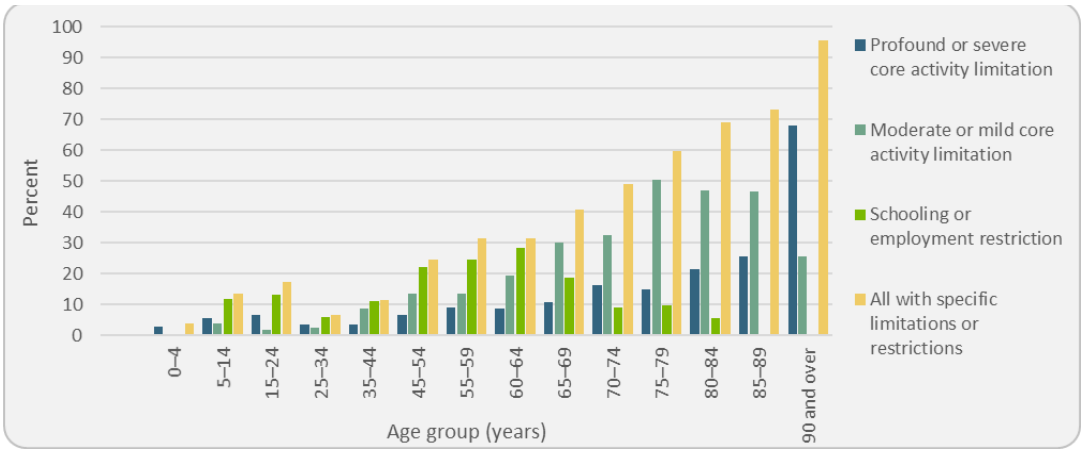
Everyday self-care activities become increasingly difficult to manage as we age and as our abilities decline. In 2018, 43% of all Tasmanians aged 65+ needed help with everyday activities[11]. This proportion increased to 56% in the 75+ age group (Figure 7).

Figure 6. 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

Figure 7. Disability status by age group, Tasmania | 2018



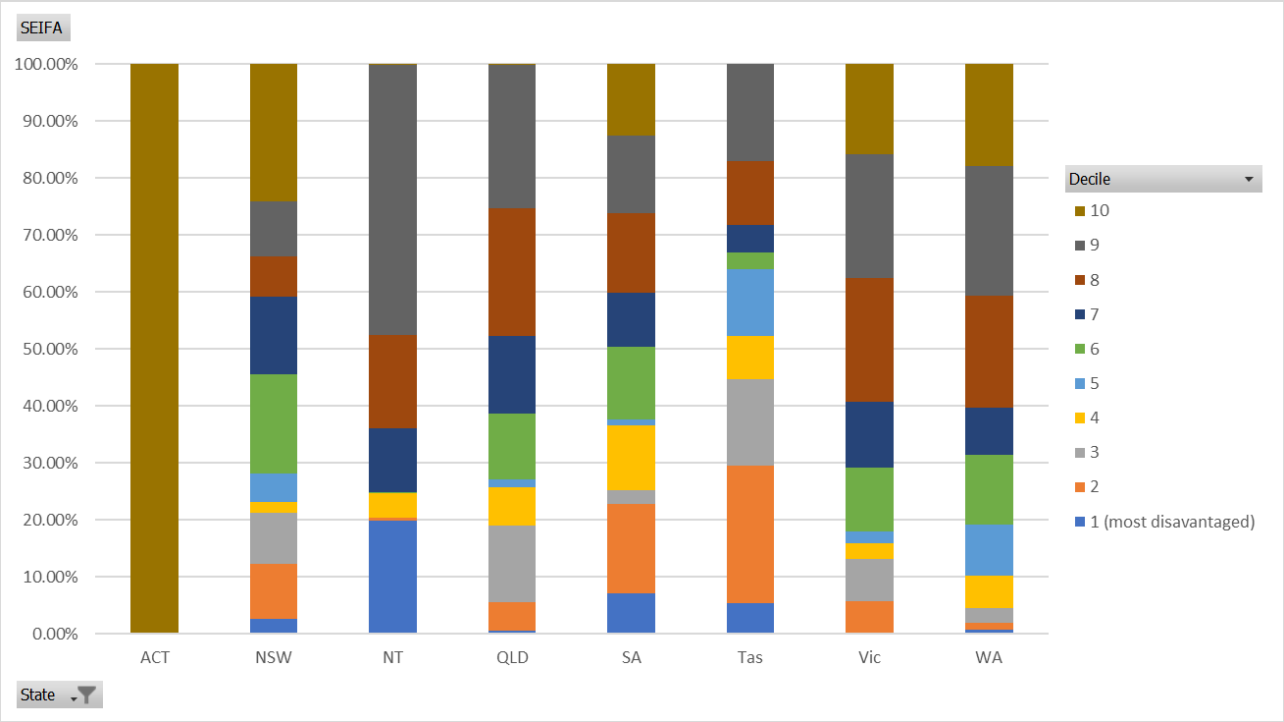
About 80% of Tasmanians living with a disability receive assistance from informal carers, while 60% receive some assistance from formal providers, mostly private commercial organisations. This indicates that about 80,000 Tasmanians are unpaid carers. Most of these are family members, with a median age of 53 years[11].

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[10-12].

1.1.5 Our community is socioeconomically diverse

Tasmania has high rates of socioeconomic disadvantage. The ABS uses Census data variables including income, education, employment, occupation and housing characteristics to categorise local areas by relative socio-economic advantage and disadvantage. Only 17% of Tasmanians live in areas categorised as being in the most socio-economically advantaged quintile (the top 20% of areas) and around 30% are in the least socio-economically advantaged quintile (bottom 20% of areas), a higher proportion than in any other state or territory[13] (Figure 8).

Figure 8. Percentage of people experiencing socioeconomic advantage and disadvantage, by Australian states and territories | 2021



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[14].

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[15]. Tasmanians are experiencing high, and growing, rates of housing stress and homelessness[16]. Chronic conditions are more common in areas with lower socioeconomic status[17].

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. Around two in three Tasmanians lack sufficient health literacy skills to manage their health[18].

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

- access and understand health information
- navigate health services, give required information to the service providers, and arrange for routine appointments
- understand their health problems to be able to manage and/or prevent them[18, 19].

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. Around 15% of Tasmanian residents were born overseas, compared to 28% of the Australian population as a whole. Only 8.7% of Tasmanian households speak a language other than English at home, compared with 22% nationally[5], and tend to be concentrated in the population centres of Launceston and Greater Hobart.

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:

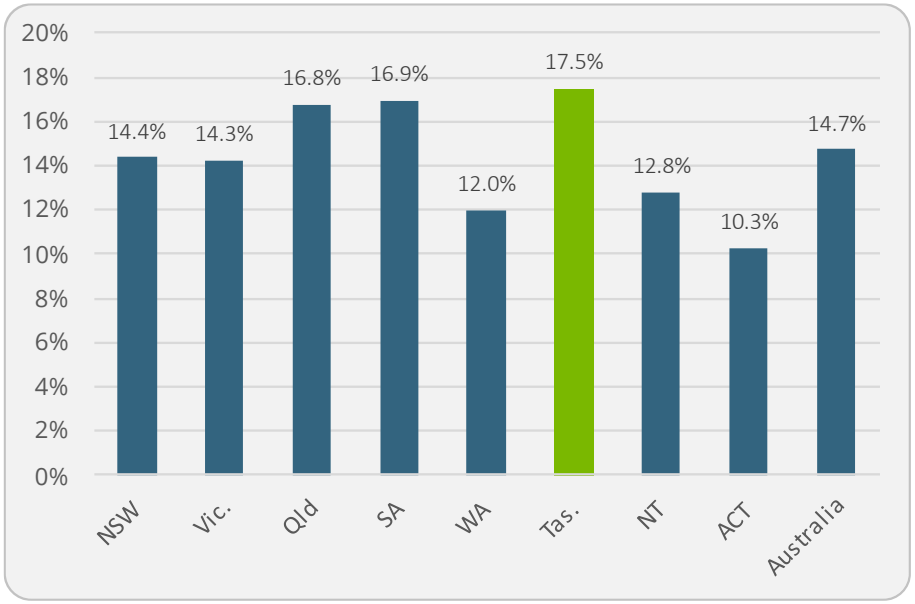
- self-assessed health
- life expectancy
- infant mortality
- causes of death.

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[20] (Figure 9).

Figure 9. 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 94% of Tasmanian children being fully vaccinated by age 5[21]. However, this also means that more than 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 5 years of age[22].

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 slightly lower than the national average. In 2020, 78.3% of Tasmanian females and 73.3% of Tasmanian males were fully vaccinated for HPV by age 15, compared with 80.5% of females and 77.6% of males nationally[23].

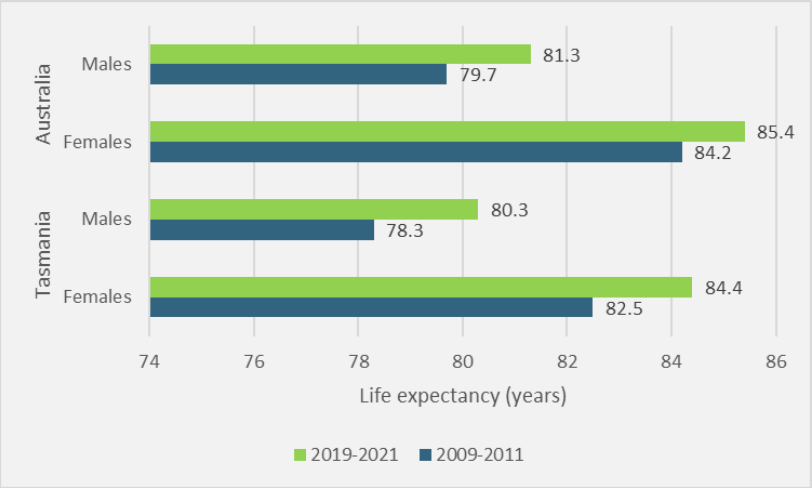
Until recently there has been no regular or nationally consistent source of data from which to estimate vaccination coverage in adults in Australia[23]. Population surveys have been used to estimate vaccination coverage in the adult population or in selected population groups[23]. In 2021, data on adult vaccination coverage from the Australian Immunisation Register were reported for the first time. In 2021, recorded zoster vaccine coverage among 70 year old adults was slightly higher in Tasmania, compared with Australia as a whole: 31.5% vs 30.6%[24]. Coverage among Aboriginal adults aged 70 was similar in Tasmania and Australia overall[25] (30.6%). Coverage of seasonal influenza vaccine in 2021 was 27.5% of 20-49 year old people, rising to 44.8% of 50-64 year olds, 68.0% of 65-74 year olds, and 74.8% of those aged 75 and over[26]. These percentages are higher for Tasmanians than for Australians overall in every age group. Vaccination coverage among Aboriginal Tasmanians is even higher, with 55.1% of 50–64-year-olds, 75.0% of 65–74-year-olds, and 84.3% of those aged 75 and over vaccinated in 2021.

1.2.4 Tasmanians have a lower life expectancy than Australians overall

Life expectancy at birth is the estimated number of years a newborn baby can expect to live, based on current age-specific death rates. 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 2.0 years for males and 1.9 years for females in the 10 years to 2019-2021[27]. Tasmanian males born in 2019-21 can expect to live to 80.3 years (compared with 81.3 years for Australian males) and Tasmanian females born today can expect to live to 84.4 years (compared with 85.4 years for Australian females)[27] (Figure 10). However, Tasmania continues to have the second lowest life expectancy of any jurisdiction, after the Northern Territory[27].

Figure 10. Life expectancy, Tasmanians compared to Australians | 2009-2011 and 2019-2021



1.2.5 Tasmania's infant mortality rates are similar to 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 3.1 deaths per 1000 live births on average in Tasmania, similar to the Australian rate of 3.2 deaths per 1000 live births during 2022[28]. This rate has decreased from the previous year when Tasmania had a higher overall infant mortality rate than Australia.

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. Ischemic heart disease and dementia are the leading causes of death, followed by chronic lower respiratory disease and cerebrovascular disease[29] (Table 2 and Table 3). 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[29].

Table 2: Top 10 leading causes of death 2022, Tasmania and Australia

Cause of death	Number of deaths	State leading cause ranking	Australia leading cause ranking
Ischaemic heart disease (ICD-10 codes I20-I25)	553	1	1
Dementia, including Alzheimer's disease (ICD-10 codes F01, F03, G30)	372	2	2
Chronic lower respiratory disease (ICD-10 codes J40-J47)	309	3	6
Cerebrovascular disease (ICD-10 codes I60-I69)	291	4	4
Malignant neoplasm of trachea, bronchus and lung (ICD-10 codes C33, C34)	280	5	5
COVID-19 (ICD-10 codes U07.1-U07.2, U10.9)	186	6	3
Diabetes (ICD-10 codes E10-E14)	179	7	7
Malignant neoplasm of colon, sigmoid, rectum and anus (ICD-10 codesC18-C21, C26.0)	157	8	8
Accidental falls (ICD-10 codes W00-W19)	132	9	11
Malignant neoplasm of lymphoid, haematopoietic and related tissue (ICD-10 codes C81-C96)	131	10	9

Source: ABS, Causes of Death, Australia, 2022

Table 3: Leading main causes of death 2022, Tasmania.

Cause of death	No. of deaths	% of all causes
Cancers	1,386	28.0
Cardiovascular disease (ischaemic/coronary and other)	1,248	25.3
Diseases of the nervous system (including dementias)	268	5.4
Chronic lung disease	300	6.1
TOTAL (includes other less common causes of death not listed here)	4,939	100.0

Source: ABS, Causes of Death, Tasmania, 2022

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 (124.1 deaths per 100,000 people) compared with the Australian average (101.3 deaths per 100,000 people) during 2018-20[30, 31].

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. In the 2021 Census, 60% of Tasmanians aged 65–74 years reported having at least one long-term health condition, rising to 69% of those aged 75-84 years and 75% of Tasmanians aged 85+[31].

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. They may also experience additional barriers connecting with appropriate aged care services. 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[32].

LGBTIQ+ people may experience stigma and discrimination when accessing primary care. They have a greater burden of chronic conditions and mental health problems[33].

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[15]. Homelessness and the disadvantages associated with it can contribute to premature ageing through early onset of health problems more commonly associated with later life[34].

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

The number of people estimated as homeless increased from 1,622 in the 2016 census, to 2,350 in 2021[16]. The number of clients who received support from Specialist Homelessness Services in Tasmania fluctuated between 2,270 clients in July 2017 to 2,567 in June 2023[35]. The estimated homeless population as a whole is concentrated in the population centres of Launceston (19%), Hobart (19%)-Glenorchy (13%)-Clarence (6%), and Burnie (4%)-Devonport (9%). People aged 65 and over made up 9% of Tasmania's total estimated homeless population in 2021[16].

Mental illness is one factor that contributes to the level of homelessness in Australia, with 29% of people receiving support from specialist homelessness services in June 2023 having a current mental health illness[35]. 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[36]. 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[37].

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[38].

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. Over 9986 people in Tasmania were estimated to be living with dementia in 2021[39].

Dementia is a major health issue, causing substantial illness, high levels of disability, and premature mortality. In 2022, dementia was the second leading cause of death in Australia and Tasmania and the leading cause of death for women[29]. 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[40].

The needs of carers are an important part of primary care and aged care service provision. In 2018, more than 10% (10,100) of Tasmanians aged 65+ provided care as a primary carer[41] (Table 4). Carers experience a greater burden of poor health due to mental health problems and chronic conditions.

Table 4: Estimated number and proportion of Tasmanians who provided care as a primary carer | 2018

Care recipients	Age of main recipient of care		
	0–64 years	65+ years	All ages
Estimated number	17,200	10,100	26,500
Estimated proportion	4.1%	10.1%	5.1%

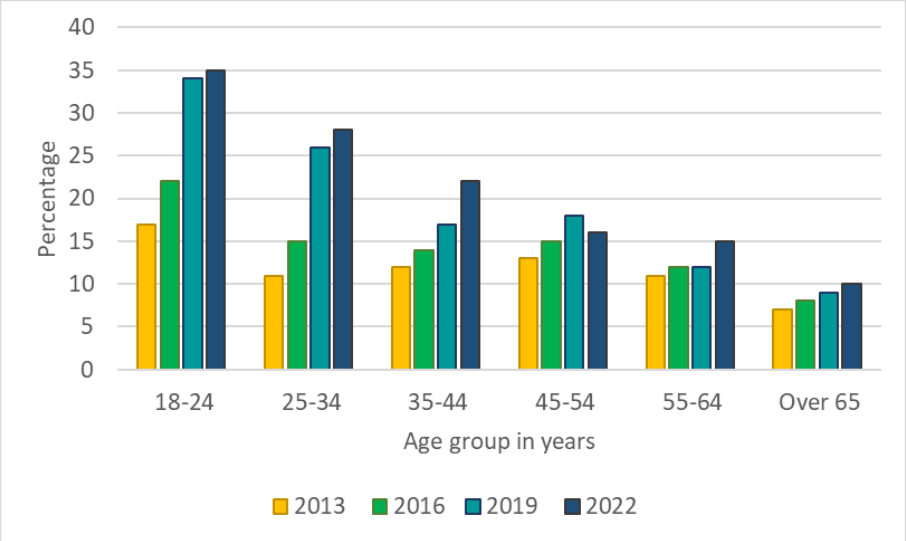
Nearly half of primary carers provide care because they feel they could give better care than the available options (46.5%). For Australians aged 65+, 3 in 10 primary carers provide care because they feel they have no other choice or there are no other care arrangements available, and 7 in 10 felt they had a family responsibility to provide care[42].

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.

Tasmania's young people are experiencing high and growing levels of high or very high psychological distress. Since 2013 the largest overall increases in the proportion of Tasmanians reporting high or very high levels of psychological distress occurred across the three youngest age groups[43].(Figure 11).

Figure 11. High or very high psychological distress by age group, Tasmania | 2013-2022



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[43].

Mental health conditions have a gendered distribution, with anxiety in adolescents being almost twice as likely to affect females than males[43].

1.2.12 COVID-19

The coronavirus (COVID-19) pandemic has had a significant impact on the Tasmanian population, initially in March and April 2020 – the earlier months of the pandemic. An outbreak at a hospital in the Northwest of the state contributed to most of Tasmania's case numbers prior to 15 December 2021. By this date, there had been 238 cases of COVID-19 recorded in Tasmania. Following changes to border restrictions on 15 December 2021, COVID-19 was repeatedly imported from interstate, with subsequent widespread community transmission of COVID-19 in Tasmania. Between 15 December 2021 and 21 September 2023 there were 304,606 cases of COVID-19 notified in Tasmania[44]. However, mandatory reporting was discontinued during this period, yet remained a notifiable disease, and as such these cases represent an underestimate. Since the beginning of the pandemic in 2020, there have been 312 COVID-19-related deaths in Tasmania[44].

General practices began providing services via telehealth in response to COVID-19 with 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)[45]. Some people with chronic conditions have delayed accessing primary care as a result of COVID-19[46]. During 2019–20 to 2020–21, there were around 120,000 fewer elective surgery procedures in public hospitals than expected[46]. A number of data sources provide evidence of delayed or missed cancer screening and procedures – such as a large decline in colonoscopies[46].

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[47]. Levels of psychological distress worsened for younger age groups (ages 18 to 44) at the start of the pandemic. Some improvement followed but not to pre-pandemic levels[46].

1.2.13 People experiencing family and domestic violence

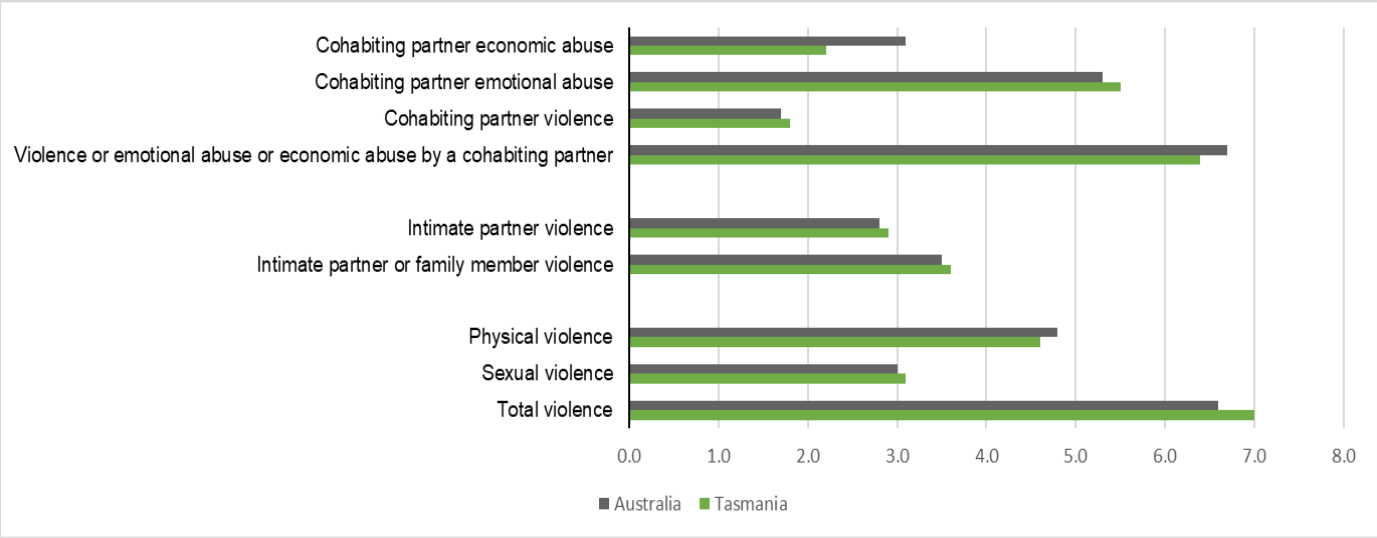
Family and domestic violence is a pattern of abusive behaviours or threats by a perpetrator with an intention to gain or maintain power and control over a family member, or against a person in a current or previous relationship[48]. The violence could be physical, verbal, emotional or economic abuse. Acts of violence can cause physical harm, emotional distress, and psychological trauma to individuals, families, and communities. Family and domestic violence is a serious health and social issue in Australia, which can affect people in all socioeconomic and demographic groups, mostly women and children[49].

In 2022, Tasmania recorded 92 victims of family and domestic violence-related sexual assault involving individuals under the age of 18. Among these 92 minors, 81 were female, and 14 were male. Of these victims, 25 were children under the age of 10, while 74 were adolescents aged between 10 and 17[50].

During the period of 2021-2022, 3.6 % of women in Tasmania aged 18 or older experienced physical and/or sexual violence inflicted upon them by a partner, family member, or in-law. Furthermore, 6.4% of women in the region suffered from multiple forms of partner violence, including physical, emotional, and economic abuse[51]. Overall, the aggregate reported incidence of violence against women aged 18 and older in Tasmania exceeded the national average (Figure 12). During the same period, Tasmania Police responded to 6,743 family violence occasions, including 4,225 incidents and 2,518 events classified as family arguments[52].

To address this issue, the Australian Government has acted by granting funding to Primary Health Tasmania to facilitate the establishment and implementation of a pilot program that aims to improve the health system's response to family and domestic violence. The program will integrate support for victim-survivors of family, domestic, and sexual violence, as well as child sexual abuse.

Figure 12: Proportion (%) of women in Tasmania who are aged 18 years and over, and experienced violence in the last two years compared to the national proportion, 2021-22.



Source: ABS. Personal Safety, Australia, 2021–22

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

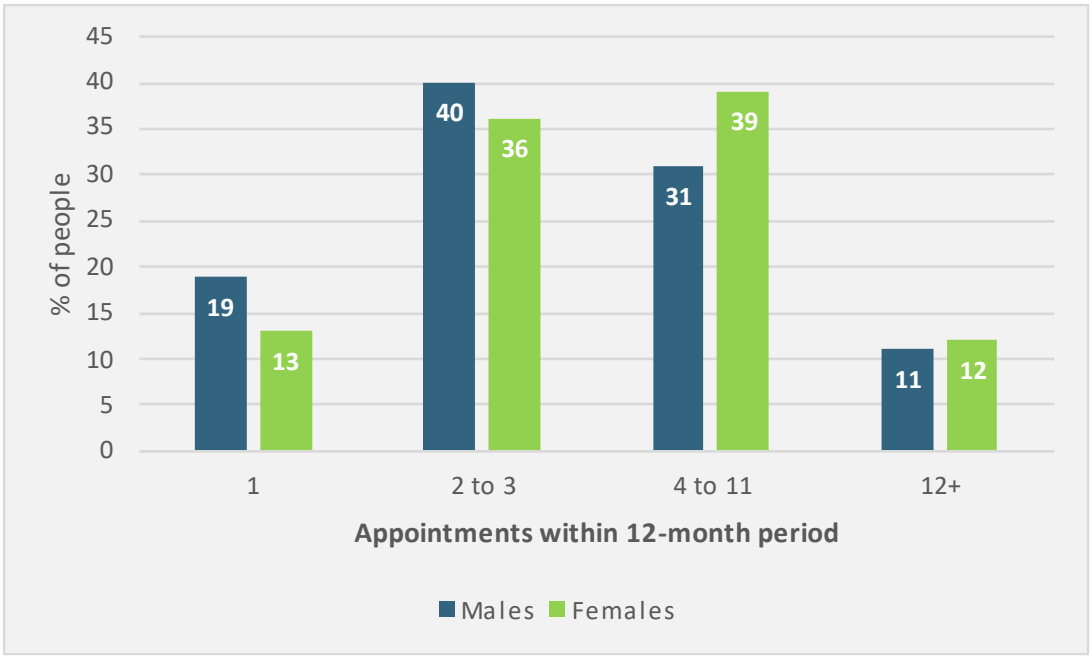
Primary care services include general practice, other medical, nursing, pharmaceutical, diagnostic, allied health, mental health, dental services, and home and community support services. Access to primary healthcare services helps reduce the number of avoidable hospital visits, improves population health, 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.

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[53].

Tasmanians saw their GP an average of 9 times in FY21/22. General practice is the point where most people enter the health system.

According to the Tasmanian general practices dataset, Tasmanians saw their GP 9 times a year on average in the financial year 2021-2022. The percentage of Australians who visited a GP in 2021-22 was 83.6%[54]. Most Australian people booked an appointment to see a GP between 3 and 12 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[55] (Figure 13).

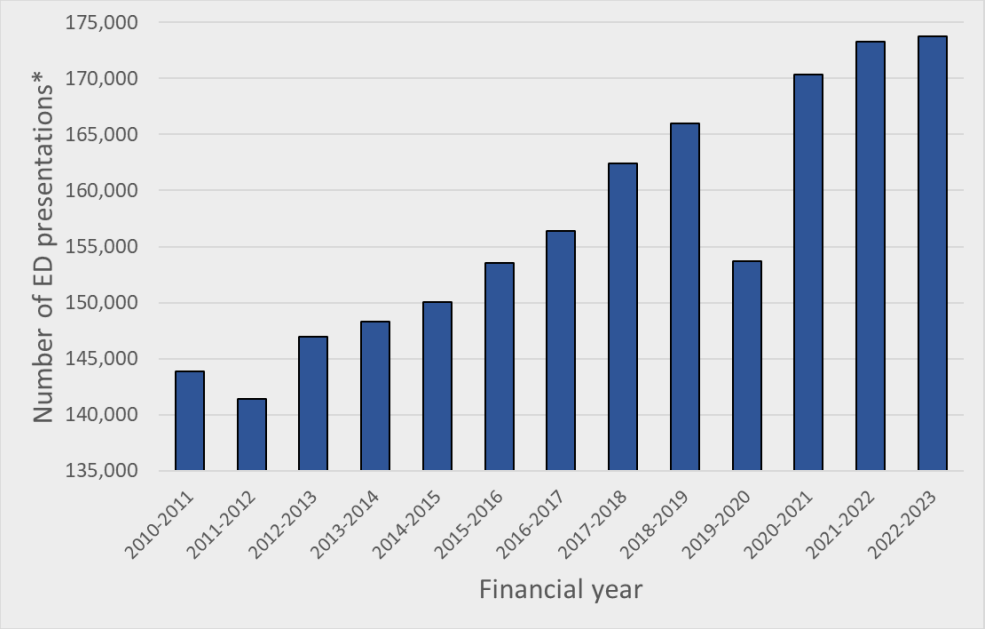
Figure 13: Percentage of males and females with multiple appointments over 12-month period, Australia | 2019



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[56] (Figure 14). There was a decrease in public hospital emergency department presentations during the coronavirus pandemic in 2019-20. After 2019-2020, public hospital emergency presentations returned to the pre-COVID-19 trend[56].

Figure 14. Public hospital emergency department presentations, Tasmania | 2011–12 to 2022-2023

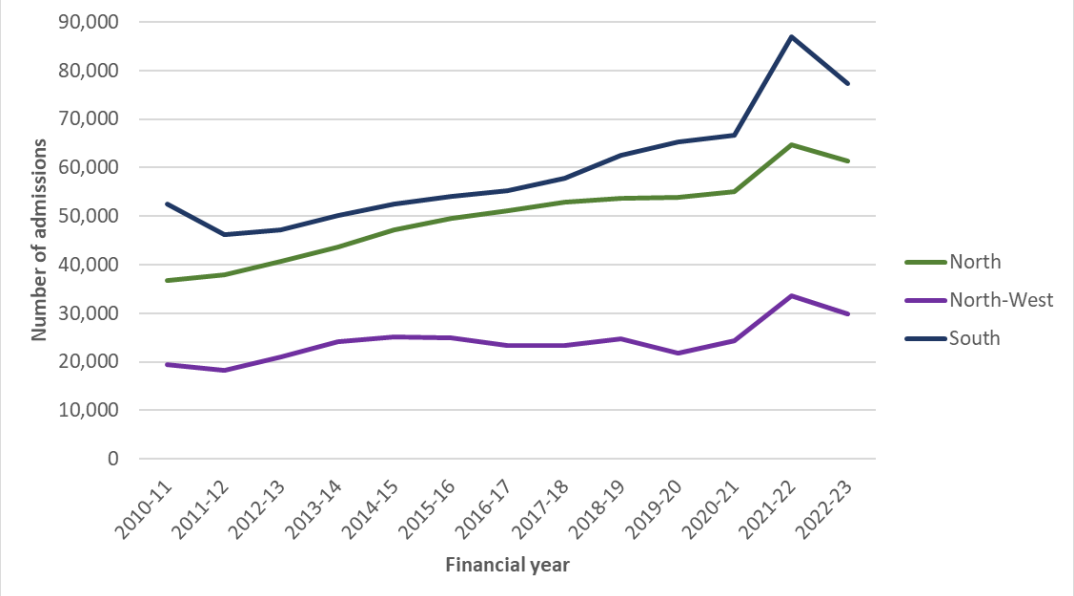


**Estimates reported from PHT internal data analyses, number reported for all ED presentations*

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 had been increasing steadily over time with a slight decrease in north west in 2020 during the COVID-19 pandemic[57] (Figure 15). During 2022-23, public hospital admissions decreased by 9% compared to 2021-22, after an increase of 27% from 2020-21 to 2021-22[57].

Figure 15: Public hospital admissions by region of hospital, Tasmania | 2010-11 to 2022-23



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.

Medicare Urgent Care Clinics (UCCs) have been funded by the Australian Government and commissioned by the Tasmanian state government. There will be four Medicare UCCs in Tasmania, open 7 days a week – two located in the South, one in the North and one in the Northwest. Launceston Medicare UCC opened on 31 July 2023 and the Hobart Medicare UCC opened on 14 August 2023. The working hours of each clinic varies, covering some of the busiest times for the EDs both in-hours and afterhours periods (from 12 PM to 10 PM). Urgent care is designed for medical attention for an illness or injury that can be managed without a trip to the emergency department but cannot wait for a regular appointment with a GP.

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[58]. 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[59].

- a 'palliative care approach', adopted by health professionals
- general palliative care provided by primary care professionals and those treating people with life threatening illnesses
- specialist palliative care provided by specialist teams for people with complex conditions[59].

In Tasmania it is estimated that most 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[59].

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[60]. More than 60% would prefer to die at home, yet currently only 14% do so[60]. Often people don't die at home either because support services are inadequate or because they

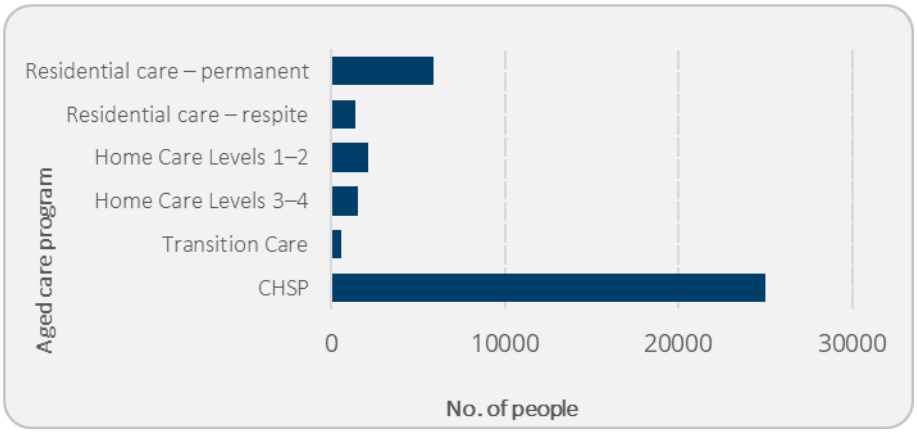
have not had a chance to articulate and implement their choice through proper discussion and planning[61].

1.3.5 Aged care 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[62]. The aged care focus population is all people aged 65+, and all Aboriginal people aged 50+.

Most aged care services are provided to people in their home or in a community setting. In 2022 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. In addition, more than 6000 Tasmanians accessed permanent residential aged care in 2022[63] (Figure 16).

Figure 16: People aged 65+ and Aboriginal people aged 50–64 years who received aged care services, by program type, Tasmania | 2022



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 2023, there were 74 aged care services in Tasmania that offered a total of 5289 residential places[63]. 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 median wait time to enter residential aged care was 139 days in 2021-22[63]. This is up from 63 days in 2015–16[63] but represents a small decrease from 2020-21 (150 days). There were 884 people approved for a home care package who were waiting to be allocated one at the end of March 2023; of these, a majority (690) had not been offered a lower level package in the interim[64].

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 consumer preference to remain at home for as long as possible[64]. As older people are also generally higher users of health services than younger people, demand is expected to increase with our ageing population[65].

The average wait time for a residential aged care place in 2021-22 was 139 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[66].

GP attendances for people using permanent residential aged care facilities (RACFs) in Tasmania are lower than for all of Australia[67]. In 2016–17 the number of GP attendances in residential aged care facilities per patient was 16.8, lower than the Australian average of 20.7 attendances[67].

One in 10 hospitalisations are from residential aged care

Hospitals and residential aged care facilities (RACFs) experience frequent patient transfers between the two types of facilities for many clinical problems. In Australia, approximately one third (31%) of residents of RACFs had at least one admission to a public hospital in 2018-19, increasing to roughly 37% when private hospital admissions are included. During the same period, 36.9% of permanent aged care residents aged 65+, presented to an emergency department[68, 69]. The total (age-adjusted) hospital admission rate for people in residential care appeared to be lower than for people aged 65 years or over in the general community, whereas the rate of emergency department presentations appeared to be higher.

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[70].

Older people who live in RACFs experience more infections than people who live in other settings[67]. 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[71].

Medical support and diagnostic capability can be limited in RACFs which can result in transfer of residents to hospitals for medical assessment and care[72].

Priority groups

Older people from CALD backgrounds made up 8.0% of the target population for aged care in June 2016. They were overrepresented for ACAT assessments, Home Care levels 1-2, and Transition Care, and slightly underrepresented for residential aged care and Home Care levels 3-4. Use of the Commonwealth Home Support Programme (CHSP) was in line with their representation in the population.

Older people in rural and remote areas made up 36.4% of the target population for aged care in June 2016. They were underrepresented for all aged care services: ACAT assessments, residential aged care, CHSP, Home Care levels 1-4, and Transition Care[62].

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.

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.

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

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 and support 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 in these groups may also experience barriers accessing appropriate aged care services and may have additional difficulties navigating the system.

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.

In alignment with this priority area, Primary Health Tasmania has taken the initiative to keep our primary care providers well-informed and up to date by organising educational events. In 2022-23, 97 events were provided, including health educational training, clinical decision support sessions, and culturally appropriate care webinars. A total of 1,620 participants attended these events and actively engaged in these learning opportunities.

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. Additionally, we will continue to provide and expand our educational events to cover emerging healthcare issues and to support the professional development of primary care providers in Tasmania.

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 Sense - Primary Health Network (PHN), 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[73]
- supporting GPs in assessing, screening, managing and referring those who have mental health problems[74]
- providing access to alternatives to medication to manage mental health problems.

1.5.6 Supporting the Primary Care sector response to Family, Domestic and Sexual Violence (FDSV)

Primary Health Tasmania's priority is to support primary care sector response to FDSV. Through a four-year pilot program, the aim is to establish and deliver family and domestic violence model of support modules to victims – survivors of sexual violence and child sexual abuse. This involves:

support for primary care providers to:

- assist in the prevention, early identification, intervention and recovery of family and domestic violence, and coordinate referrals to support services (model of support)
- implement and integrate a model of support for victims-survivors of sexual violence and child sexual abuse including health system navigation.

It is expected this program would improve primary health care system capability to respond to FDSV through enhanced primary education and training opportunities for primary care workers to better care for people living with FDSV. Moreover, improved system integration and health system navigation for victim-survivors of FDSV through collaboration and establishment of system integrators across specialist support services and sectors and integration of primary health care services with local health systems to ensure coordinated responses is another desired outcome of this pilot program.

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 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[75].

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[76]. 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[77]. 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[78].

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[79]. 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[79].

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.

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

- breast cancer
- bowel cancer
- cervical cancer.

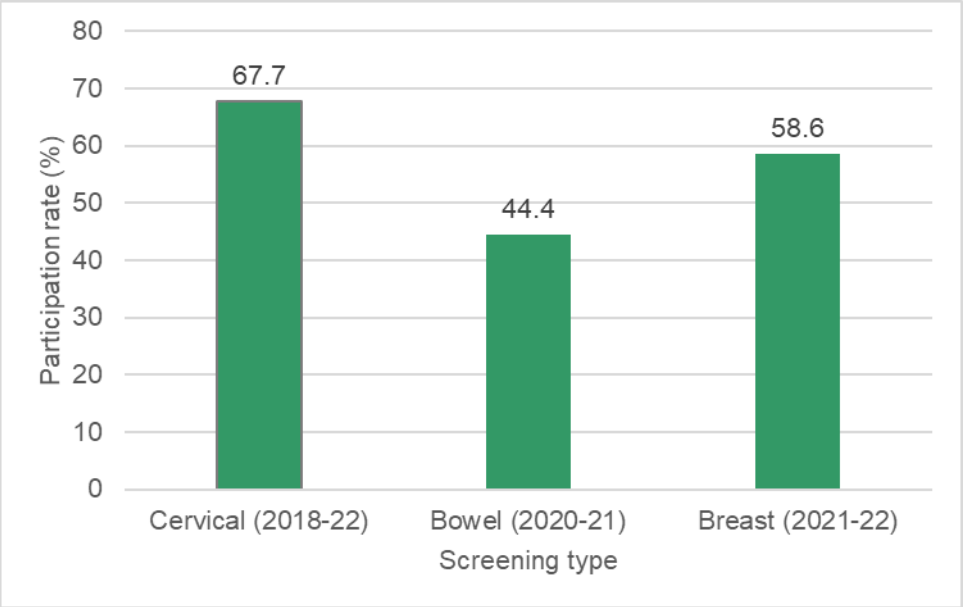
BreastScreen Australia was established in 1991. It provides free screening mammograms to women aged 40 and over every two years, and actively targets women aged 50–74.

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.

The most recent figures show that around 2 in 3 among the eligible population participated in the cervical screening program and more than half of the eligible population for breast cancer screening[79] (Figure 17).

Figure 17: Participation rates in cancer screening by type, Tasmanians



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.

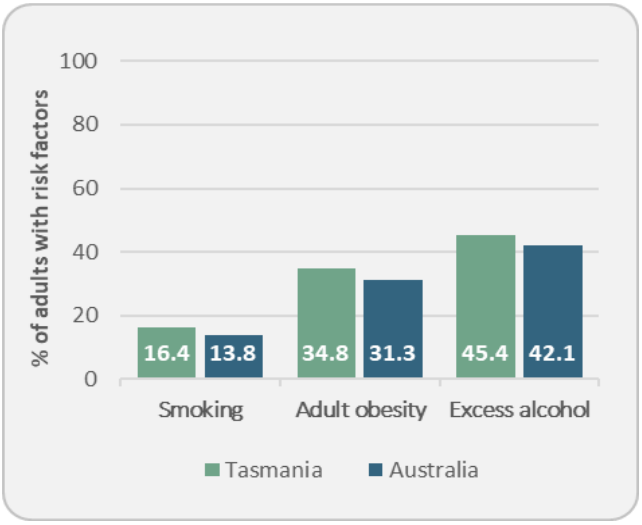
The major preventable behavioural risk factors for disease are tobacco smoking, excess alcohol consumption, physical inactivity, poor diet and nutrition and overweight and obesity.

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[43, 77] (Figure 18).

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

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.

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.

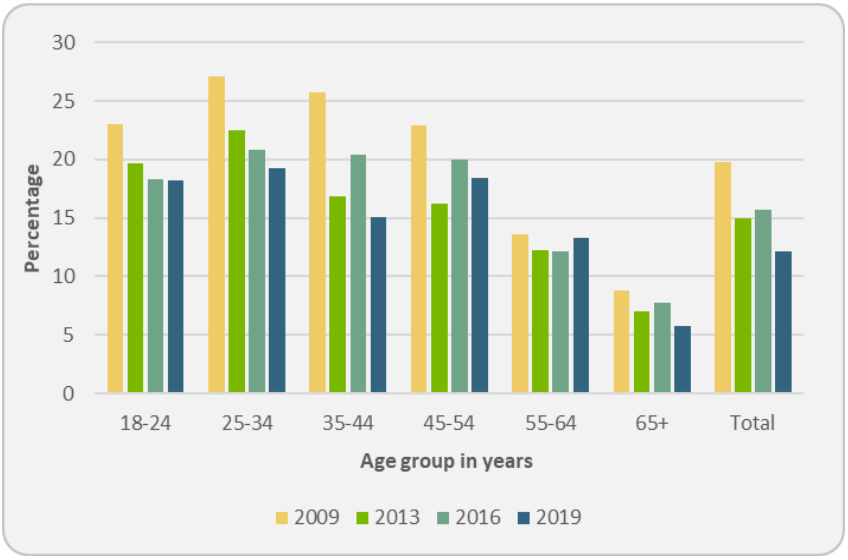
The average number of Tasmanians who died each year from tobacco use increased from 502 per year between 2008 and 2012, to 559 per year between 2013 and 2017[80].

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 15.9% of Tasmanians above 14 years of age smoke daily compared to the national figure of 15.1%[81] (Figure 19).

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



Smoking continues to be more common in lower socioeconomic areas. In the LGAs with the highest levels of socioeconomic disadvantage, 22% of residents are current smokers, compared with 13% in the LGAs with the lowest levels of socioeconomic disadvantage[43].

Excess alcohol consumption

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

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

Lifetime risk is the accumulated risk to health 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 short-term harm including road injuries, suicide, violence, alcohol poisoning as well as longer-term health problems such as:

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

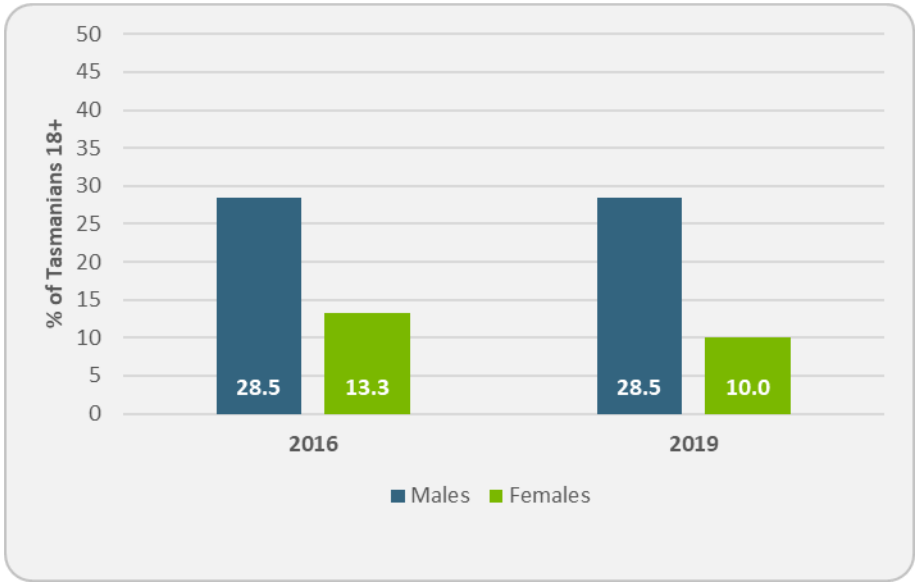
Males are at significantly greater risk of lifetime harm from alcohol, compared with females. Male Tasmanians are twice as likely as females to consume alcohol daily and are also more likely to have engaged in single occasion risk drinking (46% at least once in the past 12 months vs 28% of females)[43, 82] (Figure 20).

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

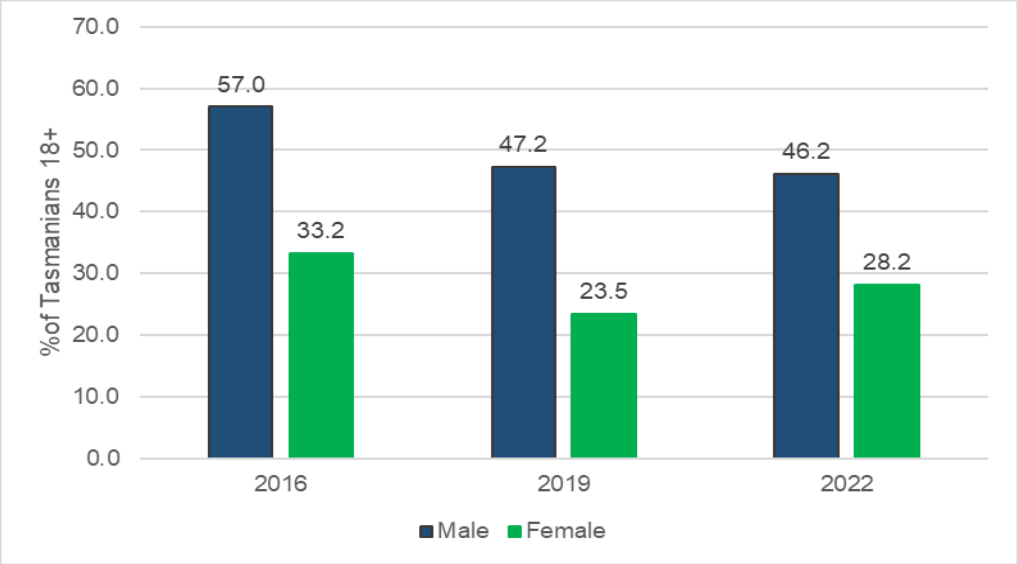
Figure 20: Alcohol causing lifetime harm, males and females aged 18+, Tasmania | 2016, 2019



Males are also at significantly greater risk of harm from single-occasion alcohol use, compared with females. While harm from single-occasion alcohol use decreased between 2016 and 2019 for both

males and females, since then it has remained stable for males and increased for females[43] (Figure 21).

Figure 21: Alcohol use associated with single occasion risk, Tasmanians aged 18+ | 2016, 2019 and 2022



Approximately 9.4 deaths per 10,000 population are alcohol-induced in Tasmania, compared to 6.0 deaths per 10,000 population in Australia as a whole[83]. 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 targets for moderate to vigorous physical activity in 2022, an increase from 2019 when only 16% did not meet these targets. Two-thirds of people reported insufficient muscle strengthening activity[43].

More than one in five Tasmanian adults reported spending eight or more hours sitting per weekday in 2022 (22%); however, the proportion of people using active transport like walking and cycling has increased significantly over time, with one third of Tasmanians using active transport four or more days a week in 2022 (34%)[43].

One-half of Tasmanians have a poor diet

In 2022, only one in three Tasmanian adults (34%) reported adequate dietary intake of two serves of fruit a day, and less than 1 in 20 reported consuming five serves of vegetables a day (6%). This was similar across socioeconomic levels but male Tasmanians were less likely than females to meet the recommended daily intake of both fruit and vegetables[43].

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.

The proportion of Tasmanians experiencing severe food insecurity has almost doubled from five per cent in 2013 to nine per cent in 2022. Almost one in ten (9%) Tasmanians had run out of food in the past 12 months and could not afford to buy more[43].

Three in 5 Tasmanian adults are overweight or obese

More than 60% of adult Tasmanians reported being overweight or obese in 2022. The data suggests the proportion of overweight adults has remained relatively stable since 2009, but the proportion of obese adults has increased from 19% to 29%. More men reported an overweight BMI than women, however slightly more women reported an obese BMI[43].

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 2022. 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

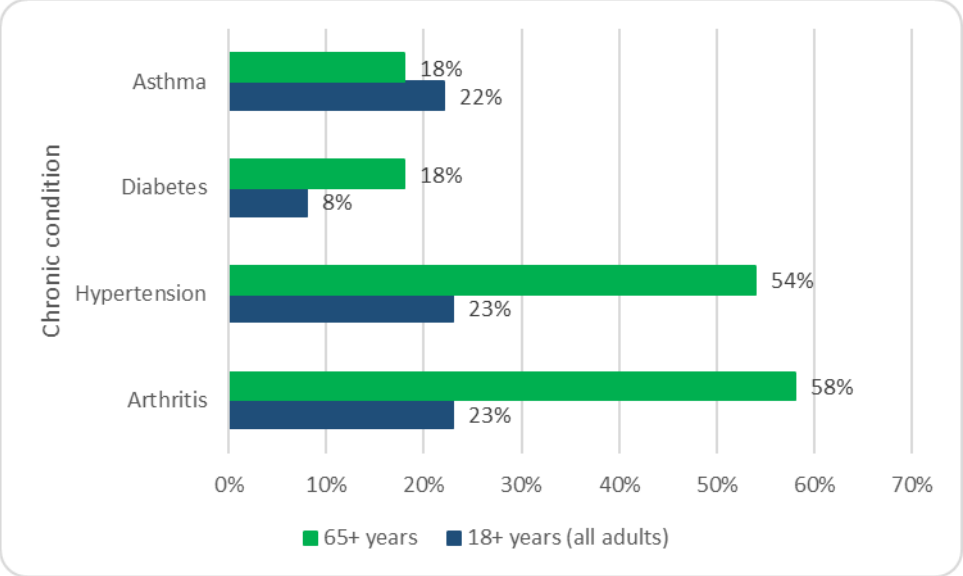
In Tasmania, over 2 in 3 people have at least one common chronic condition, and 1 in 4 Tasmanians has three or more conditions[43]. Rates of chronic conditions in Tasmania are generally higher than Australia as a whole, in part because our population is older and chronic conditions are more common as we age.

In Tasmanians aged 65+, self-reported rates of most chronic diseases are higher than in the younger population[43] (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

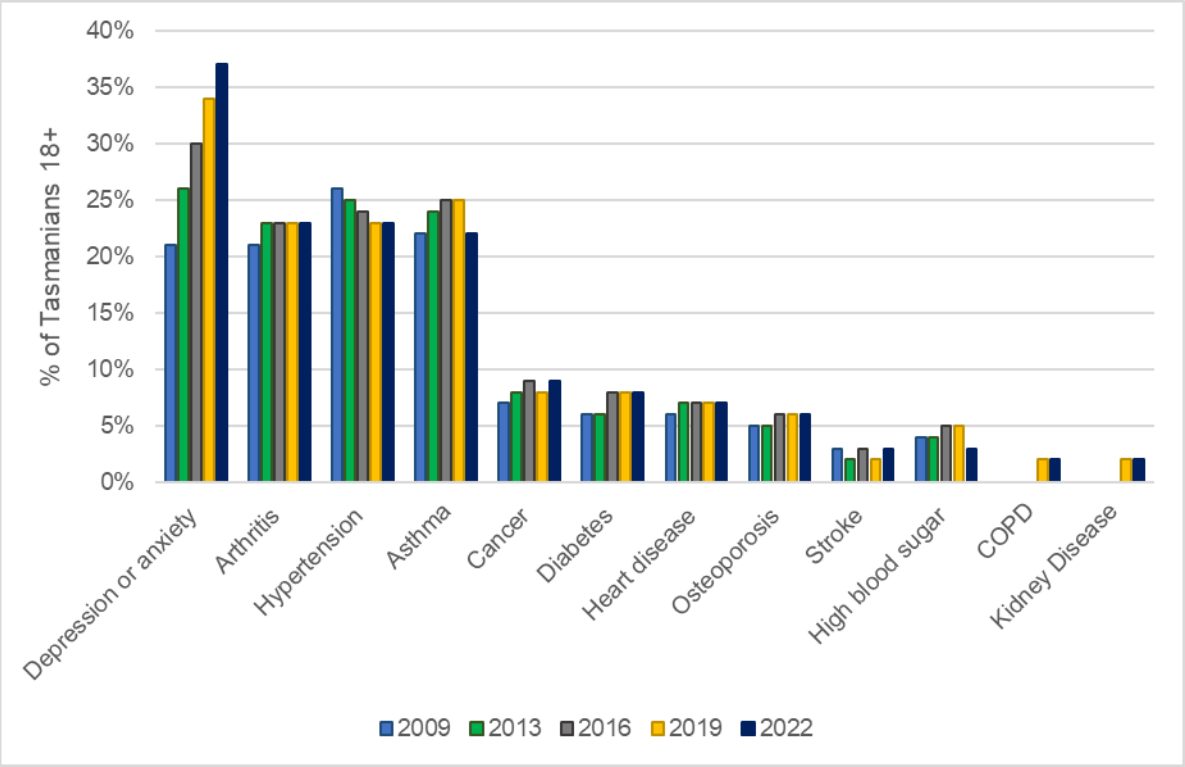
Figure 22: Self-reported ever-diagnosed chronic conditions (age standardised) in all adults aged 18+ and 65+, Tasmania



The burden of chronic conditions is increasing over time in Tasmania

Rates of specific chronic conditions are increasing over time in Tasmania. While self-reported rates of cancer and diabetes have increased slightly since 2009, the most striking and consistent increases have been for people reporting being diagnosed with depression or anxiety[43] (Figure 23).

Figure 23: Self-reported ever-diagnosed chronic conditions (age standardised) in people aged 18+, Tasmania | 2009 - 2022



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[84].

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[85].

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

There are an estimated 344 general practices in Tasmania and 1029 GPs working only in Tasmania. Approximately an additional 185 GPs are reported as working in multiple states including Tasmania. Many GPs work part-time, the full-time equivalent number of GPs in Tasmania is 599.1. This is 105.5 FTE of GPs per 100,000 Tasmanian population, compared with 120.9 per 100,000 population nationally[86].

Nationally, the most frequent chronic problems managed in general practice are hypertension, mental health problems, musculoskeletal problems, diabetes and lipid disorders[87].

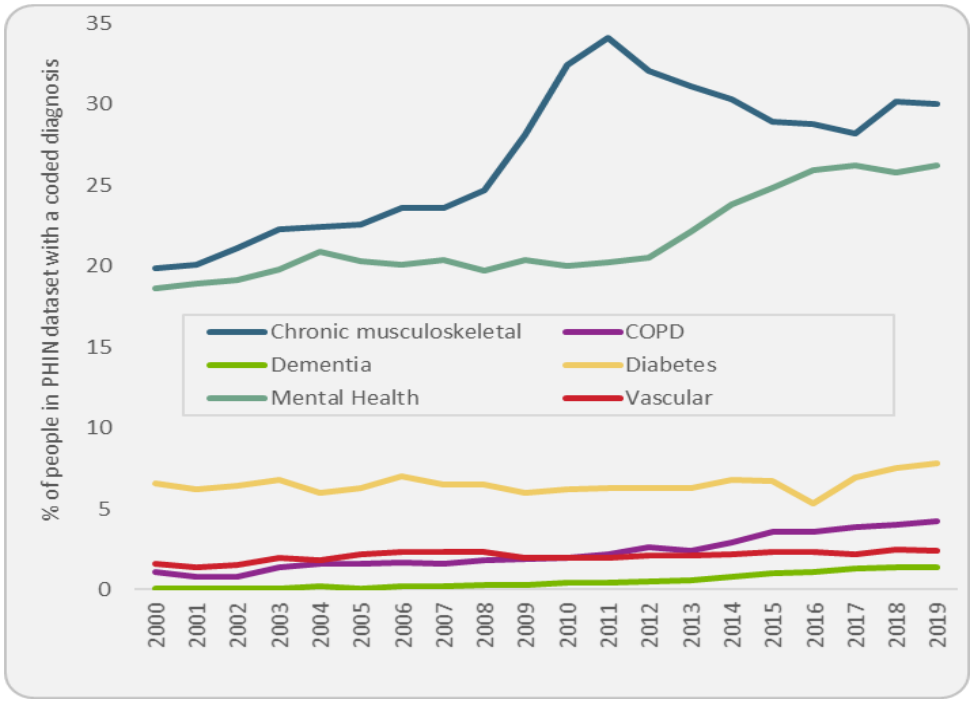
In Tasmania, most general practices contribute data to Primary Health Tasmania to inform our understanding of care delivered to people in general practice. These data show the percentages of people who visited their GP for selected chronic conditions were:

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

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

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[88] (Figure 24).

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

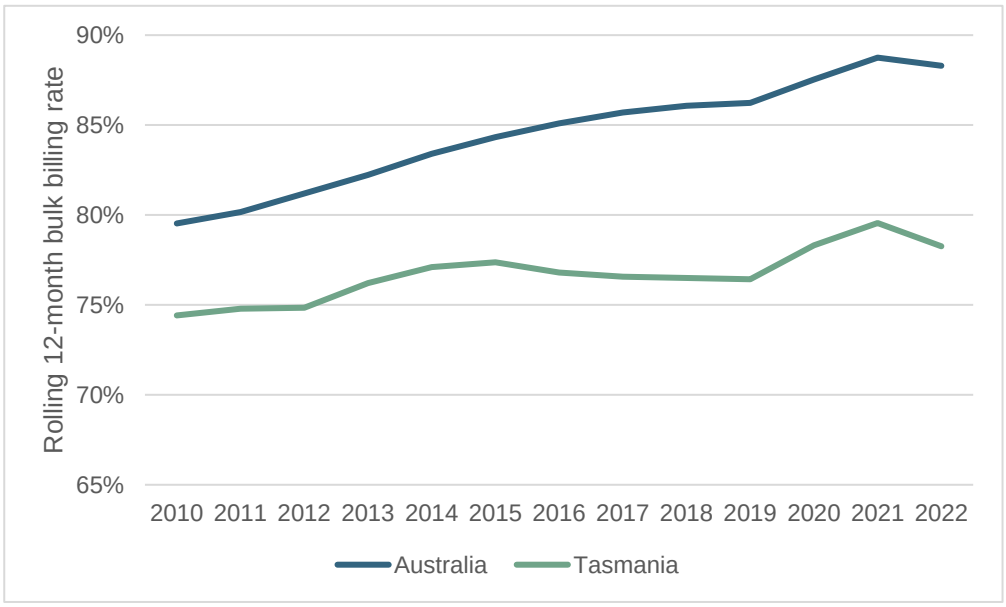


GPs care for most Tasmanians receiving health care for mental health problems. In 2019 there were approximately 80,000 people who saw their GP for a mental health problem[88]. The most common problem was depression, followed by anxiety. LGAs with the highest rates of GP attendance for mental health problems 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[89]. Tasmania has the second-lowest bulk-billing rate in the nation for GP services and is consistently below the national average[90] (Figure 25).

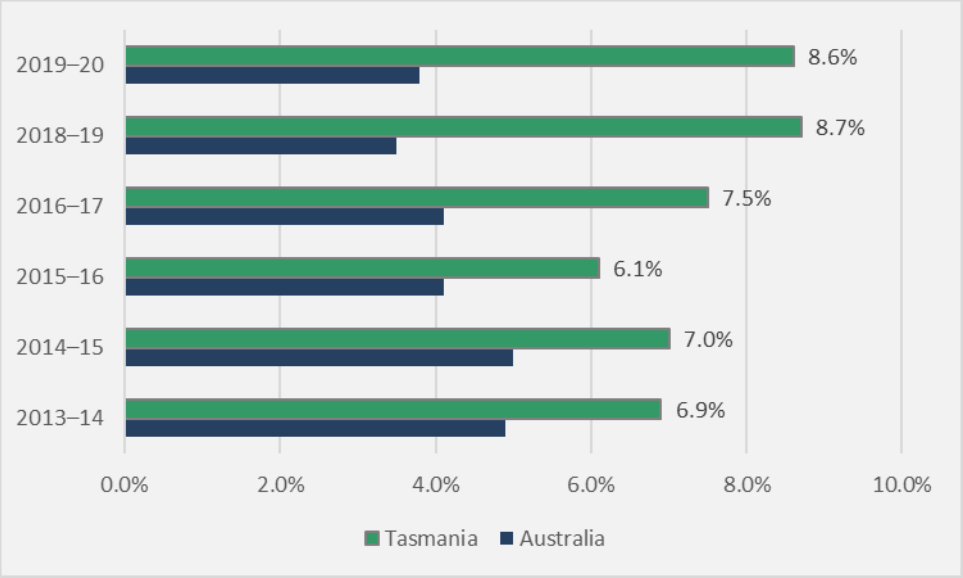
Figure 25. GP non-referred attendances, rolling 12-month bulk-billing rate, Tasmania and Australia | 2010–22



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[91] (Figure 26).

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 | 2013–20



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[92].

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.

In 2022, around 16% of patients with chronic conditions who had a GP encounter during the last three years had a 721 and 723 item recorded. Rates of 721 items were highest for patients with diabetes mellitus (37.4%), followed by chronic obstructive pulmonary disease (COPD) (32.4%) and cardiovascular disease (30.7%). Rates of 723 were highest for diabetes mellitus (33.3%), COPD (26.1%) and cardiovascular disease (25.2%).

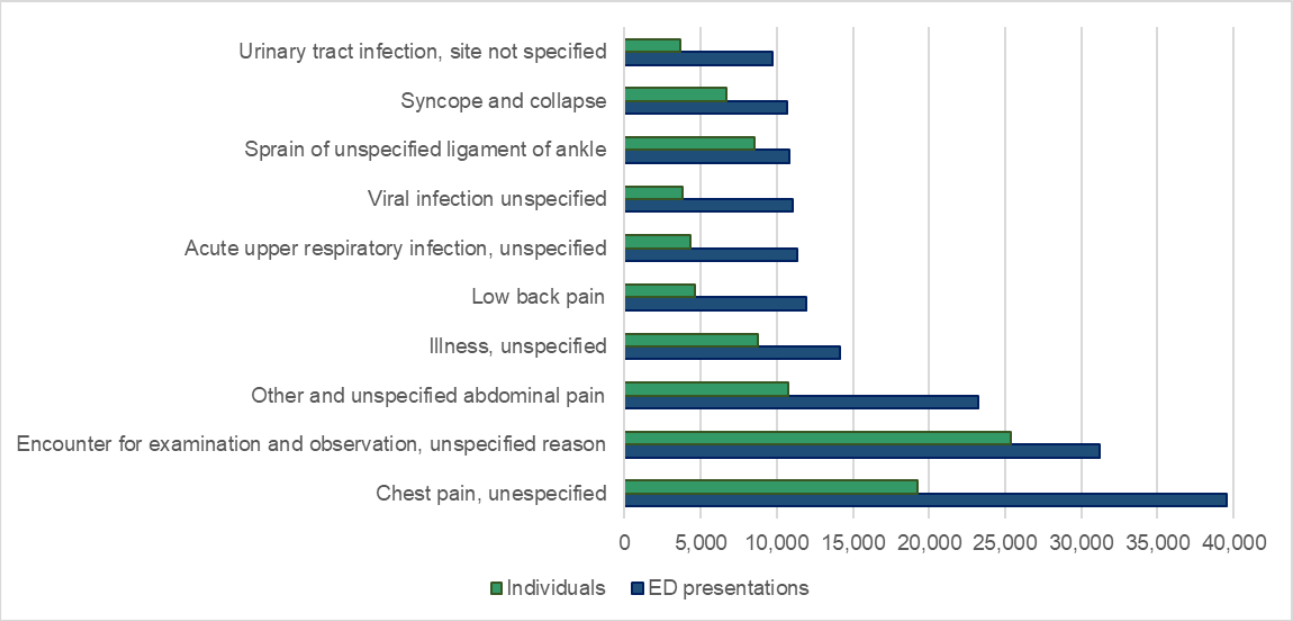
There is currently inadequate data to assess whether the high proportion of patients with chronic disease who do not have a GP Management Plan or Team Care Arrangement is due to low allied health professional availability across Tasmania, or other reasons.

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[93].

The main reasons Tasmanians access public hospital emergency departments are for treatment of pain in chest, abdomen, and back[56] (Figure 27).

Figure 27. Emergency department presentations, Tasmanian public hospitals | 2018-19 to 2022-23



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[94].

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.

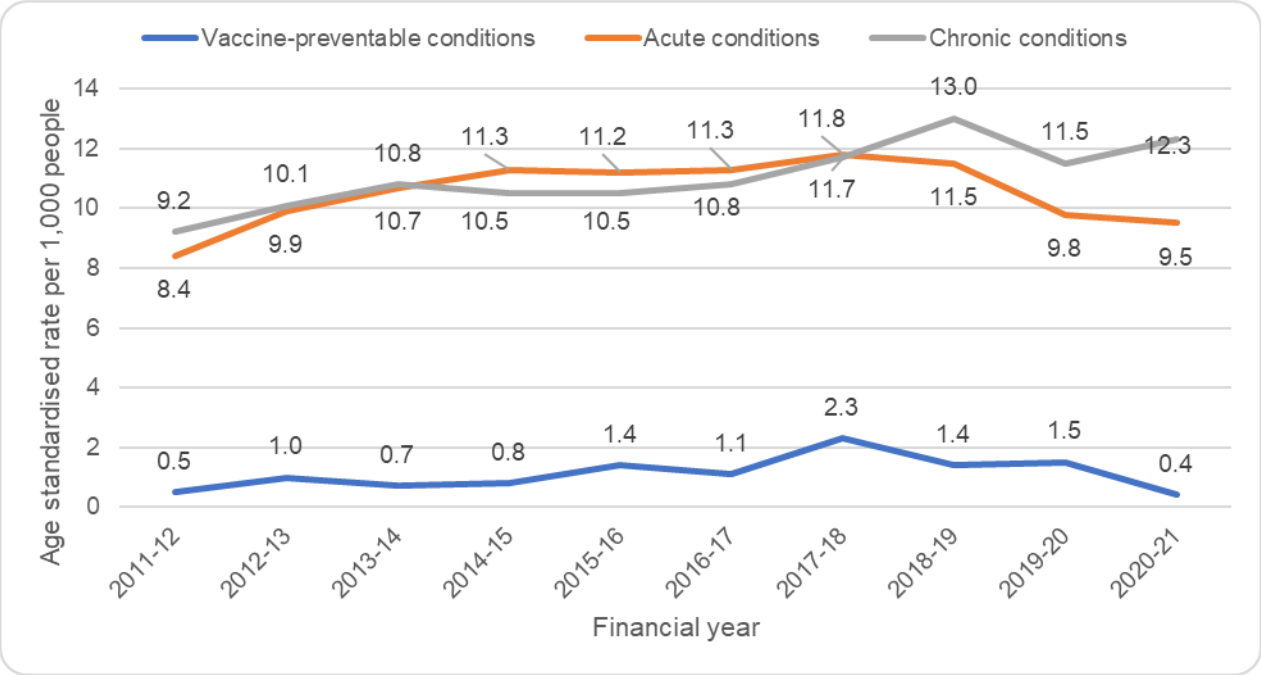
Diabetes is a priority chronic condition that contributes to preventable emergency department presentations and hospital admissions for people in residential aged care.

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 2016–17 and 2020–21 there were 50,853 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[57].

In Tasmania during 2020-2021, the rate of preventable hospitalisations for certain chronic conditions exceeded the rate of avoidable admissions related to acute and vaccine-preventable illnesses together. This gap has been widening since 2018-2019[95] (Figure 28).

Figure 28. Rate of separations of potentially preventable hospitalisations for vaccine-preventable, acute, and chronic conditions in Tasmania, from 2011-12 to 2020-21



People from our most disadvantaged communities are over-represented in our preventable hospitalisations. A number of factors, including increased age, higher socioeconomic disadvantage, multimorbidity of more than one long term health condition, frequent users of GP services, and not having access to GP services when needed, are shown to be among the factors that contributed to higher rates of PPH for chronic conditions[96].

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 could 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[57].

These people each spent an average of 120 days in hospital[57], and 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.

2.3.7 New services have been announced to address gaps in care for endometriosis and pelvic pain

In March 2023, the Commonwealth government announced funding for multidisciplinary services for women with endometriosis and pelvic pain.

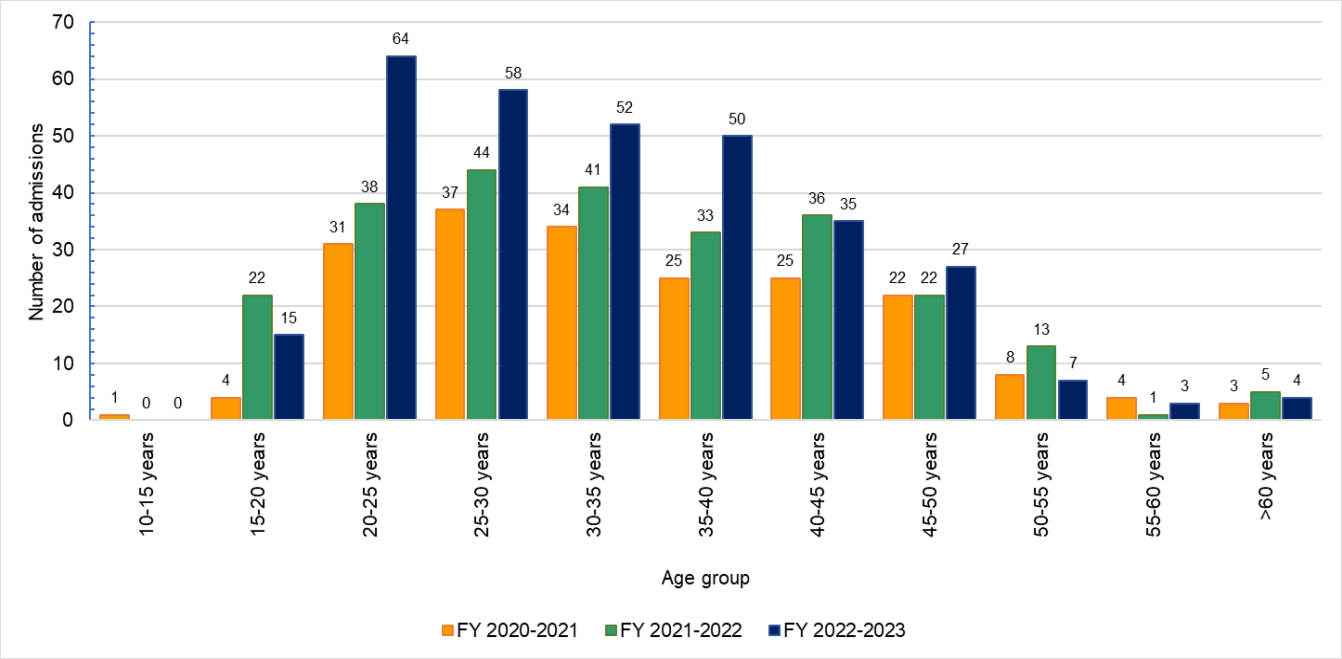
Endometriosis is a progressive chronic condition which causes a substantial disease burden among Australian women[97]. In Tasmania's public hospitals, there were 83 endometriosis-related emergency department presentations in 2022-23, (28.7 presentations per 100,000 females[56], in line with the national rate[97]).

Rates of endometriosis-related hospitalisations are lower for women aged 15-44 in Tasmania than in Australia as a whole (representing 12.3 out of every 1000 hospitalisations in this age group vs 18 per

1000 for Australia)[56, 97]. The reasons for this discrepancy are unclear, but the Tasmanian figures do not include admissions to private hospitals, or Tasmanian women who travel to the mainland for treatment.

Hospital admissions due to endometriosis have increased in women of reproductive age 20-45 years during the past three years in Tasmania[57] (Figure 29). This can be considered as an implication for increasing burden of disease from endometriosis in women of reproductive age and increasing economic burden related to the disease group.

Figure 29. Endometriosis (any diagnosis) admissions in Tasmanian public hospitals by age group in three years from 2020-21 to 2022-23 (Admitted Patient Care-Minimum Dataset)



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[98].

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.

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.

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 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 Healthcare Connect Service, targeting northern Tasmania in the first instance, aims to reduce preventable hospitalisations for frequent 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.

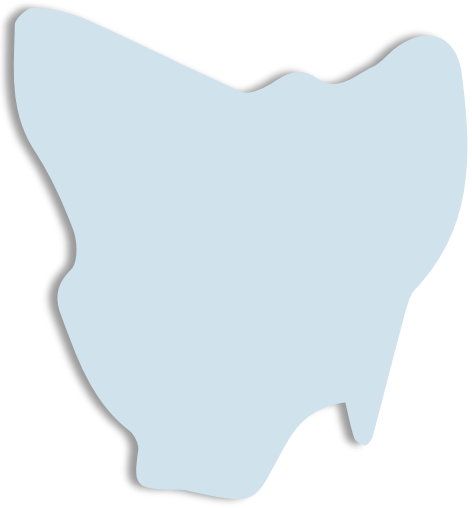
Primary Health Tasmania prioritise commissioning and supporting the delivery of team-based models of primary care that are comprehensive and meet the primary care needs of priority populations and for priority chronic conditions.

Primary Health Tasmania continue:

- partnering 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
- integrating a team-based approach to delivery of care through our commissioned services
- supporting delivery of multidisciplinary primary care to people as close to home as possible through our Rural Primary Health Services commissioning
- supporting Aboriginal Community Controlled Health Organisations to care for community members with chronic health conditions through our ITC program
- focusing on diabetes support, particularly for Tasmanians in residential aged care
- working 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.
- Supporting residential aged care facilities by providing an afterhours support plan toolkit to plan for the afterhours care of their residents

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

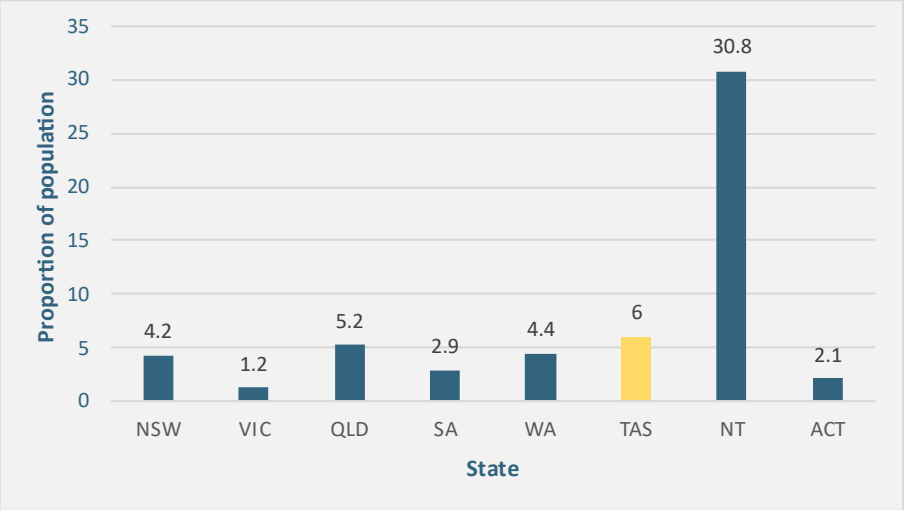
3.1 Overview

Aboriginal and Torres Strait Islander Australians are descended from the people who lived in Australia and surrounding islands prior to European colonisation[99]. 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[100].

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

In 2021, Tasmania was home to more than 33,894 Aboriginal people, of whom 2,302 were aged 65 or over, and 6,589 were aged 50 or over[101]. At 6% of the total Tasmanian population, this is the second highest proportion of Aboriginal people of any other state or territory[101] (Figure 30). Similar to the previous census, about one-quarter of Tasmanian Aboriginal people live in the greater Hobart region[102].

Figure 30. Estimated resident population by Indigenous status, Australia | June 2021



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[103].

Indigenous people also face ongoing challenges associated with racism, stigma, environmental adversity and social disadvantage[104].

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[105]. Improving the health and wellbeing of Aboriginal Tasmanians 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.

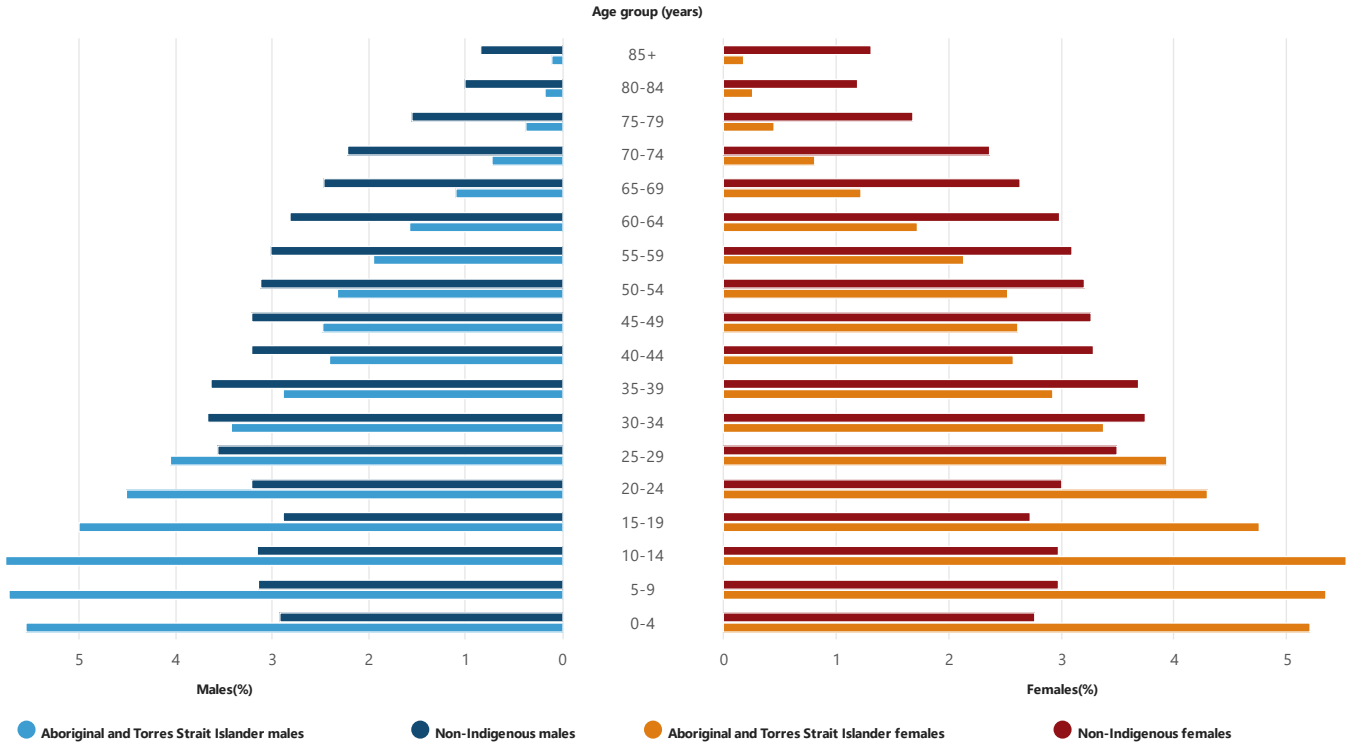
In general, compared with non-Indigenous Australians, Indigenous people in Australia have:

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

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

In 2021, one-third (32.3%) of Aboriginal and Torres Strait Islander people were aged under 15 years compared with 15.9% of non-Indigenous people in the same age group[101]. Figure 31 illustrates the estimated resident population in 2021 with a higher proportion of young people and lower proportion of older people. This reflects the previous estimations of higher fertility rates and higher death rates compared with the non-Indigenous population[101].

Figure 31. Estimated population distribution by Indigenous status and age group, proportion of Australian population | 2021

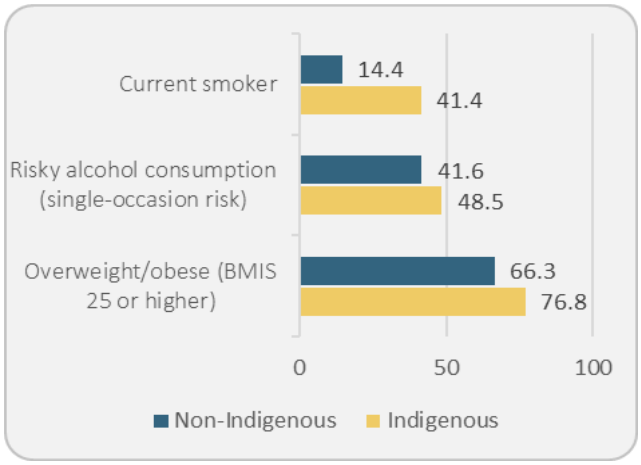


3.2.2 Indigenous people have poorer health status and higher health risk factors

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[104].

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[106] (Figure 32).

Figure 32. Age-standardised prevalence of selected health risk factors by Indigenous status, Australia | 2018–19

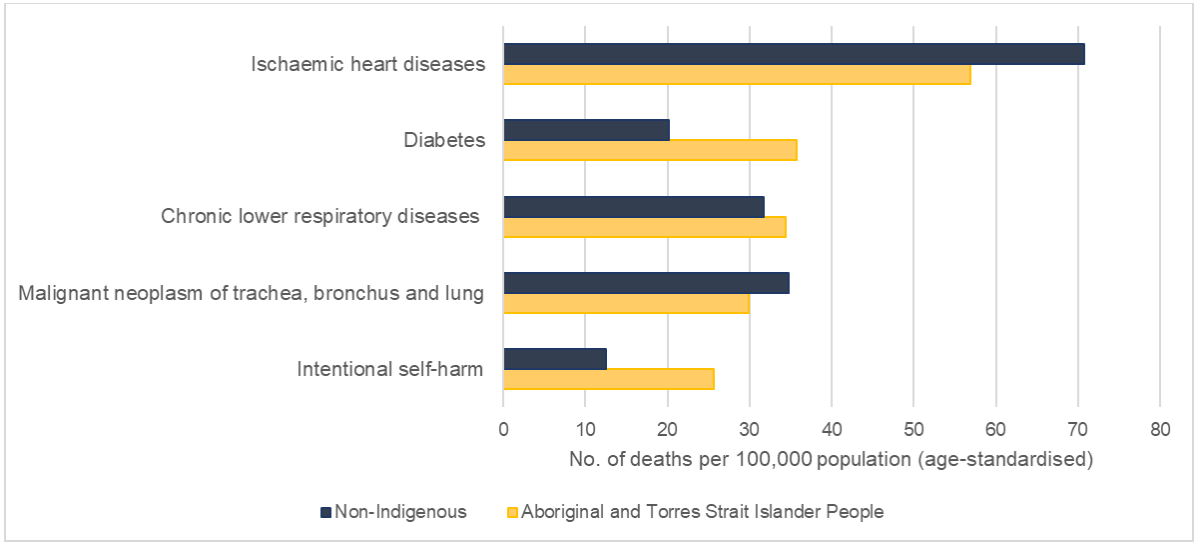


Notes: 1. For non-Indigenous rates, 2017–18 was used.
2. The rate ratio is calculated by dividing the age standardised rate for Indigenous people by the comparable age standardised rate for non-Indigenous people.

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[107]. In 2022, the national age-standardised rates of death from diabetes was more than five times as high for Indigenous people, compared to non-indigenous Australians (85.9 deaths per 100,000 compared with 16.5 deaths per 100,000, respectively)[108]. Chronic disease is the single leading cause of death, with ischemic heart disease, diabetes, respiratory diseases, and cancer among the leading causes of death in 2022[108] (Figure 33).

Figure 33. Leading broad causes of death by Indigenous status, selected Australian jurisdictions* | 2022



*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 2022 approximately 40% of Aboriginal Tasmanians reported high or very high levels of psychological distress. This compares to 19% of Tasmanian adults overall[43].

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[109].

Age-standardised rates of Indigenous deaths by suicide have increased nationally over the past ten years from 18.9 per 100,000 people in 2012, to 27.1 per 100,000 people in 2021, while for non-Indigenous Australians there has been a slight increase from 11.4 to 11.8 per 100,000 people in the respective time period.

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

Suicide rates were significantly highest for the 25-44 year age group at 47.6 per 100,000 (compared to 16.2 per 100,000 for the same non-indigenous age group), followed by 45- 64-year age group at 21.1 per 100,000 (compared to 17.4 per 100,000 for the same non-Indigenous age group) during the period between 2017-2021[110].

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[104]. Indigenous people also experience discrimination accessing services[104] 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[111].

3.2.6 Potential impact of the Voice to Parliament Referendum on the Aboriginal and Torres Strait Islander people's mental health and wellbeing

Aboriginal and Torres Strait Islander people have expressed experiencing additional stress, division and conflict, racism, and pressure to educate and inform non-Indigenous people in the time leading up to and following the referendum. This may have a negative influence on the mental health and well-being of the Indigenous population during the time period before the referendum, or longer lasting effects after this period[112].

Providing education for the workforce can help support the impact of these reforms on the Aboriginal and Torres Strait Islander people. Additional support for Aboriginal and Torres Strait Islander consumers of mental healthcare services may be required.

3.3 Service needs

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

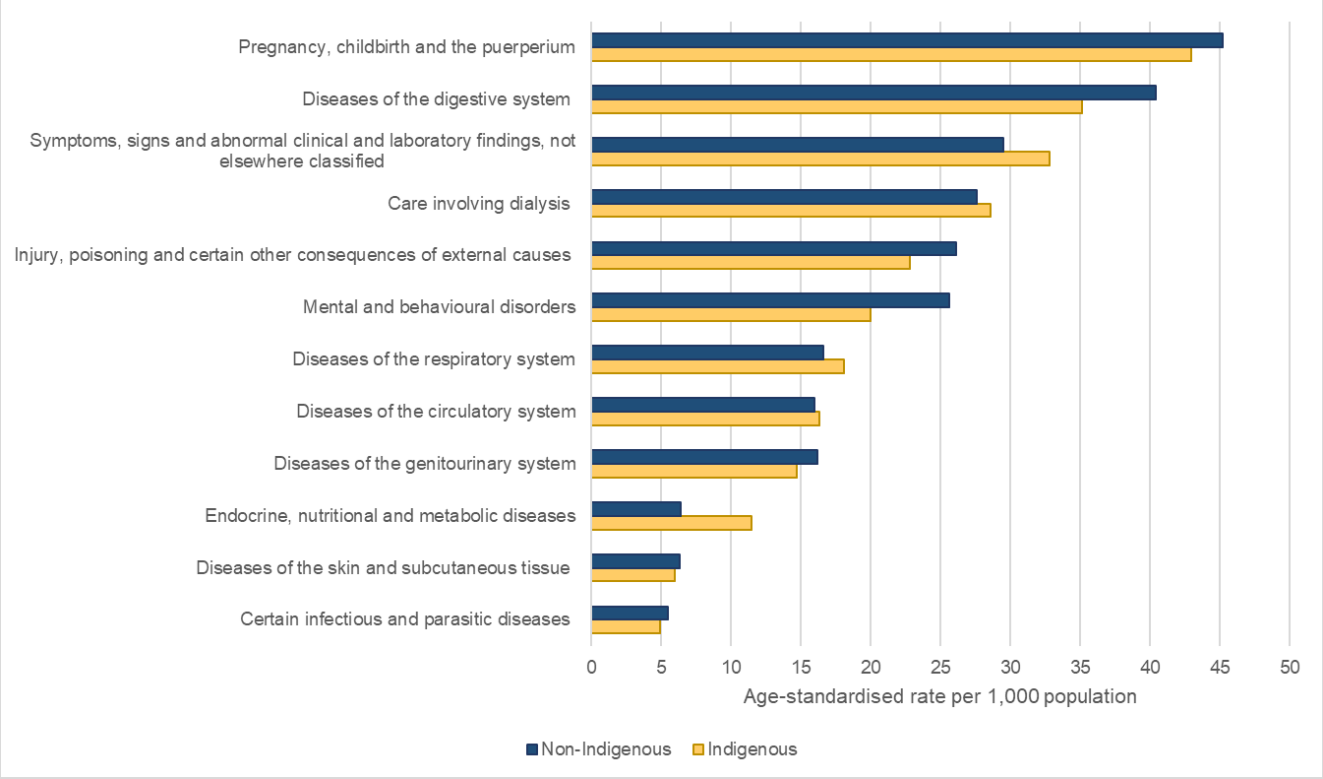
3.3.1 Avoidable hospitalisations for Tasmanian Aboriginals

During 2021-22, there were 341.6 hospital separations per 1,000 population for Aboriginal Tasmanians – about 1.5 times the rate for other Tasmanians[113]. 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 26.8 per 1000 Tasmanian Aboriginal residents, lower than national rates of 67.8 potentially preventable hospitalisations per 1000 Indigenous residents[95]. The top five potentially preventable conditions in Tasmanian Aboriginal people who were hospitalised were dental conditions, COPD, ear, nose and throat conditions, cellulitis, and urinary tract infections.

3.3.2 Emergency department use

During 2021-22, there were 402.1 emergency department presentations per 1,000 population for Aboriginal Tasmanians – about 1.3 times the rate for other Tasmanians[114]. A large part of this difference was due to substantially higher rates of dialysis. Among the leading causes of hospitalisations for Indigenous Australians, the age-standardised hospitalisation rate per 1000 population was higher for dialysis, respiratory disease, circulatory system, and endocrine and metabolic diseases than the corresponding non-Indigenous rate in respective causes[115] (Figure 34).

Figure 34. Age-standardised rates of the leading causes of Indigenous hospitalisations per 1,000 population, by Indigenous status, Australia | July 2017 – June 2019



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[116]. 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, two of which report having fewer than 500 clients[117]. Six of these organisations are Aboriginal Community Controlled Health Organisations and one is a mainstream provider. In 2021–22 these organisations reported seeing more than 7460 clients, mostly Aboriginal. These clients received a total of 85,036 episodes of care, approximately 11 per person[117].

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[117].

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

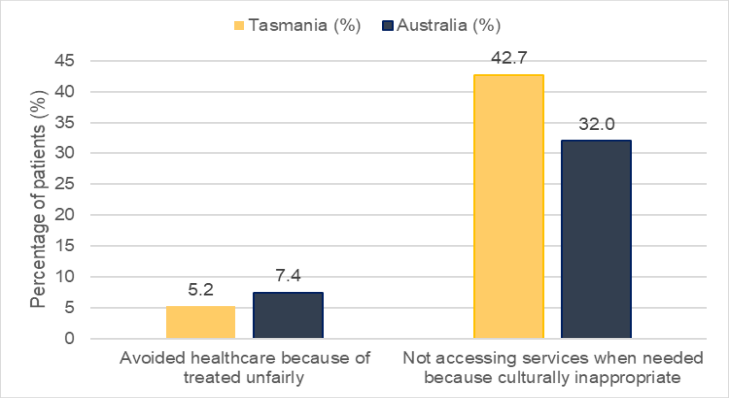
In 2020, influenza vaccination coverage nationally was 34.6% for Indigenous adults aged 20-49, 58.1% among those aged 50-64, 77.2% for those aged 65-74, and 80.3% for those aged 75 or over[26]. Indigenous Australians have a higher chance of serious illness, such as pneumonia or death if they get influenza (the flu). Influenza vaccination substantially reduces the risk of hospitalisation and death from influenza and pneumonia, especially for older Indigenous Australians[26].

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[118].

In Tasmania, cultural appropriateness of most health services remains an issue for more than 40% of Aboriginal people[119] (Figure 35). 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[120]. While culturally appropriate care is an important matter, Aboriginal people have reported multiple factors as reasons for their poorer access to health care services including cost, fear, non-availability of services, and transport problems[107].

Figure 35. 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

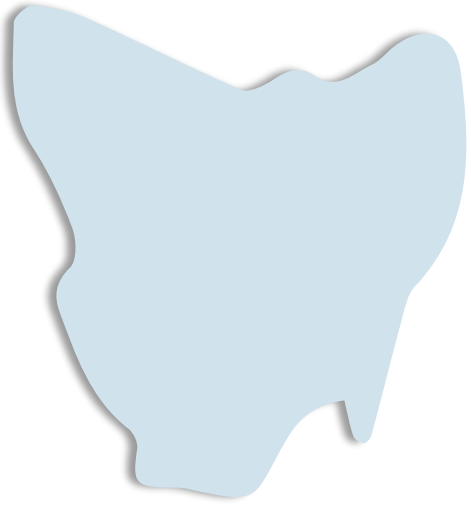
A priority for Primary Health Tasmania is to build workforce capacity and capability of Aboriginal health professionals. We will support ACCHOs to identify gaps in Aboriginal health workforce and support model of care development to address gaps.

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 13% of Australia's total burden of disease in 2018, making it the equal-second highest disease group contributing to the total burden, along with cardiovascular diseases and musculoskeletal diseases[121].

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[122].

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[123]. 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[88].

Estimated number of people with mental health conditions in Tasmania

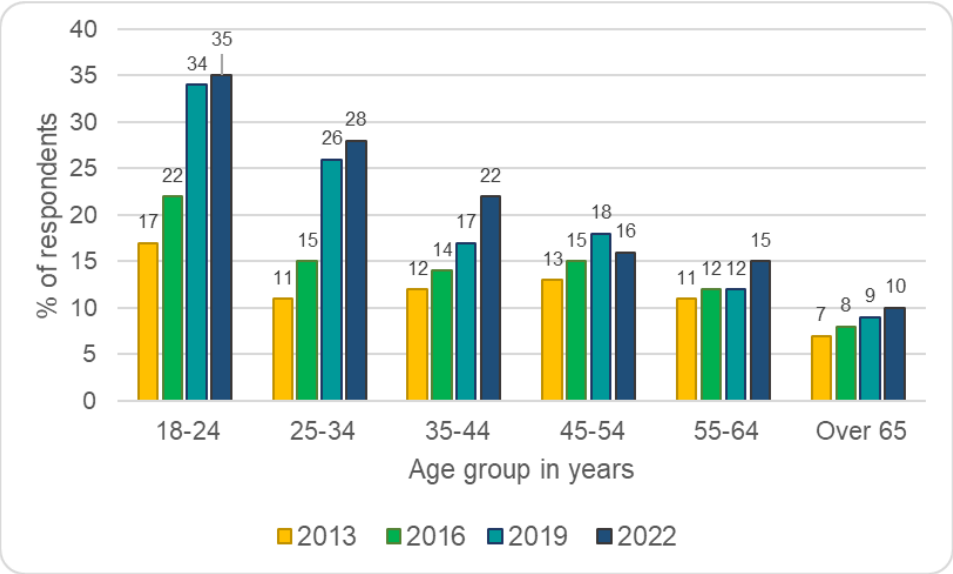
17,605 people are living with a severe mental health disorder

26,124 people are living with a moderate mental health disorder

51,112 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. Almost one in five Tasmanian adults (19%), reported very high or high levels of psychological distress in 2022[43]. More female Tasmanians reported high or very high levels of psychological distress than males in 2022, similar to previous years (Figure 36).

Figure 36. Self-reported high and very high level of psychological distress by age group, Tasmanian Population Health Survey: 2013–22



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 2022 the percentage of Tasmanian adults reporting ever being diagnosed with anxiety or depression increased from 21% in 2009 to 37% in 2022[43].

The burden of mental health problems and mental illness is concentrated in people who are most socioeconomically disadvantaged[88].

4.2.2 People with mental illness often have additional physical health issues

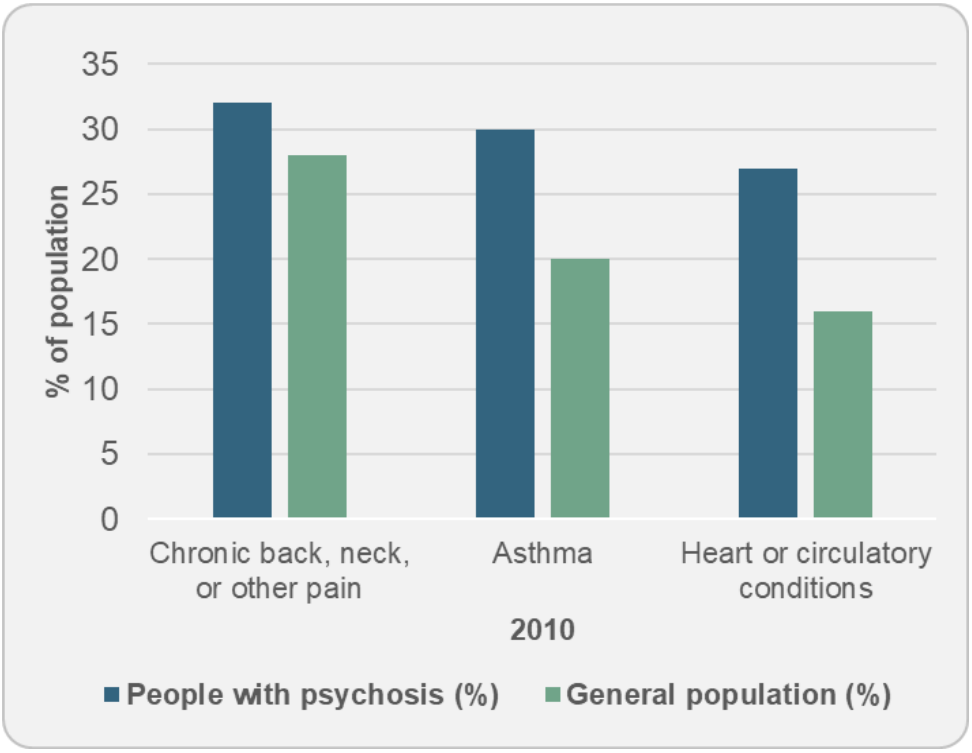
Most people with mental illness also have chronic disease.

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 2020-21 Australian Health Survey, for people who reported having a mental illness:

- the most common additional health conditions that people living with mental illness experience are arthritis (including back problems), asthma, cancer and diabetes[85].
- 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[85]. The second national survey of People Living with Psychotic Illness[124] 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%)[124] (Figure 37).

Figure 37. 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[125].

About 65% 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[126].

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[127].

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[124].

- 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

Between 2017 and 2021, 82 Tasmanians on average have died by suicide annually (ranging from 65 to 106). The age-standardised suicide rate in Tasmania in 2021 was 13.5 per 100,000 people, compared with 12.0 per 100,000 nationally[128]. Suicide was the leading cause of death among Tasmanians aged 25–44 years in 2022 and accounted for the highest number of years of life lost[129]. Suicide rates are higher among males than females in all age groups, and are highest among men aged 35–44[126].

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 (64%) of people who died by suicide in Tasmania in 2012–18 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[126]. For people with available toxicology reports, pharmaceutical drugs had been consumed before death by 73%, alcohol by 36%, and illicit drugs by 14%.

Suicide prevention has been identified as a national priority and in December 2018 it was elevated to a whole-of-government issue. The *National mental health and suicide prevention plan (2021)* 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[126]. In alignment with that, the Tasmanian Suicide Prevention Strategy 2023-27 includes a focus on collaboration to prevent suicide in Tasmania[130].

4.3 Service needs

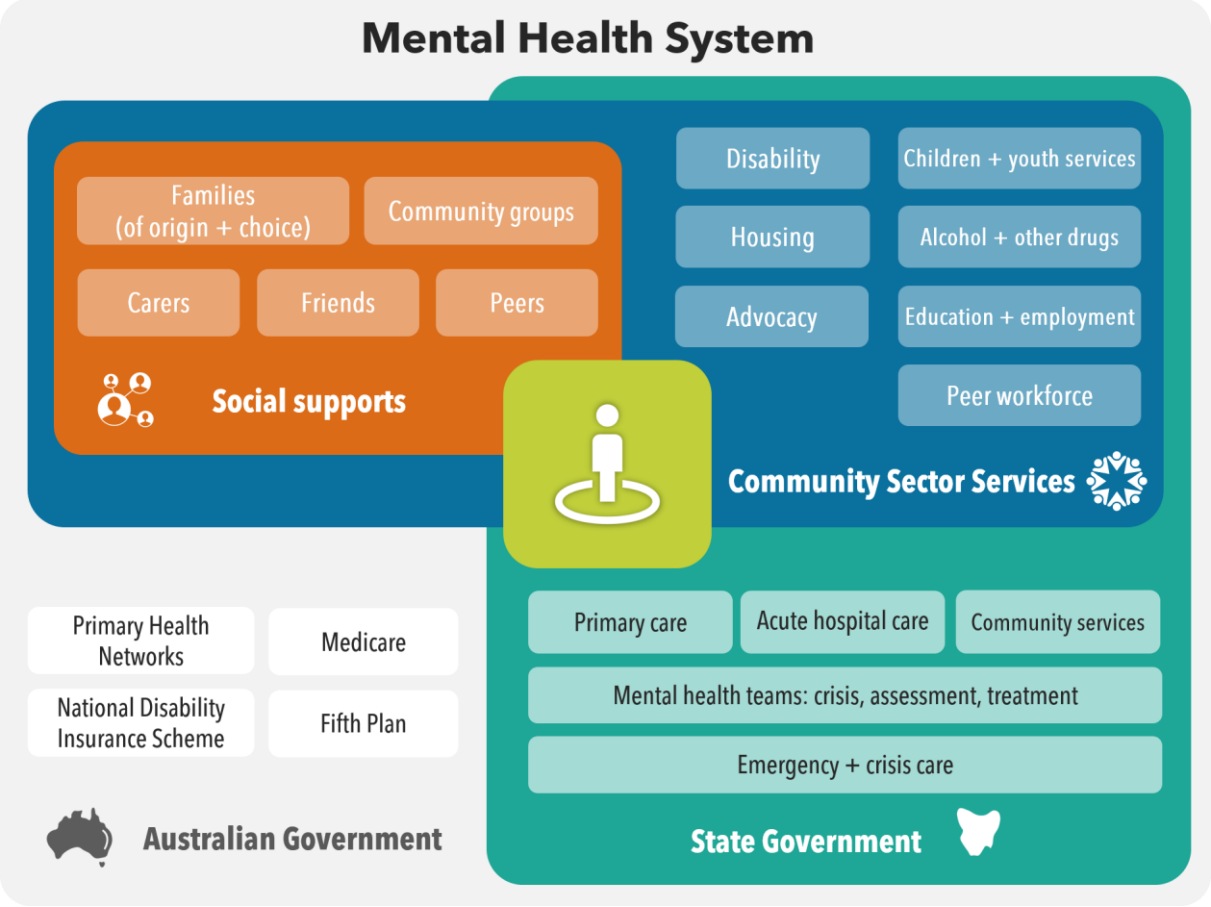
4.3.1 Tasmania's mental health system is complex

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 38).

Figure 38. Tasmania's mental health system



The 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.

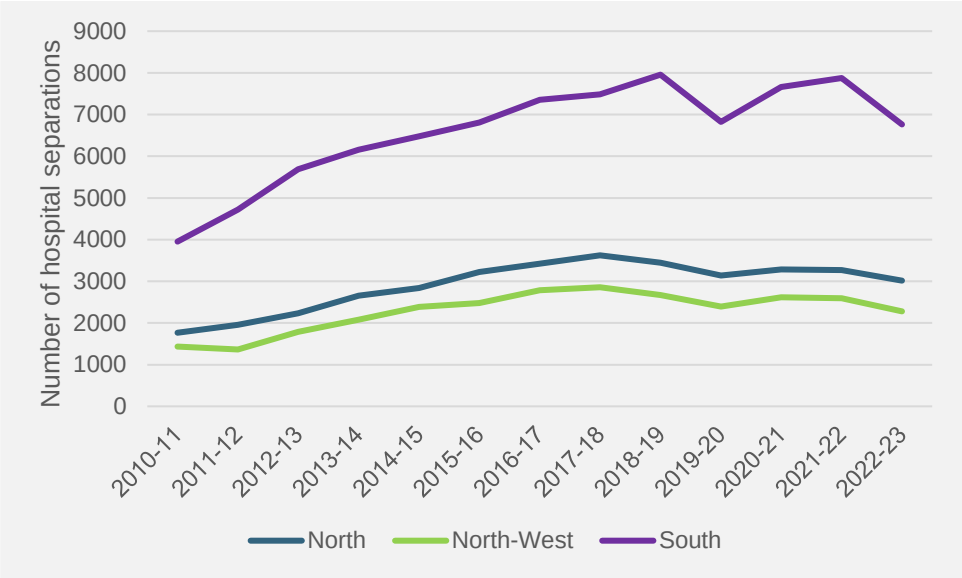
Rethink 2020: Key Reform Directions

	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

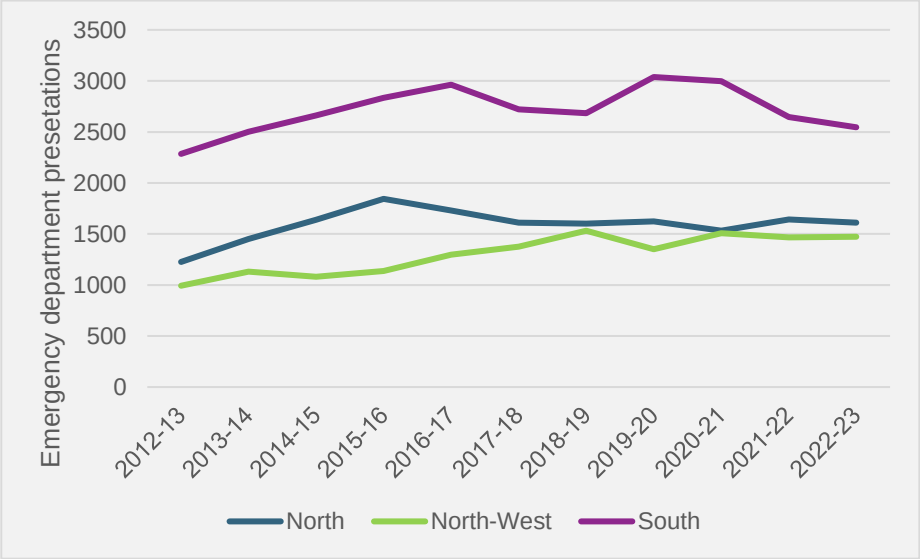
The number of hospital separations in people with mental and behavioural disorders has increased in Tasmania since 2010–11, despite a significant temporary decrease during the initial stage (2019-20) of the COVID-19 pandemic[57] (Figure 39).

Figure 39. Public hospital separations, mental and behavioural disorders, Tasmania | 2010–11 to 2022-23



Emergency department presentations in people with mental and behavioural disorders have also increased in Tasmania since 2012-13 [56] (Figure 40).

Figure 40. Public hospital emergency department presentations, mental and behavioural disorders, Tasmania | 2010–11 to 2022-23

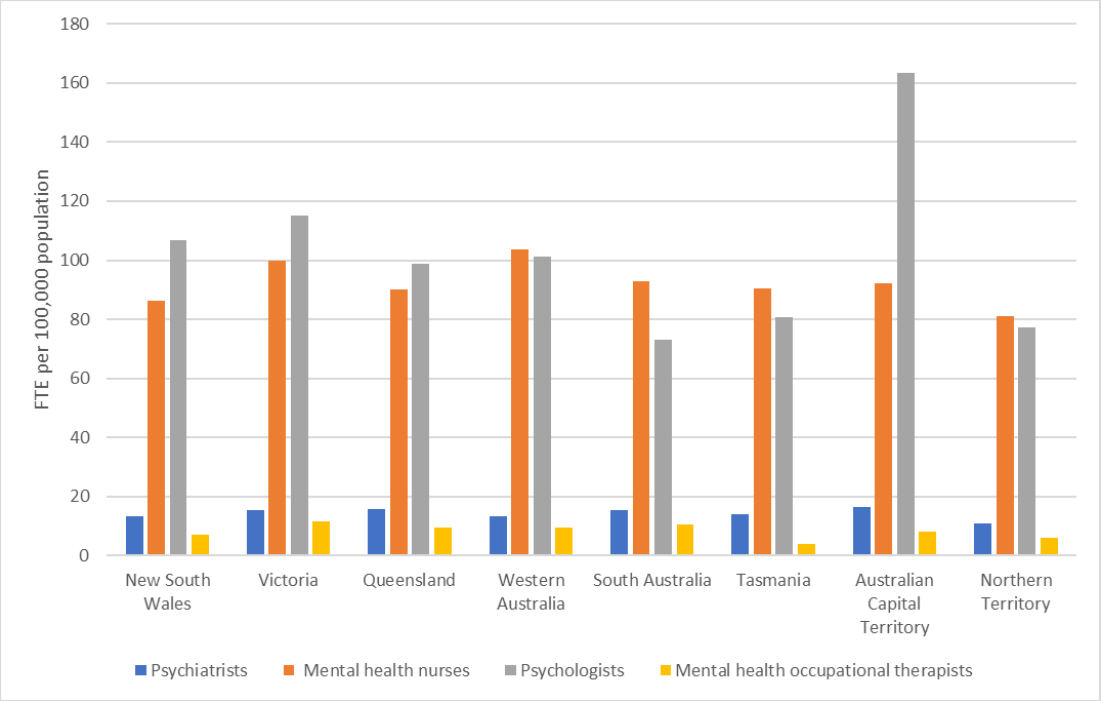


4.3.3 Tasmania has a smaller mental health workforce compared with other jurisdictions

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[131] (Figure 41).

Figure 41. Clinical full-time equivalent mental health disciplines per 100,000 population, Australian states and territories | 2021



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

The 2020-21 National Survey of Mental Health and Wellbeing collected data on mental health service access in the preceding 12 months. From this survey, it was estimated that 17.5% of Australians aged 16-85 saw a health professional for their mental health, 22.8% of females and 12.2% of males[132]. Among people with a mental health disorder who had experienced symptoms in the previous 12 months, 47.1% saw a health professional for their mental health:

- 45.8% of females and 26.4% of males consulted a GP
- 25.3% of females and 16.7% of males consulted a psychologist
- 8.1% of females and 7.4% of males consulted a psychiatrist[132].

It has been suggested that increases in treatment rates may have been influenced by the introduction of government-subsidised mental health treatment items to Medicare[133].

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)[134].

In Tasmania, GPs provide most mental health 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[88].

COVID-19 has further influenced treatment patterns. During the course of the COVID-19 pandemic (between 16 March and 1 May 2022) over 29 million MBS-subsidised mental health-related services were processed in Australia. MBS-subsidised mental health services were also delivered via telephone or videoconference. Eleven per cent (11%) of the Australian population received Medicare-subsidised mental health specific services in 2021-22. In 2021-22, 49% of MBS mental health-specific services were provided by psychologists (including clinical psychologists), 27% were provided by GPs and 19% were provided by psychiatrists[134].

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[117, 134].

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. In 2021-22, Primary Health Tasmania commissioned services to provide urgent mental health support in Devonport as a response to the Hillcrest Primary School tragedy. Most commissioned services are for delivery of short-term interventions to people with mild to moderate mental illness [135] (Table 5).

Table 5. Profile of Primary Health Tasmania commissioned mental health programs | 2018–19 to 2022-23

Program	Clients	Episodes	Services
Low-intensity	1441	1507	10255
Short-term	6,530	8,579	58,533
Youth severe	406	437	26,680
ASC	777	823	25,556
Psychosocial	471	511	14,911
Aged	605	675	5,187
Adult Mental Health Centre*	615	651	6796
Way Back*	482	492	9940
Bushfires**	119	149	1216

*Commenced during 2021-22; ** Discontinued during 2021-22

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 score of less than 20 are considered to have no psychological distress, those with a score of 20–24 have mild psychological distress, a measure of 25–29 indicates moderate psychological distress and >29 indicates severe psychological distress.

At baseline, people accessing commissioned residential aged care mental health services had mild level of psychological distress on average, whereas those who accessed bushfire recovery services and low-intensity services had moderate levels of psychological distress.

The average level of psychological distress in the clients of all other Primary Health Tasmania's mental health programs was assessed as severe. A significant improvement in psychological distress was observed across all commissioned mental health services [135] (Table 6).

Table 6. Percentage changes in psychological distress as per K10 (first and last measurements), Primary Health Tasmania | 2018–19 to 2022–23

Program	Improved	No Change	Deteriorated
Low-intensity	54.5%	42.4%	3.1%
Short-term	47.1%	43%	9.9%
Youth severe	48.0%	38.8%	13.2%
ASC	60.8%	32.0%	7.2%
Psychosocial	N/A	N/A	N/A
Aged	53.8%	39.2%	7.1%
Adult Mental Health Centre*	70.5%	26.0%	3.4%
Way Back*	72.8%	23.7%	3.5%
Bushfires**	65.0%	35.0%	0.0%

*Commenced during 2021-22; ** Discontinued during 2021-22

Primary Health Tasmania also commissions mental health services for young people through headspace centres in Tasmania's three regions. Each year, over 3000 young people received services from four centres located in south, north and north-west of Tasmania[135] (Table 7).

Table 7. Profile of the headspace program in Tasmania | 2019–20 to 2022–23

Centre	2019-20			2020-21			2021-22			2022-23		
	P	E	S	P	E	S	P	E	S	P	E	S
Burnie	0	0	0	60	66	148	172	214	443	129	186	325
Devonport	178	217	784	352	390	1485	396	493	1294	495	652	1768
Hobart	1805	2304	7064	1712	2062	6439	1349	1634	4116	1351	1684	4396
Launceston	1033	1316	4548	1226	1537	5462	1195	1482	4936	833	1107	3400
Total	3016	3837	12396	3350	4055	13534	3112	3823	10789	2808	3629	9889

*P=Persons; E=Episodes; S=Services

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[135] (Table 8).

Table 8. Outcome of services by K10 score, people who received services from headspace, Tasmania | 2018–19 to 2022–23

Region	Outcome group (%)		
	Significant improvement	No significant change	Significant deterioration
FY 2019-20 (n=913)	33.5	52.1	14.3
FY 2020-21(n=866)	33.9	51.7	14.3
FY 2021-22 (n=877)	37.1	51.2	11.7
FY 2022-23 (n=686)	36.9	46.6	16.5

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.

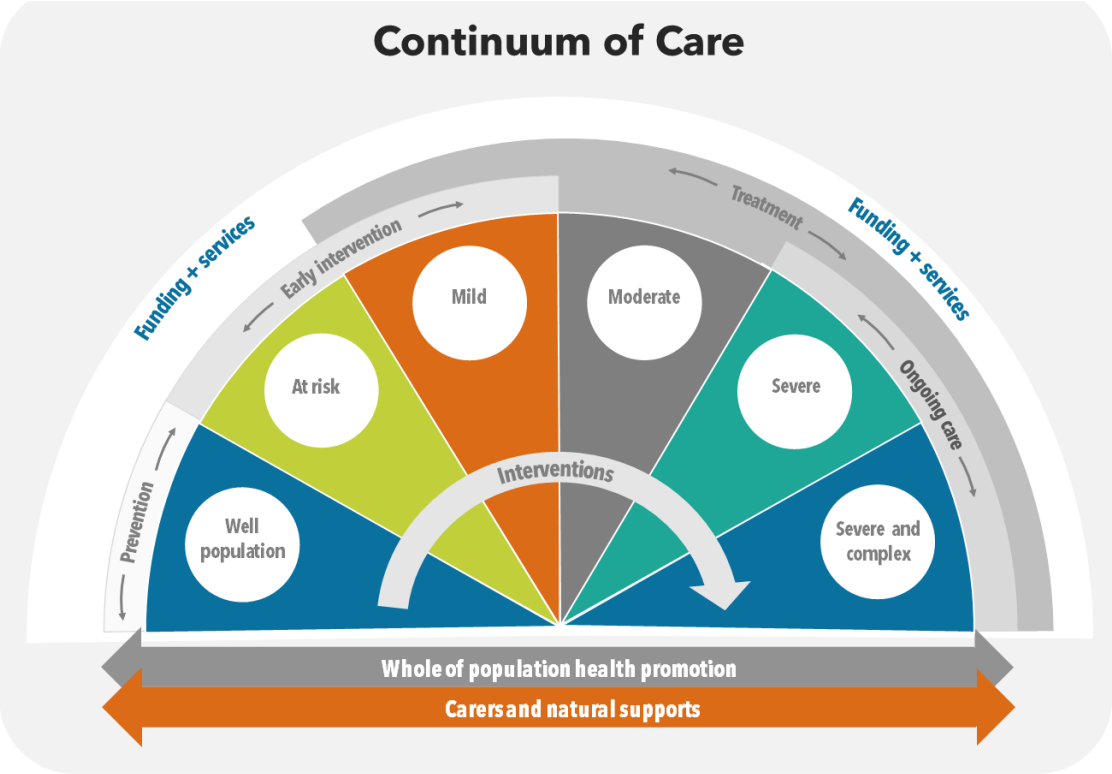
4.5 Priority actions

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 42. Tasmanian Mental Health Continuum of Care Model).

Figure 42. Tasmanian Mental Health Continuum of Care Model



4.5.2 Establish a primary mental health service gateway in North Tasmania

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.

To improve access to mental health care services for people with psychosocial distress and different levels of mental health problems, Head to Health adult mental health services were commissioned in northern Tasmania. This service provides an entry point to help people in distress receive immediate support, assessment and be connected with other local services for ongoing care. This service is being expanded to northwest Tasmania and outer Hobart.

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 and early psychosis service
- 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[81].

'Other drug use' or 'illicit drug use' (used interchangeably) can include[136]:

- 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[137].

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[137] (Table 9).

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 9. 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 80% of Tasmanians consumed alcohol in 2022[43]. The proportion of Tasmanians drinking daily, weekly, monthly or less than monthly, or who are ex-drinkers, did not change significantly between 2016 and 2019[82].

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, 37% of people drink alcohol at levels that exceed single-occasion risk (consume 4 or more drinks on a single occasion at any time in the last 12 months)[43].

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)[137].

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

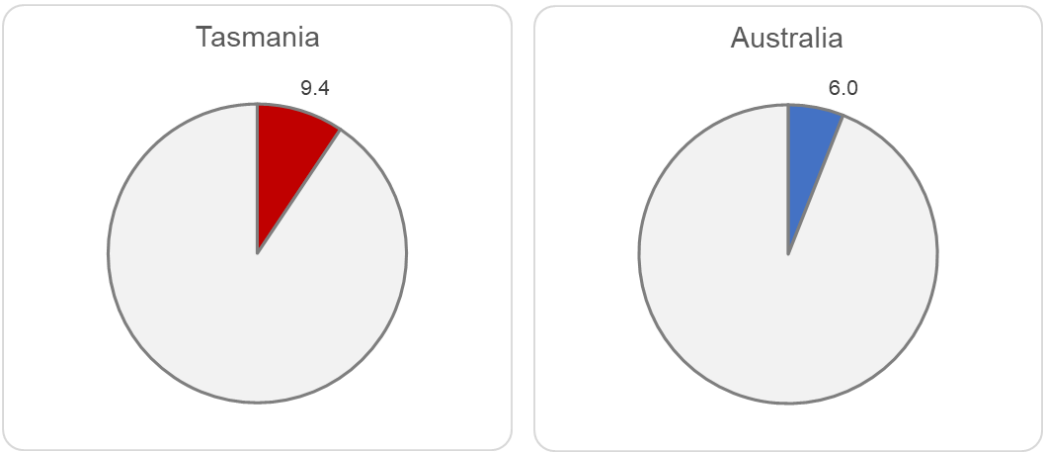
Lifetime risk is drinking more than 2 standard drinks a day.

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 increased nationally since 2013 from 4.9 to 6.0 per 100,000 persons in 2022[83]. 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. Approximately 9.4 deaths per 10,000 population (age-standardised) are alcohol-induced in Tasmania, compared to 6.0 deaths per 10,000 population in Australia as a whole[83] (Figure 43) .

Figure 43. Alcohol-induced deaths, rate per 100,000 population (age-standardised), Tasmania and Australia | 2022



Alcohol-related deaths extend beyond those deaths which are directly attributable to alcohol. In 2017 there were 4,186 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[83].

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[136].

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[137]. 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. 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 10).

Table 10. Top 5 illicit drugs used in the previous 12 months, people aged 14+, Tasmania | 2001, 2016 and 2019

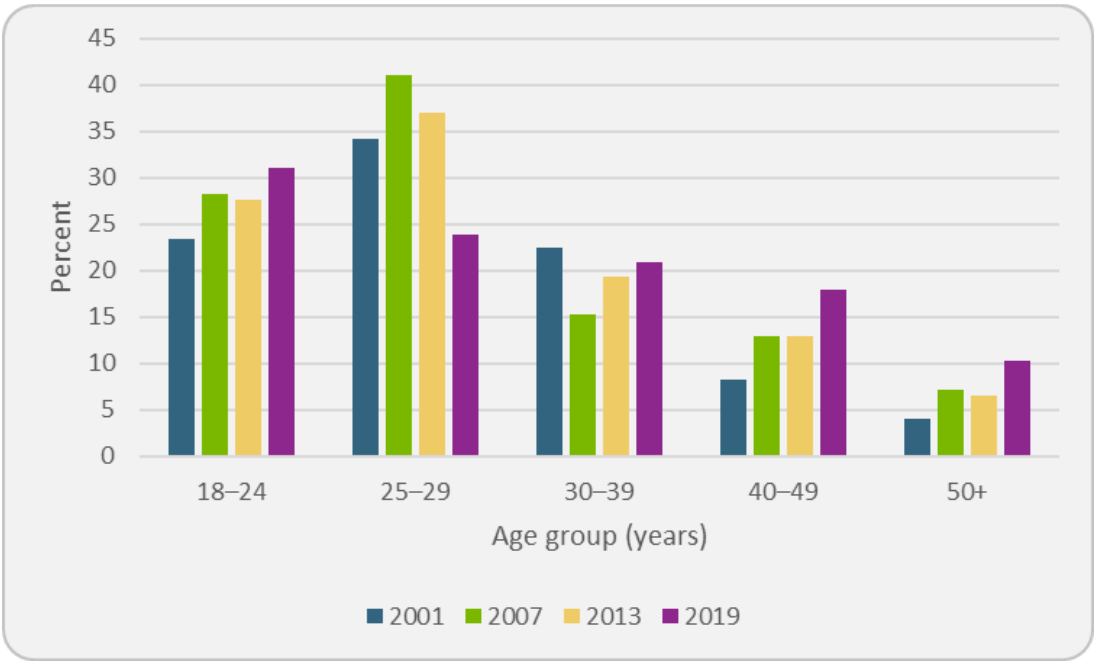
Rank	2001		2016		2019	
	Drug	%	Drug	%	Drug	%
1	Cannabis	11.9	Cannabis	12.4	Cannabis	12.6
2	Meth/amphetamine	2.1	Tranquillisers/sleeping pills	2.9	Ecstasy	*2.4
3	Hallucinogens	*1.0	Hallucinogens	*2.2	Cocaine	*1.6
4	Injected drugs	*1.0	Meth/amphetamine	*2.1	Tranquillisers/sleeping pills	*1.3
5	Tranquillisers/sleeping 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 44), while in 2019, there was a shift to younger age group of 18-24 years for highest rate of illicit drug use for the previous 12 months[137].

Figure 44. 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)[137].

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 2020-21, publicly funded AOD treatment agencies provided treatment to an estimated 139,300 clients nationally. The four most common drugs that led clients to seek treatment for their own drug use were alcohol (37% of all treatment episodes), amphetamines (24%), cannabis (19%) and heroin (4.6%). Almost two-thirds of all clients receiving treatment were male (62%), and over half of the clients were aged 20-29 years[106].

5.3.1 Tasmania's specialist alcohol and other drug treatment services

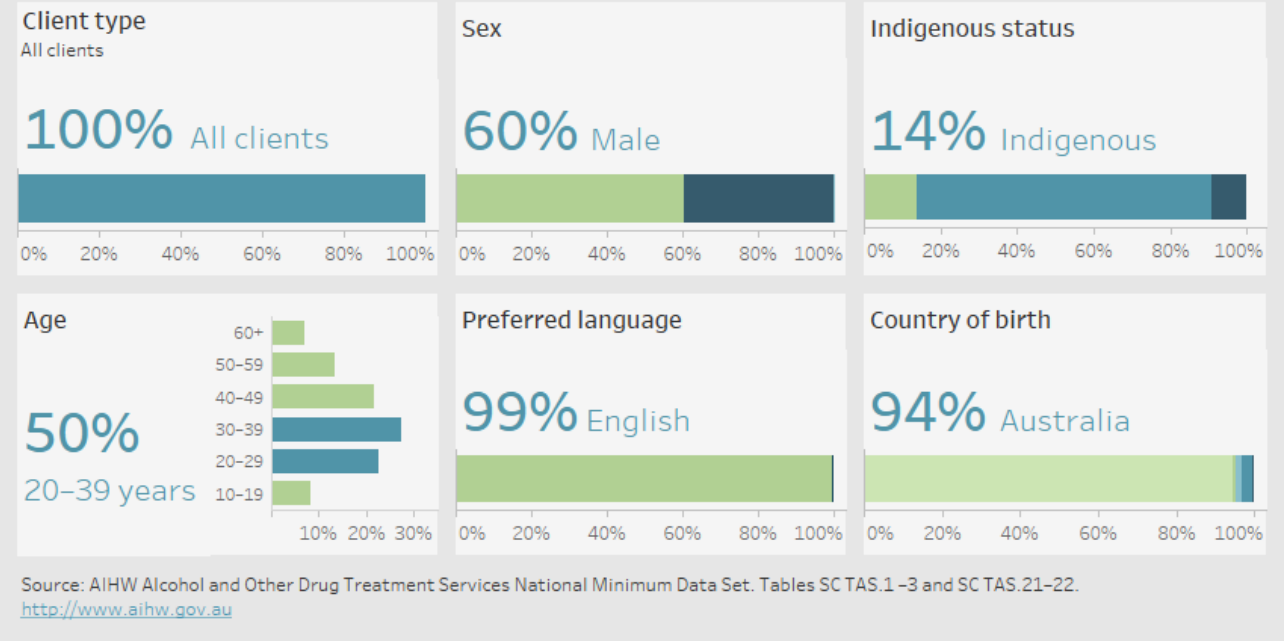
In 2021-22 there were 24 publicly funded alcohol and other drug treatment agencies in Tasmania that provided 3,483 treatment episodes to 2,684 clients. Our rate of treatment episodes is 685 people per 100,000 population, which is lower than the national treatment rate of 1009 people per 100,000 population[106]. In addition, our rate of clients is 528 clients per 100,000 people, which is lower than the national rate of 576 clients per 100,000 population.

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

Approximately 60% of Tasmanians who received specialist treatment were male and 14% identified as Aboriginal. Tasmanians aged 20–39 years were most likely (50%) to receive specialist services[106] (Figure 45).

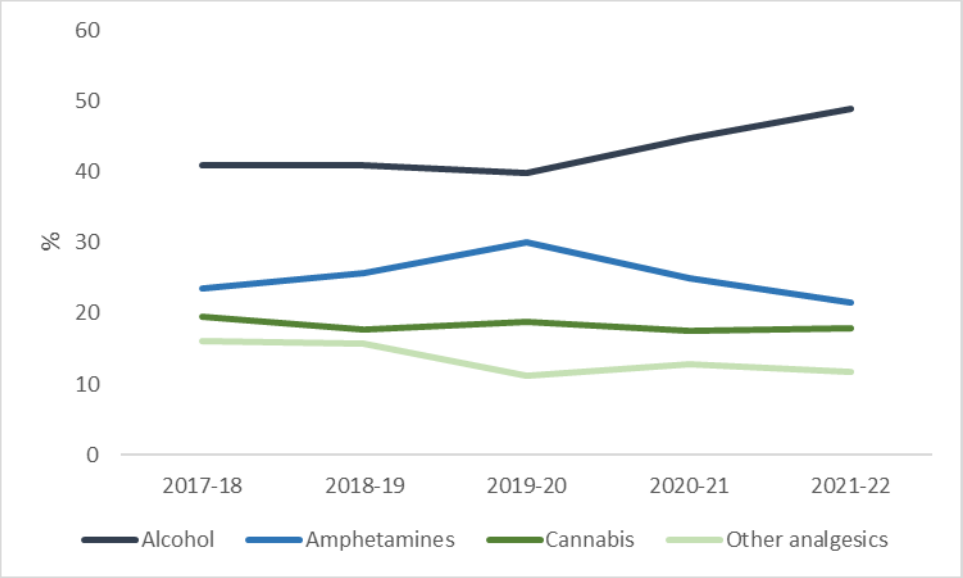
Figure 45. Alcohol and other drug treatment services, client demographics (n=2,684), Tasmania | 2021–22



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[106] (Figure 46). Rates of people seeking treatment for alcohol as a principal drug of concern have been increased in Tasmania since 2017-18 whereas rates of people seeking treatment for amphetamines have decreased to the same level in 2017-18 from an increase that had been shown in previous years[106].

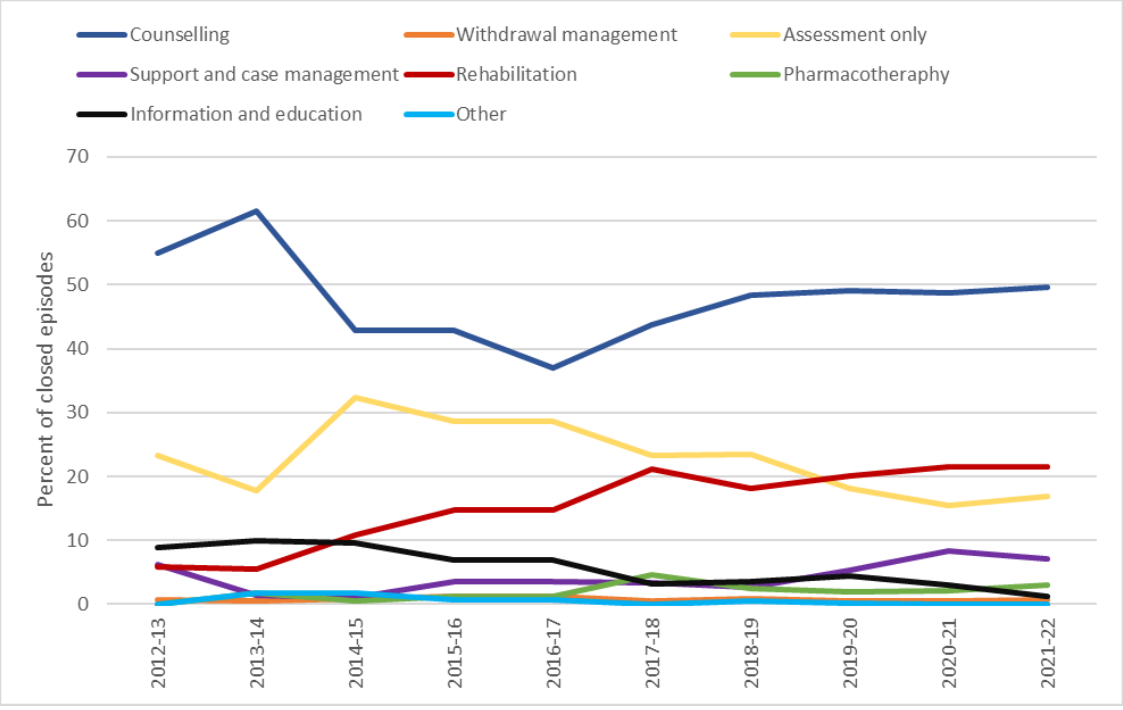
Figure 46. Proportion of closed treatment episodes (n=3,483) for own drug use by drug of concern, and presentation rates for principal drugs of concern Tasmania | 2021–22



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 –13 and rates of rehabilitation as the main treatment type have increased (Figure 47).

Figure 47. Main treatment type provided by specialist AOD services, Tasmania | 2012–22



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[138].

Hospitalisations

In 2022-2023, approximately 3% of all hospitalisations in Tasmania (5,018 out of 169,614) had a drug-related diagnosis[57]. Figure 48. Number of alcohol and drug related hospital admission in Tasmania 2022-23 shows that drug-related hospital admissions (principal and additional diagnosis) have decreased since 2021-22 after a sudden increase in 2019-20. The main reasons for the drug related hospitalisations are consistent with national ones (Figure 49).

Figure 48. Number of alcohol and drug related hospital admission in Tasmania 2022-23

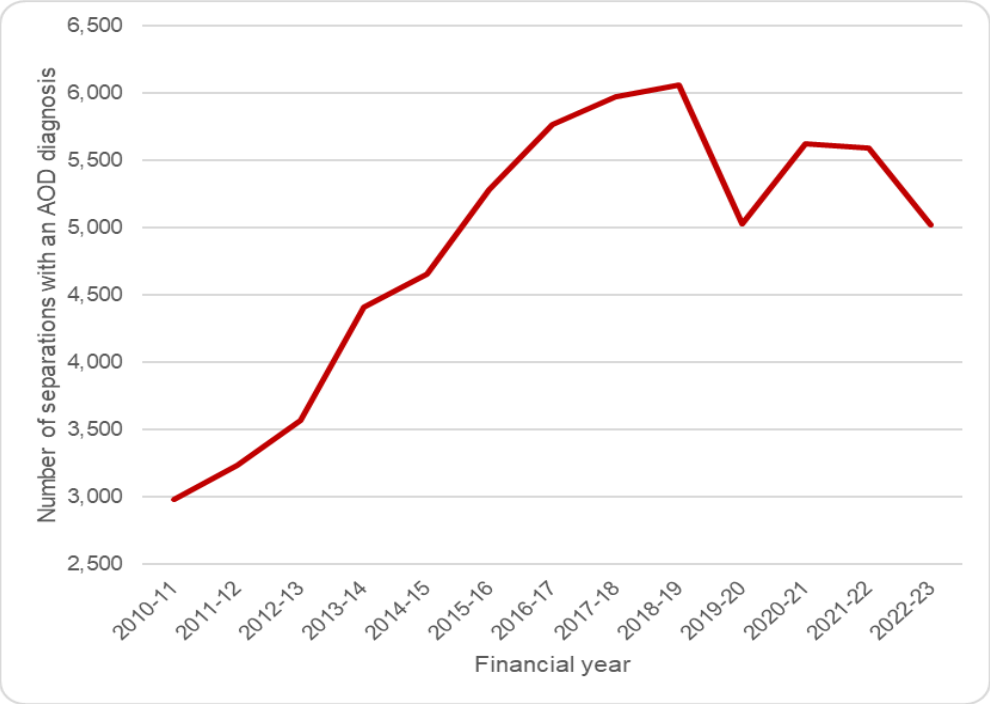
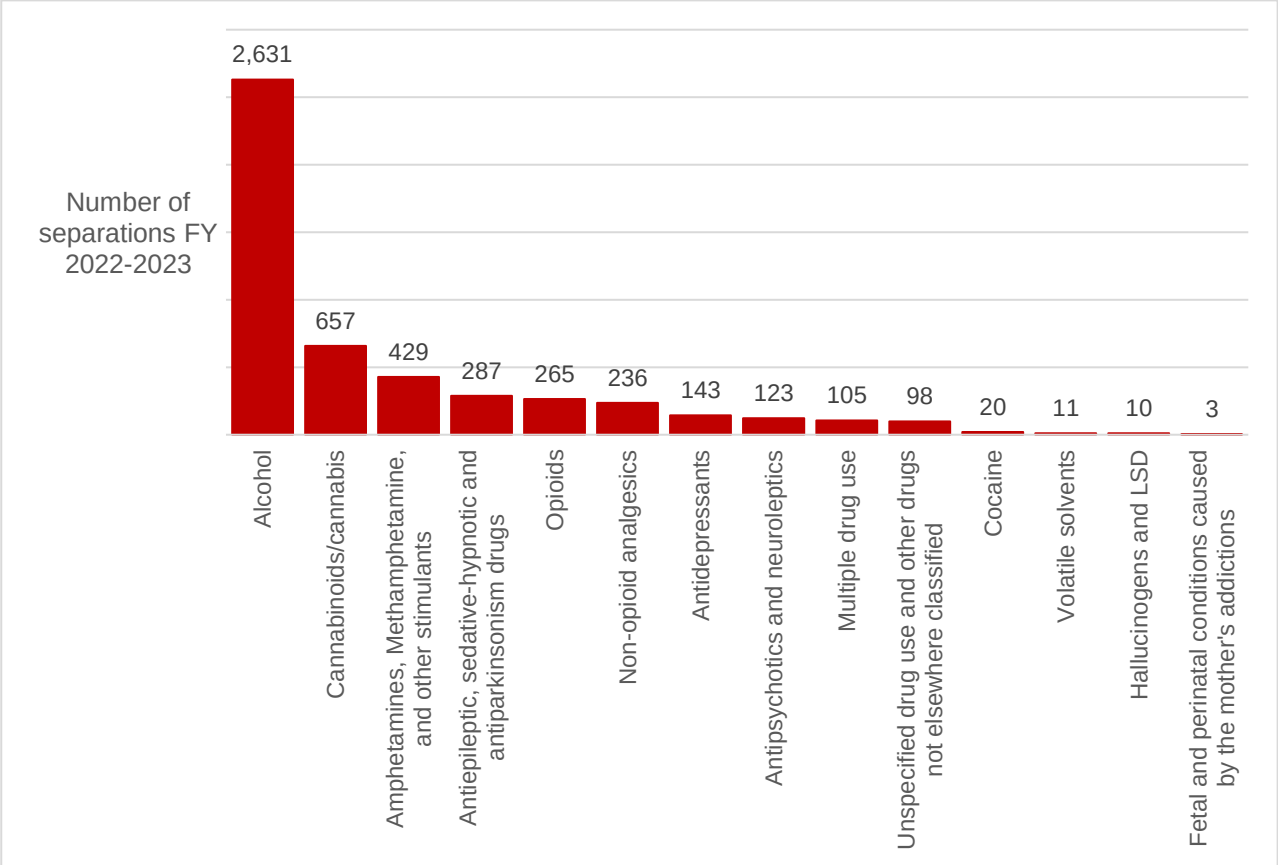


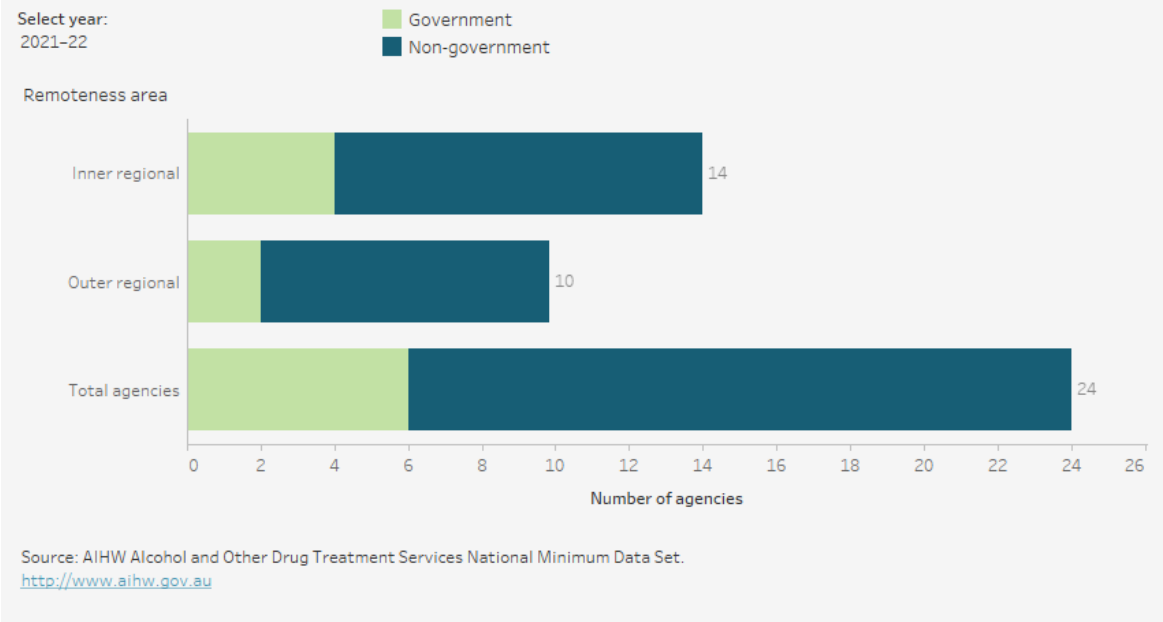
Figure 49. Number of alcohol and drug related hospital admission by reason in Tasmania 2022-23



5.3.3 Available AOD treatment services in Tasmania

Figure 50 illustrates the proportion of government and non-government AOD treatment agencies in Tasmania. The total number of AOD treatment services in Tasmania has risen in the past ten years. In 2021-22, 18 of the 24 AOD agencies in Tasmania were non-government treatment agencies that receive public funding; 14 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[106].

Figure 50. Number of AOD treatment agencies by remoteness area and sector, Tasmania | 2021–22



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.

5.5 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[139].

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