phn TASMANIA
An Australian Government Initiative

primary health TASMANIA

Health in Tasmania

PRIMARY HEALTH TASMANIA HEALTH NEEDS ASSESSMENT 2025-28

November 2025

Primary Health Tasmania Limited
1300 653 169
info@primaryhealthtas.com.au
www.primaryhealthtas.com.au
ABN 47 082 572 629

Contents

EXECUTIVE SUMMARY 6
1 OUR GENERAL HEALTH 12
1.1 Overview 12
1.2 Health needs 17
1.3 Service needs 24
1.4 Stakeholder perspectives 32
1.5 Priority actions 34
2 PRIORITY POPULATIONS 37
2.1 Overview 37
2.2 Older people 38
2.3 Aboriginal and Torres Strait Islander people 40
2.4 Multicultural communities 41
2.5 People experiencing or at risk of homelessness 42
2.6 People with disability 43
2.7 People living in rural and remote areas 45
2.8 People experiencing socioeconomic disadvantage 46
2.9 Children and young people 47
2.10 LGBTIQA+ people 48
2.11 Health needs 49
2.12 Service needs 52
2.13 Stakeholder perspectives 53
2.14 Priority actions 54
3 CHRONIC CONDITIONS 57
3.1 Overview 57
3.2 Health needs 58
3.3 Service needs 66
3.4 Stakeholder perspectives 73
3.5 Priority actions 74
4 ABORIGINAL PEOPLE 77
4.1 Overview 77
4.2 Health needs 78
4.3 Service needs 82
4.4 Stakeholder perspectives 85
4.5 Priority actions 87
5 MENTAL HEALTH 90
5.1 Overview 90
5.2 Health needs 91
5.3 Service needs 95
5.4 Stakeholder perspectives 103

5.5 Priority actions 106
6 ALCOHOL AND OTHER DRUGS 109
6.1 Overview 109
6.2 Health needs 110
6.3 Service needs 113
6.4 Stakeholder perspectives 118
6.5 Priority actions 120
References 121

Figures

Figure 1. Primary Health Tasmania's Strategic Plan 2021-25 8
Figure 2. Tasmanian population density by local government area | 2024 12
Figure 3. Population by local government area, Tasmania 2024 13
Figure 4. Population age distribution, Tasmania and Australia 2023 14
Figure 5. Percentage of people experiencing socioeconomic advantage and disadvantage, by Australian states and territories | 2021 15
Figure 6. Self-assessed health as fair or poor in people aged 15+, percentage of population by Australian states and territories | 2022 17
Figure 7. Life expectancy, Tasmanians compared with Australians | 2011-2013 and 2021-2023 18
Figure 8. Proportion (%) of women in Tasmania who are aged 18 years and over, and experienced violence in the last two years compared with the national proportion, 2021-22 22
Figure 9. Average GP attendances per person from 2017-18 to 2023-24 24
Figure 10. Proportion of males and females aged 15 years and over utilising health services over 12-month period, Australia | 2022-23 | ABS Patient Experience Report 25
Figure 11. The supply and demand modelling for workforce. Number of GPs supply vs demand in Tasmania | 2024 26
Figure 12. The supply and demand modelling for workforce. GP FTE supply vs demand in Tasmania | 2024 26
Figure 13. Public hospital emergency department presentations, Tasmania | 2011 to 2024 27
Figure 14. Public hospital admissions by region of hospital, Tasmania | 2011 to 2024 27
Figure 15. People aged 65+ and Aboriginal people aged 50–64 years who received aged care services, by program type, Tasmania | 30 June 2024 29
Figure 16. People aged 65+ who need assistance with personal activities, by age and activity type, proportion of age group | 2022 43
Figure 17. Disability status by age group, Tasmania | 2022 44
Figure 18. Tasmania’s areas classification as regional, rural and remote, according to the Modified Monash Model. MM 1 representing a major city and MM 7 representing a very remote area 45
Figure 19. Distribution of socioeconomic disadvantage across Tasmania's Local Government Areas through one of the Socio-Economic Indexes for Areas (SEIFA), using the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD), Census data| 2021 46
Figure 20. High or very high psychological distress by age group, Tasmania | 2013-2022 51
Figure 21. Participation rates in cancer screening by type, Tasmania 59
Figure 22. Percentage of adults with lifestyle risk factors, Tasmania compared with Australia | 2022 60
Figure 23. Trends of regular smoking Tasmania and Australia 2001-2023* 61
Figure 24. Alcohol causing lifetime harm, males and females aged 18+, Tasmania | 2016, 2019 62
Figure 25. Alcohol use associated with single occasion risk, Tasmanians aged 18+ | 2016, 2019 and 2022 62
Figure 26. Self-reported ever-diagnosed chronic conditions (age standardised) in all adults aged 18+ and 65+ years, Tasmania 2022 64
Figure 27. Self-reported ever-diagnosed chronic conditions (age standardised) in people aged 18+, Tasmania | 2009 - 2022 64
Figure 28. Trends in visit reasons estimates from active and inactive patients in general practice with a coded diagnosis, Tasmania | 2019/20-2023/24 67
Figure 29. GP non-referred attendances, per patient 100% bulk billing (% of patients) Tasmania and Australia | 2012–24 68

Figure 30. 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 68

Figure 31. 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 70

Figure 32. Rate of separations of potentially preventable hospitalisations for vaccine-preventable, acute, and chronic conditions in Tasmania, from 2011-12 to 2022-23 71

Figure 33. Endometriosis (any diagnosis) admissions in Tasmanian public hospitals by age group in three calendar years from 2021 to 2024 (Admitted Patient Care data) 72

Figure 34. Estimated resident population by Indigenous status, Australia | June 2021 77

Figure 35. Estimated population distribution by Indigenous status and age group, proportion of Australian population | 2021 78

Figure 36. Age-standardised prevalence of selected health risk factors by Indigenous status, Australia | 2022–23 79

Figure 37. Leading broad causes of death by Indigenous status, selected Australian jurisdictions* | 2022 80

Figure 38. Age-standardised rates of the leading causes of Indigenous hospitalisations per 1,000 population, by Indigenous status, Australia | July 2017 – June 2019 82

Figure 39. Indigenous patient experiences of health care, Tasmania and Australia | 2018–19 84

Figure 40. Self-reported high and very high level of psychological distress by age group, Tasmanian Population Health Survey: 2013–22 91

Figure 41. Physical health of people living with psychosis compared with the general population, Australia | 2010 92

Figure 42. Tasmania's mental health system 96

Figure 43. Public hospital separations, mental and behavioural disorders, Tasmania | 2011 to 2024 98

Figure 44. Public hospital Emergency Department presentations, mental and behavioural disorders, Tasmania | 2011 to 2024 98

Figure 45. Clinical full-time equivalent mental health disciplines per 100,000 population, Australian states and territories | 2021 99

Figure 46. Tasmanian Mental Health Continuum of Care Model 106

Figure 47.Alcohol-induced deaths, rate per 100,000 population (age-standardised), Tasmania and Australia | 2022 111

Figure 48. Illicit drugs used in the previous 12 months, according to age category, age 18+, Tasmania | 2007, 2013, 2019 and 2022-23 112

Figure 49. Alcohol and other drug treatment services, client demographics (n=2,757), Tasmania | 2023-24 114

Figure 50. Proportion of closed treatment episodes (n=3,535) for own drug use by drug of concern, and presentation rates for principal drugs of concern Tasmania | 2023-24 114

Figure 51. Proportion of main treatment concluded episodes by type provided by specialist AOD services, Tasmania | 2014-15 to 2023-24 115

Figure 52. Number of alcohol and drug related hospital separations in Tasmania 2014 to 2024 116

Figure 53. Number of alcohol and drug related hospital separations by reason in Tasmania 2024 116

Figure 54. Number of AOD treatment agencies by remoteness area and sector, Tasmania | 2023-24 117

Tables

Table 1. Descriptions of disability by degree of limitation to perform core activities 15
Table 2: Top 10 leading causes of death 2023, Tasmania and Australia 19
Table 3: Underlying cause of death 2023, Tasmania. 19
Table 4: Estimated number and proportion of Tasmanians who provided care as a primary carer | 2022..... 50
Table 5. Profile of Primary Health Tasmania commissioned mental health programs | 2020–21 to 2024-25 101
Table 6. Percentage changes in psychological distress as per K10 (MDS definition: first and final measurements), Primary Health Tasmania | 2020–21 to 2024–25 101
Table 7. Profile of the headspace program in Tasmania | 2021–22 to 2024–25 102
Table 8. Outcome of services by K10 score, people who received services from headspace, Tasmania | 2020–21 to 2024–25 102
Table 9. Selected statistics on AOD use among people aged 14 and over in Tasmania compared with Australia | 2022-23 110
Table 10. Top 5 illicit drugs used in the previous 12 months, people aged 14+, Tasmania | 2001, 2019 and 2022-23 112

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
HPV	human papillomavirus
IAHP	Indigenous Australians' Health Programme
ITC	integrated team care
LGA	local government area
LGBTIQA+	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.

Primary Health Tasmania's Health Needs Assessment 2025–28 sets out our priorities for the coming three-year period to inform our cycle of planning and commissioning health services. It reflects Primary Health Tasmania's commitment to be a key partner in improving primary care in Tasmania.

This needs assessment builds on our Health Needs Assessment 2022-25 by incorporating up to date stakeholder feedback, data and other health information. The document is organised into six chapters: general health, priority populations, chronic conditions, Aboriginal people, mental health, and alcohol and other drugs (AOD). Each chapter follows a consistent structure, including an overview of the current health status, identification of key health needs, highlighting of service needs, insights from stakeholders' perspectives, and embedded recommendations outlining priority actions that may help drive better health outcomes for all Tasmanians.

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.

Priority populations in Tasmania face significant health challenges. To address these issues, Primary Health Tasmania is focusing on advancing health equity, improving access to healthcare, developing culturally appropriate services, enhancing data collection, and implementing healthcare models tailored to the needs of these priority groups.

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. An important contributor 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 health care to Tasmanians and improve management of chronic conditions in people with mental health problems.

Use of AOD 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 AOD use that are integrated across the boundaries of primary, community, and acute services.

The priority actions outlined in this needs assessment highlight Primary Health Tasmania's evidence-based approach to supporting primary care service delivery 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.

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 annual evidence-based health needs assessment to identify unique regional and local priorities. This work is guided by national health priorities. The purpose of the Health Needs Assessment 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 the policy and strategy environment
- data analysis (mix of qualitative and quantitative)
- stakeholder consultation.

Analysis of the following data sets enabled understanding of program gaps with recommendations embedded throughout the document:

- Australian epidemiological datasets obtained through the Australian Institute of Health and Welfare, Australian Bureau of Statistics (ABS) 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
- PHN Medicare Urgent Care Clinics (UCC) data
- 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 (ACCOs), 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 Health Strategy and Performance team.

Additional data needs and gaps

We are committed to building upon the findings of this Health Needs Assessment to better understand the health needs of the Tasmanian population with an aim of improving the health of Tasmanians. The Health Needs Assessment 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 Health Needs Assessment process, a range of complex issues and ideas for solutions emerged across the identified priority areas.

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

1

Our general health

1 Our general health

1.1 Overview

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

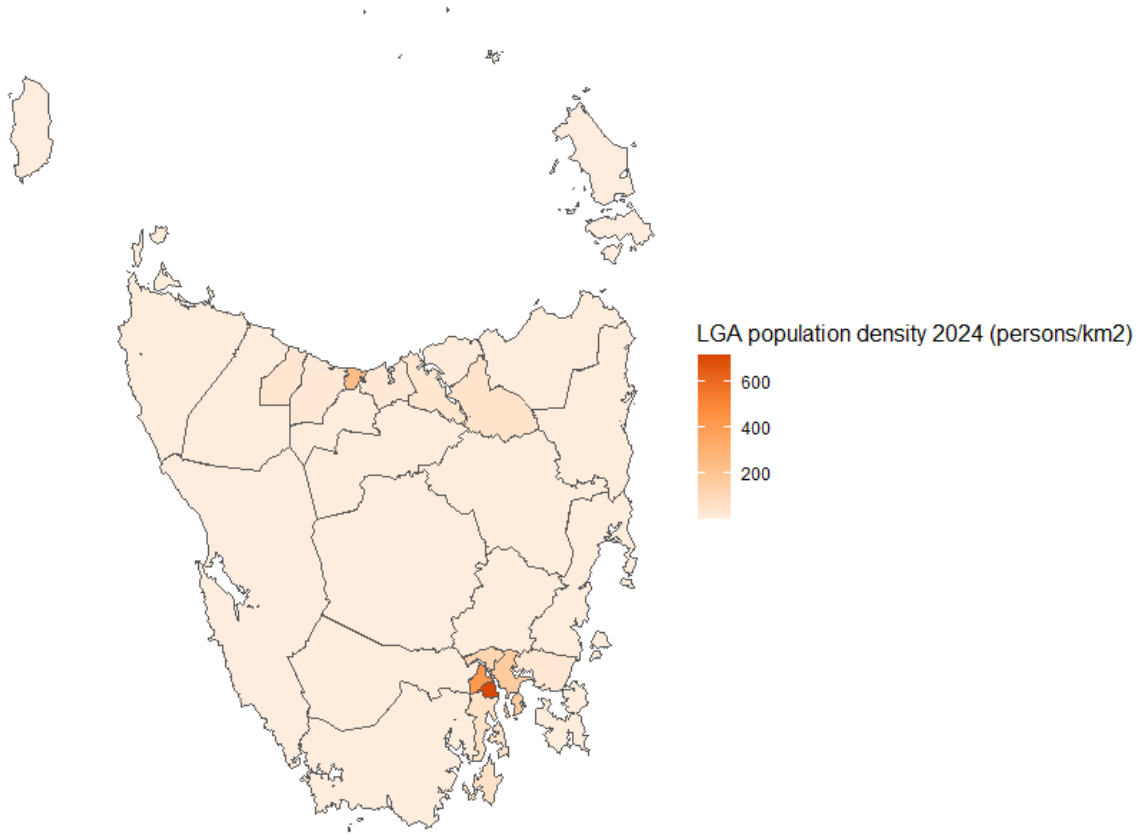
Access to health care is problematic for many Tasmanians, particularly for people living in rural areas, for those experiencing socioeconomic disadvantage, for Aboriginal and Torres Strait Islander people, and for people who are from culturally and linguistically diverse backgrounds.

Tasmania is home to a regionally dispersed population of just over 557,000[1] people. An ageing population and socioeconomic disadvantage are contributing to significant pressure on our entire health system.

1.1.1 About our community

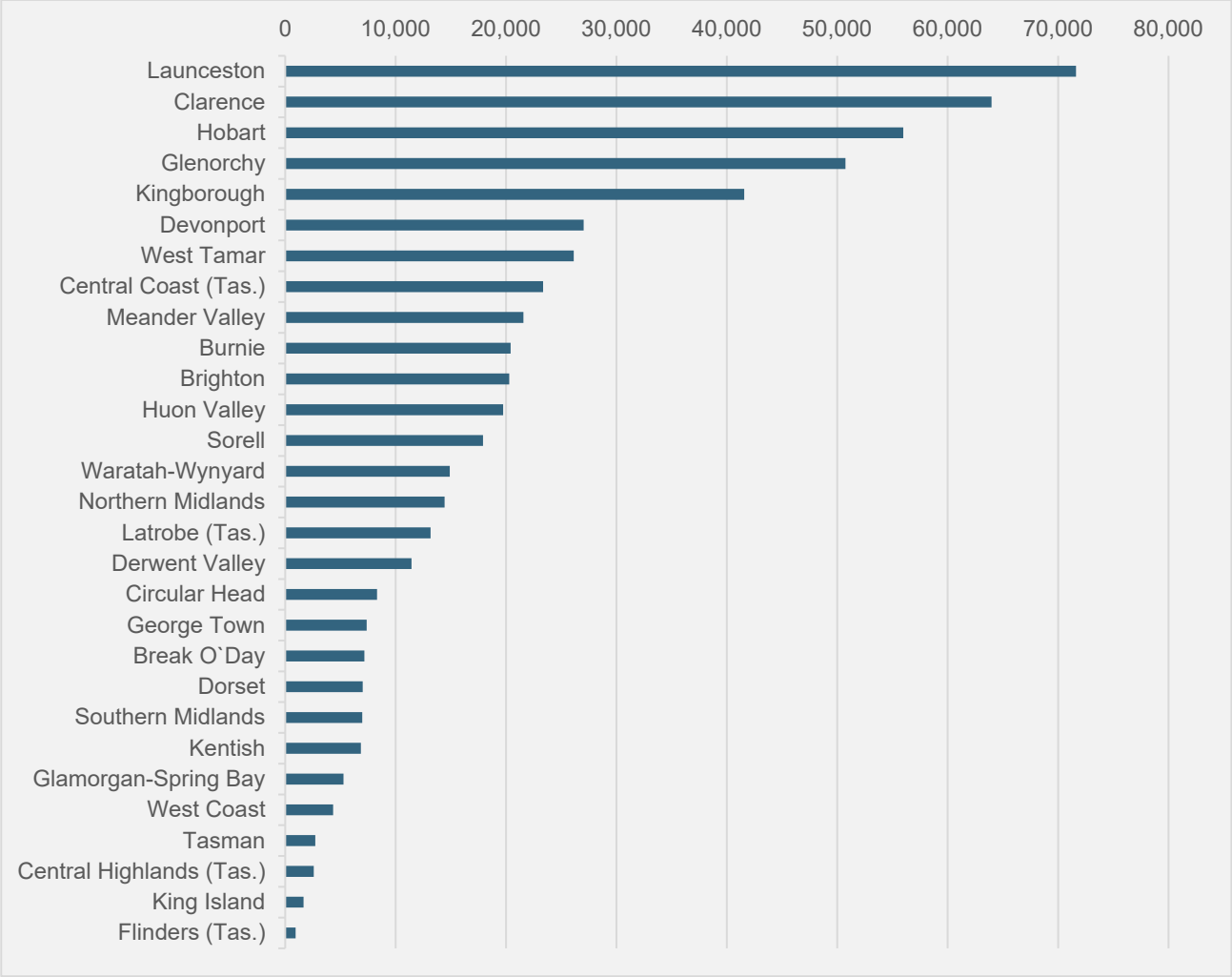
There were 557,571 people who were residents of Tasmania on 28 June 2021, approximately 2.2% of Australia's total population[1]. The highest population density in Tasmania is in the Hobart LGA, followed by the Glenorchy and Devonport LGAs[2] (Figure 2).

Figure 2. Tasmanian population density by local government area | 2024



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[3].

Figure 3. Population by local government area, Tasmania 2024



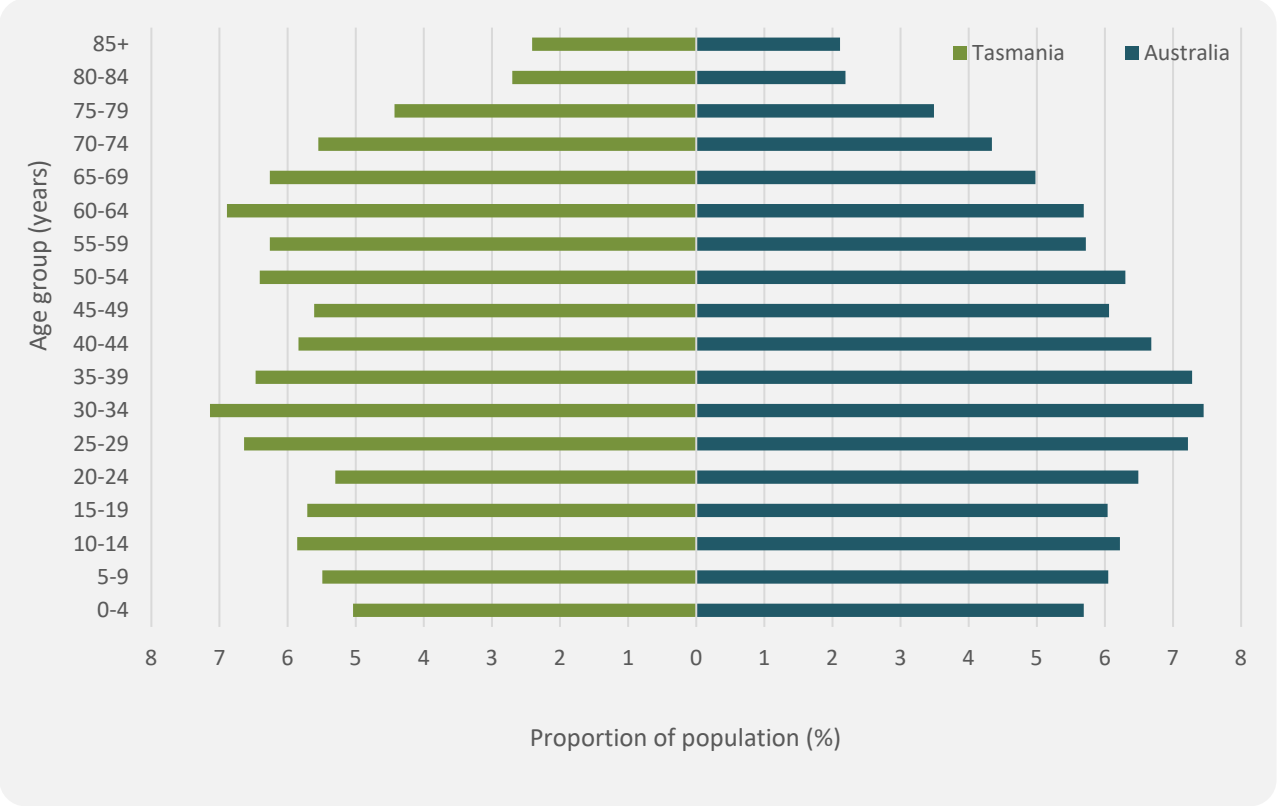
In Tasmania, 86.1% of people only spoke English at home. Other languages spoken at home include Mandarin (1.5%), Nepali (1.3%) and Punjabi (0.5%)[4].There are 29 local government areas (LGAs) in Tasmania. Of our 29 LGAs, 21 are classified as outer regional or remote. The population size of each LGA is shown in Figure 3[5].

Note: The 8 LGAs that are classified as inner regional areas are Hobart, Glenorchy, King borough, Launceston, Meander Valley, Northern Midlands, Sorell, and West Tamar.

1.1.2 We have an ageing population

Figure 4 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 4. Population age distribution, Tasmania and Australia 2023



1.1.3 Our population is growing

The Tasmanian Department of Treasury and Finance published its latest population projections in May 2024 based on the estimated resident population as of 30 June 2023. These predicted that Tasmania's population would grow to around 641,045 people by 2053[7]. 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[8].

1.1.4 Many people in our community experience disability

Over 30% of Tasmanians have a disability, a significantly higher proportion than the national average of 21.4%[9]. 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. In 2022, 5.4% of Tasmanians experienced a profound core activity limitation, 5.5% had a severe limitation, 3% had a moderate limitation, and 9.5% had a mild core activity limitation[9].

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

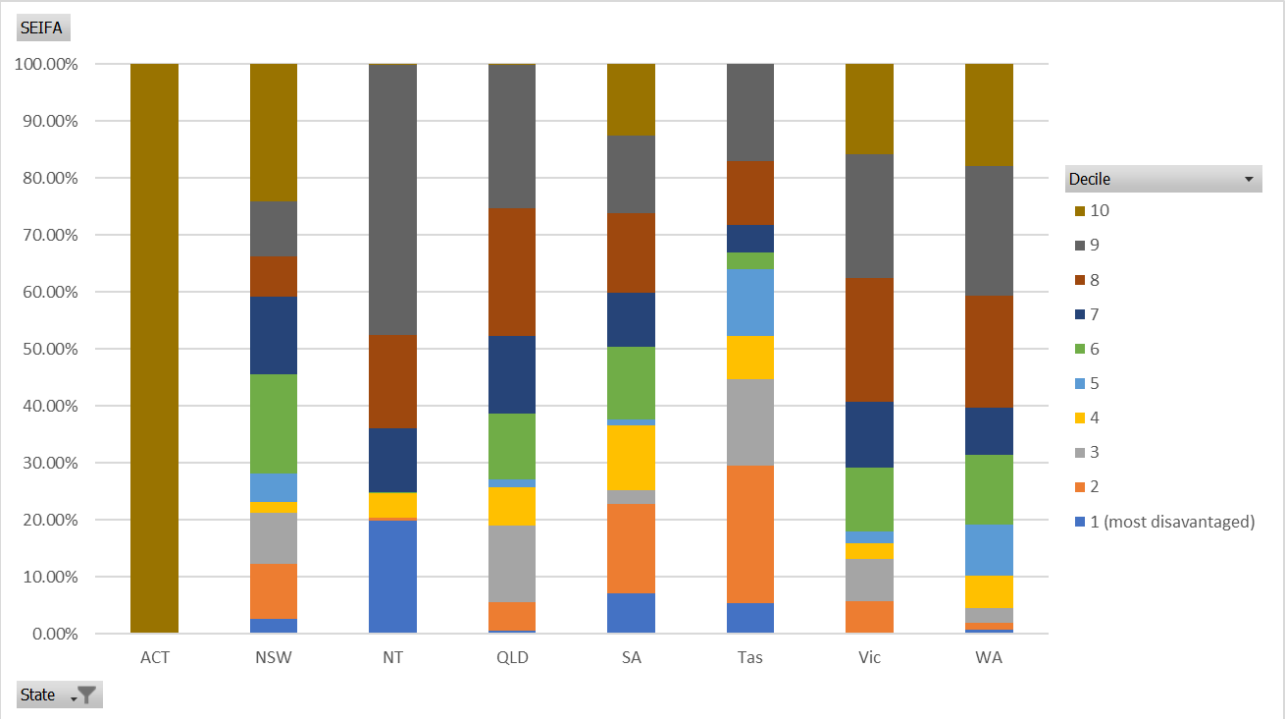
Degree of limitation	What this means for people with a disability
Profound	greatest need for help; that is, always needs help with at least one core activity
Severe	needs help sometimes or has difficulty with a core activity
Moderate	no need for help but has difficulty
Mild	no need for help and no difficulty,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

Source: ABS. Disability, Ageing and Carers, Australia. 2022

1.1.5 Our community is socioeconomically diverse

Tasmania has high rates of socioeconomic disadvantage. The ABS uses Census data 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[10] (Figure 5).

Figure 5. 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[11].

Housing stress and homelessness contribute to poor health. People who experience homelessness also experience significantly higher rates of death, disability and chronic illness than the general population[12, 13]. Tasmanians are experiencing high, and growing, rates of housing stress and homelessness[14]. Chronic conditions are more common in areas with lower socioeconomic status[15].

1.1.6 Health literacy influences health outcomes

Health literacy is the knowledge and skill people need to be able to 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 have limited health literacy, which can make it harder to understand and use health information effectively[16].

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[16, 17].

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.

1.2 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:

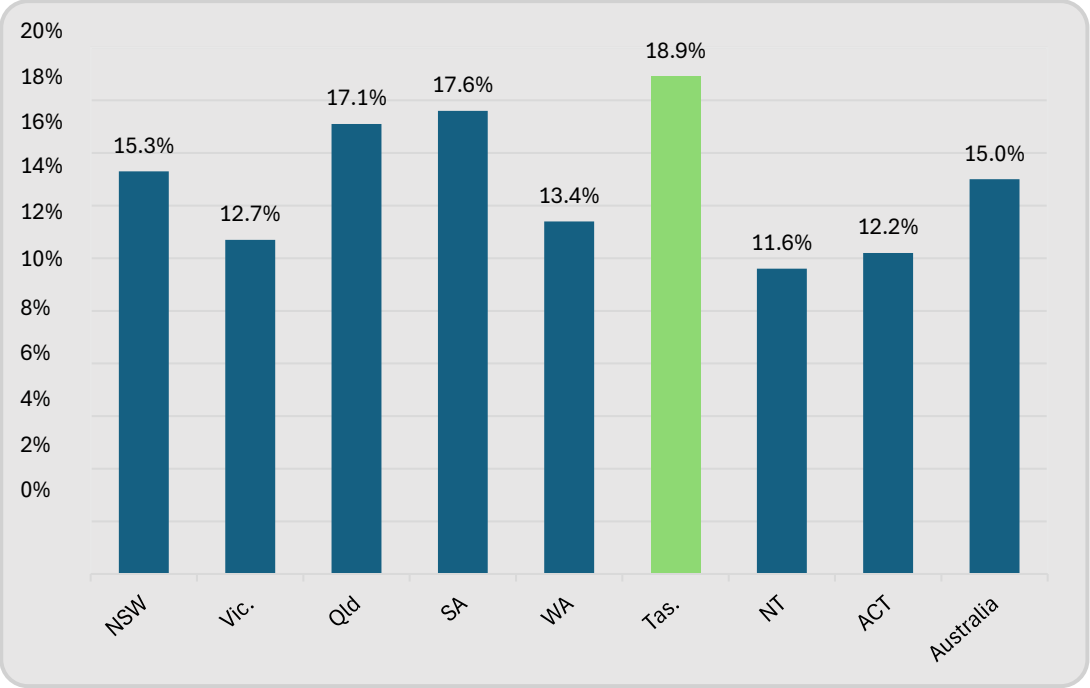
- self-assessed health
- quality of life
- life expectancy
- infant mortality
- causes of death.

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[18] (Figure 6).

Figure 6. Self-assessed health as fair or poor in people aged 15+, percentage of population by Australian states and territories | 2022

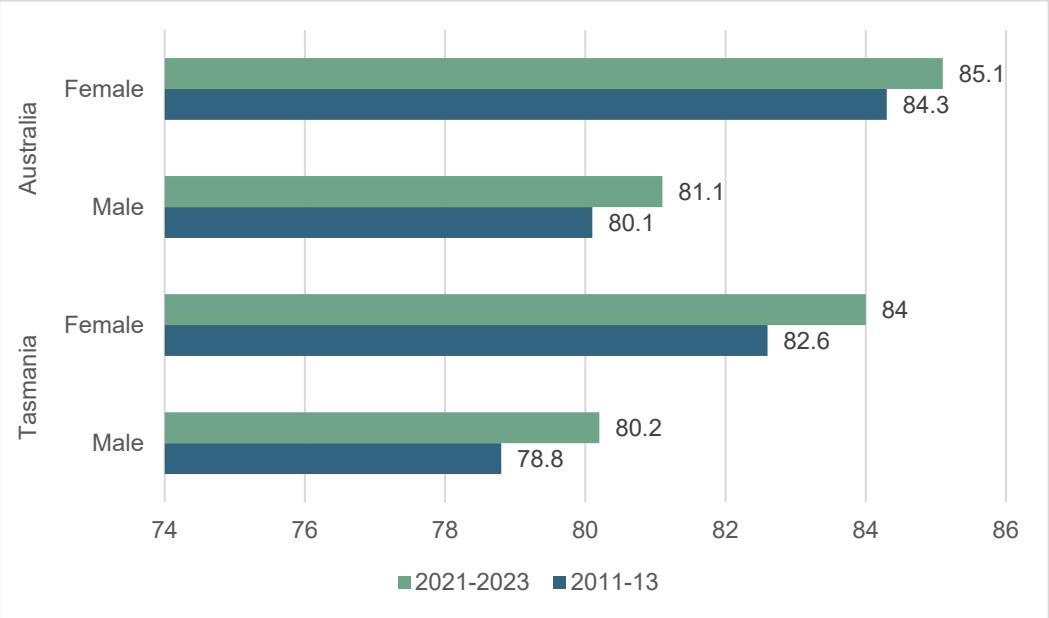


1.2.3 Tasmanians have a lower life expectancy than Australians overall

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 1.4 years for males and 1.4 years for females in the 10 years to 2021-2023[19]. Tasmanian males born in 2021-23 can expect to live to 80.2 years (compared with 81.1 years for Australian males) and Tasmanian females born today can expect to live to 84.0 years (compared with 85.1 years for Australian females)[19] (Figure 7). However, Tasmania continues to have the second lowest life expectancy of any jurisdiction, after the Northern Territory[19].

Figure 7. Life expectancy, Tasmanians compared with Australians | 2011-2013 and 2021-2023



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

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

There are 3.6 deaths per 1000 live births on average in Tasmania, slightly higher than the Australian rate of 3.2 deaths per 1000 live births during 2023[20]. This rate has increased compared to the previous year when Tasmania had a similar overall infant mortality rate compared to Australia (3.1 vs 3.2 deaths per 1000 live births).

1.2.5 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. Ischaemic heart disease and dementia are the leading causes of death, followed by chronic lower respiratory disease and cerebrovascular disease[21] (Table 2 and Table 3). See Chapter 2 Chronic Conditions for detailed information about specific chronic conditions in Tasmania.

Tasmania's age-standardised death rates are higher than for Australia overall (5.6 vs 5.1 deaths per 1,000 standard population)[21].

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

Table 2: Top 10 leading causes of death 2023, 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)	536	1	1
Dementia, including Alzheimer's disease (ICD-10 codes F01, F03, G30)	492	2	2
Chronic lower respiratory disease (ICD-10 codes J40-J47)	298	3	5
Cerebrovascular disease (ICD-10 codes I60-I69)	260	4	3
Malignant neoplasm of trachea, bronchus and lung (ICD-10 codes C33, C34)	239	5	4
Diabetes (ICD-10 codes E10-E14)	167	6	6
Malignant neoplasm of colon, sigmoid, rectum and anus (ICD-10 codes C18-C21, C26.0)	149	7	7
Accidental falls (ICD-10 codes W00-W19)	144	8	11
COVID-19 (ICD-10 codes U07.1-U07.2, U10.9)	131	9	9
Malignant neoplasm of lymphoid, haematopoietic and related tissue (ICD-10 codes C81-C96)	128	10	8

Source: ABS, Causes of Death, Australia, 2023

Table 3: Underlying cause of death 2023, Tasmania.

Underlying cause of death	No. of deaths	% of all causes
Neoplasms (ICD-10 codes C00-D48)	1,406	27.7
Diseases of the circulatory system (ICD-10 codes I00- I99)	1,247	24.6
Diseases of the respiratory system (ICD-10 codes J00-J99)	451	8.9
Mental and behavioural disorders (ICD-10 codes F00-F99)	378	7.5
External causes of morbidity and mortality (ICD-10 codes V01-Y98)	365	7.2
Diseases of the nervous system (ICD-10 codes G00-G99)	303	6.0
TOTAL (includes other less common causes of death not listed here)	5,073	100.0

Source: ABS, Underlying Causes of Death, Tasmania, 2023

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 (142 deaths per 100,000 people) compared with the Australian average (107.9 deaths per 100,000 people) during 2019-2021.

This is significant because many of these premature deaths could likely have been prevented with improved access to timely and effective primary care services[21, 22].

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

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.

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. According to 2022 estimates, individuals in Tasmania aged 65+ years were the most likely among all age groups to have at least one chronic condition[23].

Dementia is the leading cause of death in women in Australia and is predicted to soon become the leading cause of death in men[24, 25]. Dementias are progressive neurodegenerative conditions that are terminal illnesses. Alzheimer's disease, vascular dementia, Lewy body disease and frontotemporal dementia are the leading causes of dementia, with many people having a mix of these dementias. Although dementia itself cannot be fully prevented, managing lifestyle risk factors and chronic health conditions can influence the progression of the illness and potentially improve quality of life for some people[26].

It is also important to acknowledge emerging health concerns, including the potential preventability of some types of dementia. For example, chronic traumatic encephalopathy is a type of dementia that can be prevented. It is linked to repeated head injuries, especially in contact sports, experiencing assault including family violence, being in active war zone, or engaging in high-risk occupations[27]. While this is not yet a primary focus, raising awareness and implementing early preventive measures can help reduce associated risks.

1.2.6 Vaccine preventable respiratory infection continues to be prevalent

Vaccine preventable respiratory infections are serious conditions that can impair normal breathing function, including the COVID-19 virus, pertussis, influenza, respiratory syncytial virus.

COVID-19

The coronavirus (COVID-19) was declared a pandemic from March 2020 until 20 October 2023. During this period, Tasmania recorded 306,026 notified cases and 314 COVID-19 related deaths. Although the pandemic phase has officially ended, COVID-19 continues to affect the Tasmanian population. Between 20 October 2023 and 31 July 2025, there were a further 23,896 notified cases and 160 additional COVID-19 related deaths[28].

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, including vulnerable Tasmanians, were satisfied with services delivered via telehealth and would continue to use telehealth to access their general practitioner (GP)[29, 30].

Some people with chronic conditions have delayed accessing primary care as a result of COVID-19[31]. During 2019–20 to 2020–21 there were around 120,000 fewer elective surgery procedures in public hospitals than expected[31]. A number of data sources provide evidence of delayed or missed cancer screening and procedures – such as a large decline in colonoscopies[31]. In 2024, the number of elective surgeries has not yet returned to pre-pandemic levels[32].

Evidence suggests an elevated burden of mental health-related disorders during the COVID-19 pandemic and after[32, 33]. Anxiety, post-traumatic stress disorder (PTSD) and major depression remain among the principal conditions affecting survivors of severe COVID-19 illness[34].

Children who are isolated or quarantined during a pandemic can develop acute stress disorder, mood disorders, adjustment disorder and experience grief reactions

Psychological distress among younger age groups (18-44 years) rose sharply at the start of the pandemic, and although levels have since improved, they have not fully returned to pre-pandemic levels.

Long COVID

Post-acute sequelae of COVID-19, post-COVID-19 syndrome, or long COVID is still a relatively new condition, and evidence is still emerging. It refers to the ongoing symptoms that some people face after recovering from a COVID-19 infection. This condition can impact various body systems with a negative impact on daily life. People with long COVID experience a range of symptoms that vary in duration and intensity and often require unique disease management with complex care needs[35].

Given that GPs are the first point of contact for patients within the healthcare system, an internal analysis of GP data was conducted to assess the number of long COVID cases in Tasmania. Out of the total number of patients in Tasmania who had at least one encounter with a GP in the financial year 2024-25, approximately 35 were diagnosed with long COVID per 100,000 patients[36].

Pertussis

Pertussis, also known as whooping cough, is a serious bacterial disease that can be transmitted through airborne droplets, and could lead to pneumonia, brain damage and even death. It affects people in all age groups, but it can be particularly serious infection for babies, often requiring hospitalisation[37].

Whooping cough can be prevented through vaccination, which is provided under the national immunisation program[37]. Immunisation provides good protection against whooping cough, but immunity fades, requiring booster doses. The most effective approach to protect young babies from whooping cough is to receive the vaccine during pregnancy[38]. Pertussis has a rate of 159.3 per 100,000 population in Tasmania and was the highest rate among all vaccine preventable disease in Tasmania for 2024, followed by Varicella and Rotavirus with rates of 153.8 and 23.2 per 100,000 population respectively[39].

Influenza

Influenza, commonly known as the flu, is a highly contagious respiratory infection that can be particularly severe for babies, young children, pregnant women, and individuals with underlying health conditions. Influenza vaccines are the safe and effective way to prevent serious illness caused by influenza. It is annually recommended for everyone aged six months and older. High-risk groups, such as Aboriginal and Torres Strait Islander people, children under five, pregnant people, adults over 65, and those with certain medical conditions, are eligible for free vaccines under the National Immunisation Program[40].

1.2.7 People experiencing family, domestic and sexual violence

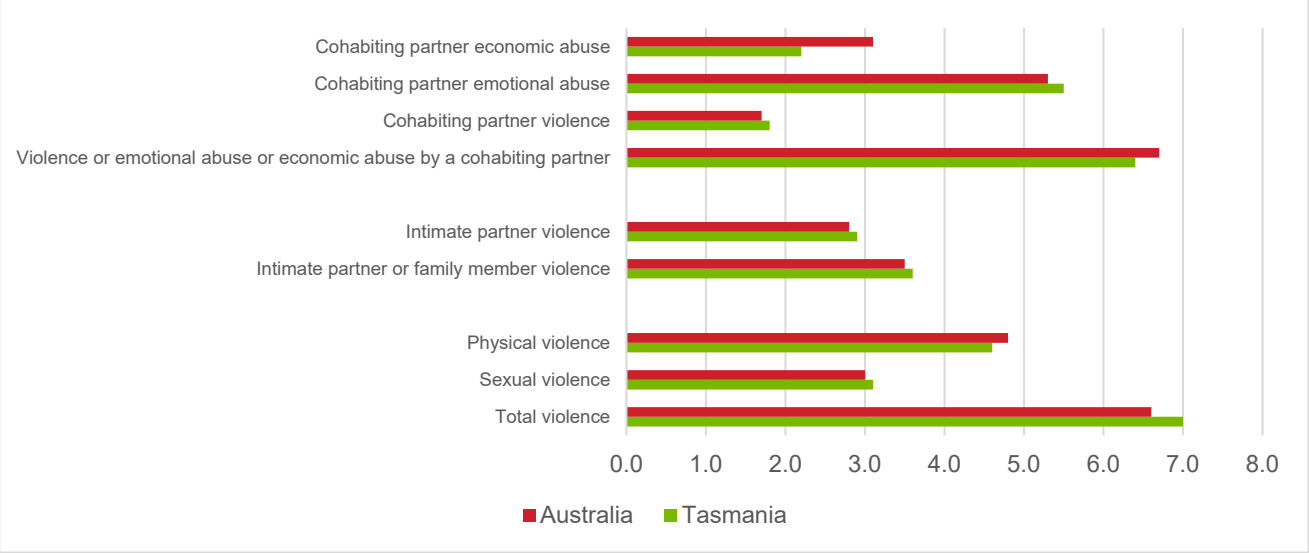
Family and domestic violence is a pattern of abusive behaviours or threats by a perpetrator with an intention to gain or maintain power and control over a family member, or against a person in a current or previous relationship[41]. The violence could be physical, verbal, emotional or economic abuse. 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[42].

In 2023, Tasmania recorded 94 victims of family and domestic violence-related sexual assault involving individuals under the age of 18. Among these 94 minors, 81 were female, and 14 were male. Of these victims, 20 were children under the age of 10, while 77 were adolescents aged between 10 and 17[43].

During the period of 2021-2022, 3.1% 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 and/or sexual, emotional, and economic abuse[44]. Overall, the aggregate reported incidence of violence against women aged 18 and older in Tasmania exceeded the national average (Figure 8). During 2023-24, Tasmania Police responded to 8,372 family violence occasions, including 5,353 incidents and 3,019 events classified as family arguments[45].

Figure 8. Proportion (%) of women in Tasmania who are aged 18 years and over, and experienced violence in the last two years compared with the national proportion, 2021-22



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

1.2.8 Potential population health risks

Health risk factors are attributes, characteristics or exposures that potentially increase the possibility of developing a disease or health disorder[46]. These factors can be biological, behavioural, environmental, or social that may vary across different population groups. Population health risks are the factors that influence the health of population groups or entire populations[47].

Examples of these emerging health risks may include, climate sensitive infectious diseases, increased exposure to environmental toxins, and traumatic brain injuries, such as chronic traumatic encephalopathy dementia. While these issues are being monitored as part of a "watching brief," they are not current priorities for immediate intervention.

Maintaining a watching brief allows Primary Health Tasmania to stay informed about these risks and respond appropriately if they escalate. Preventative health measures, such as vaccination programs, and health education to reduce harmful exposures and promote healthier environments, remain crucial for overall population health

Climate sensitive infectious diseases

Extreme weather crises including heatwaves, bushfires, storms, or flooding can cause injury, health issues, hospitalisations, and death. These weather crises are also linked to climate-sensitive diseases, which are influenced by changes in climate conditions such as temperature, humidity, and rainfall. These changes can significantly amplify the spread and intensity of these diseases. This is because vector-borne diseases are highly sensitive to climate factors including heat, rainfall, and flooding which provides favourable environments for breeding. These diseases can be transmitted through vectors like mosquitoes, water or food contamination, or airborne. Examples of these diseases include malaria, cholera, and influenza[48, 49].

Increased exposure to environmental toxins

Environmental toxins and contaminants are harmful substances or organisms that can cause a range of serious health issues including cancer, cardiovascular disease, endocrine disorders, and respiratory conditions. These environmental toxins include chemicals such as pesticides; physical materials such as asbestos; and biological hazards including mould and blue-green algae. Exposure to these toxins can occur through the air, water, soil, or food[50].

Traumatic brain injuries

Head injuries, ranging from small cuts to traumatic brain injuries are a major cause of hospitalisation, disability, and death in Australia[51]. Most head injury events are preventable and can be a result of intentional events (such as assault, and self-harm), unintentional events (such as falls, and transport incidents). Traumatic brain injuries involve an external assault to the head that cause brain damage or an alteration in brain function[51].

In 2020–21, head injuries resulted in: 406,000 ED visits, 1,600 per 100,000 population. 142,000 hospitalisations, 517 per 100,000 population. 2,4000 deaths, 9.3 per 100,000 population[51]. Adults aged 65 and older are at the greatest risk for being hospitalized and dying from a traumatic brain injury, most often from a fall. In every age group, serious traumatic brain injury rates are higher for men than for women. Men are more likely to be hospitalized and are nearly three times more likely to die from a traumatic brain injury than women[52].

Traumatic brain injuries are associated with increasing the risk of developing neurological conditions, such as chronic traumatic encephalopathy dementia, Parkinson's disease, and potentially multiple sclerosis. Chronic traumatic encephalopathy dementia is linked to repetitive brain trauma, often seen in athletes and military veterans[27].

People who have experienced traumatic brain injuries are at higher risk of developing Parkinson's disease[53]. Recent research suggested that repetitive head trauma could increase the risk of multiple sclerosis in genetically susceptible individuals[54].

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.

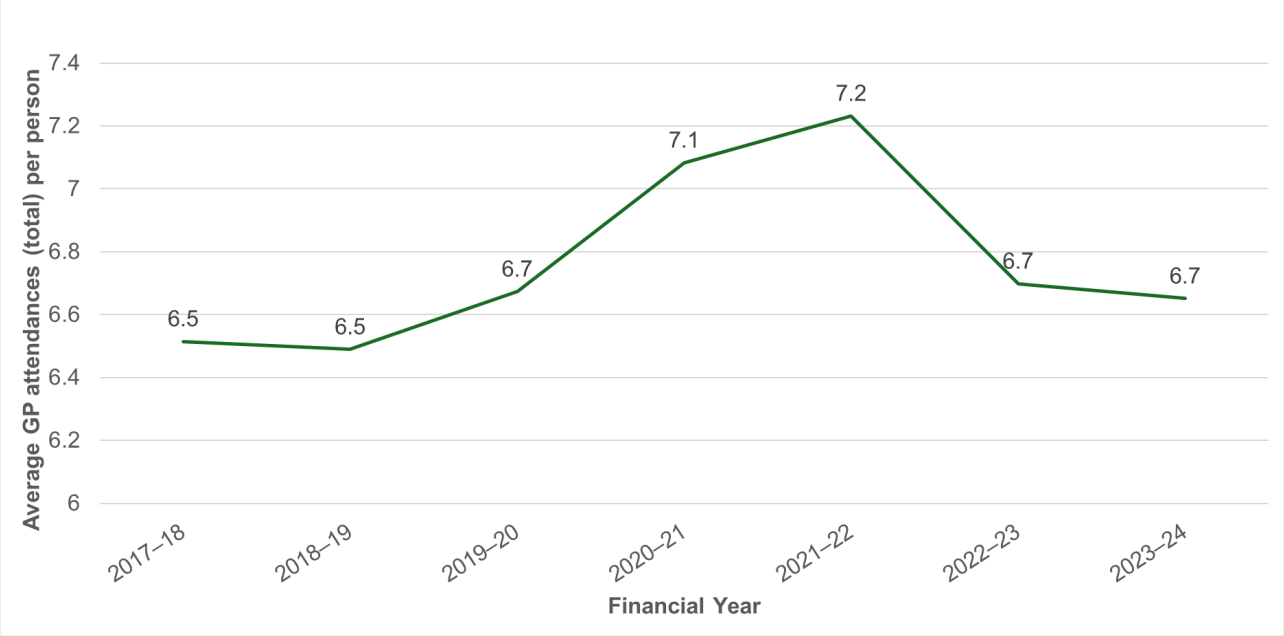
General practice is the point where most people enter the health system. GPs and practice nurses deliver health care and refer people who require other health services, helping people to navigate a complex healthcare system[55].

Tasmanians saw their GP an average of between 7 and 8 times in FY24/25. General practice is the point where most people enter the health system.

According to Medicare report people in Tasmania attended a general practice 6.7 times a year on average in the financial year 2023-2024[56].

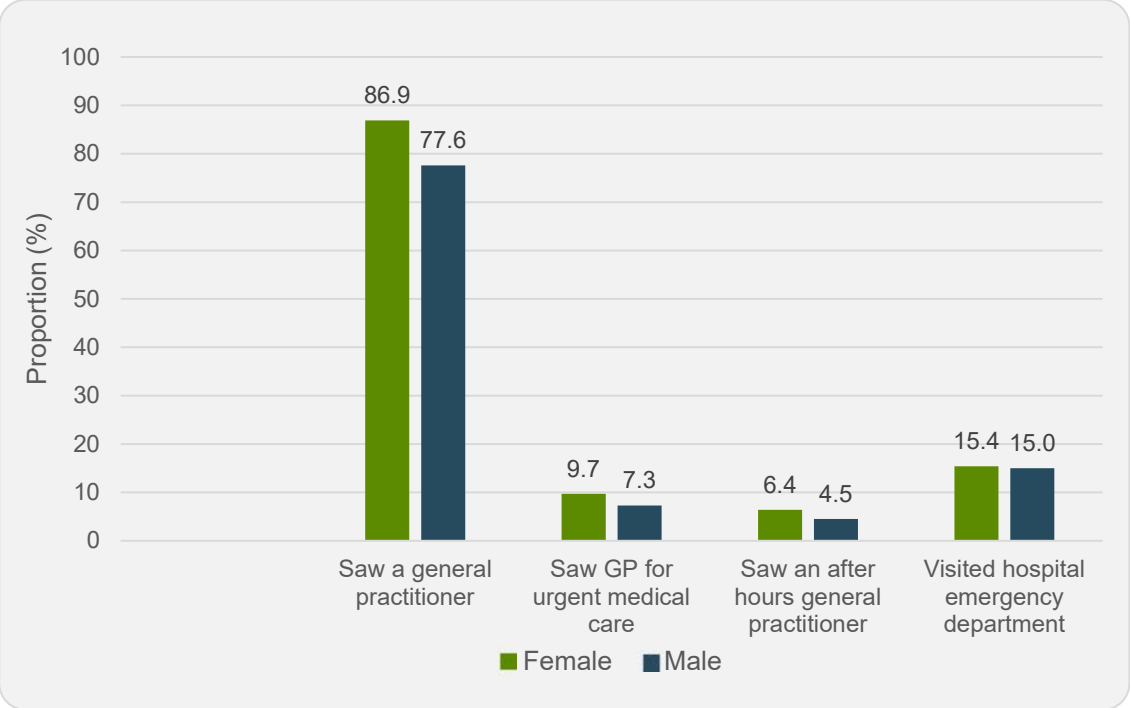
The average number of visits per person increased from 6.5 in 2018-19 to 7.2 in 2021-22, then decreased to 6.7 in 2022-23 and remained similar in 2023-24[56] (Figure 9).

Figure 9. Average GP attendances per person from 2017-18 to 2023-24



The percentage of Australians who visited a GP in 2022-23 was 82.3%[57]. Australians visited general practitioners more frequently than any other health professionals in 2022-23. Females were more likely than males to utilise health services, such as seeing a GP (86.9% compared with 77.6%)[57] (Figure 10).

Figure 10. Proportion of males and females aged 15 years and over utilising health services over 12-month period, Australia | 2022-23 | ABS Patient Experience Report



General practice workforce and projection (2023 - 2024)

To understand the currently available GP workforce (supply) and the needs for the GP service (demand), a model of supply and demand was developed by Australian Government Department of Health, Disability and Ageing. Supply and demand modelling for GP workforce planning helps assess whether there are enough GPs in the right locations to meet patient care needs, both currently and in the future. The main outputs of the GP model are a projection of number of GPs and a projection of GP FTE. Based on number of GPs and GP FTE, the model produces one supply estimate and two demand estimates - baseline demand and unmet demand. The number of GPs is provided to offer a comprehensive view of both the headcount and the actual work effort contributed by GPs (Figure 11). The FTE metric accounts for part-time and full-time work, giving a more accurate picture of the workforce capacity (Figure 12)[58].

The supply and demand study for the number of GP in Tasmania highlights a growing gap between the availability of GPs and the increasing demand for their services. Projections indicate that demand will continue to exceed supply until 2048, highlighting the need for strategic workforce planning.

In 2024, the baseline demand gap is estimated at just over 13.0 FTE which is expected to rise to over 30.0 FTE by 2048, with a total undersupply of 30.0 FTE by 2048. Baseline demand is the number of GPs that are needed to meet the current and future health needs of the community. In the GP model, baseline demand is projected assuming the supply of GPs meets the demand in the base year.

Additionally, the unmet demand gap in 2024 is approximately 150.0 FTE, which is projected to grow to over 180.0 FTE by 2028 and exceed 190.0 FTE by the end of the projection period in 2048. Unmet demand is calculated by applying the average GP service utilisation levels to each age, gender and chronic condition cohort, and then adjusted based on the expected proportion of the population accessing MBS GP services per year by age and gender[58].

Figure 11. The supply and demand modelling for workforce. Number of GPs supply vs demand in Tasmania | 2024

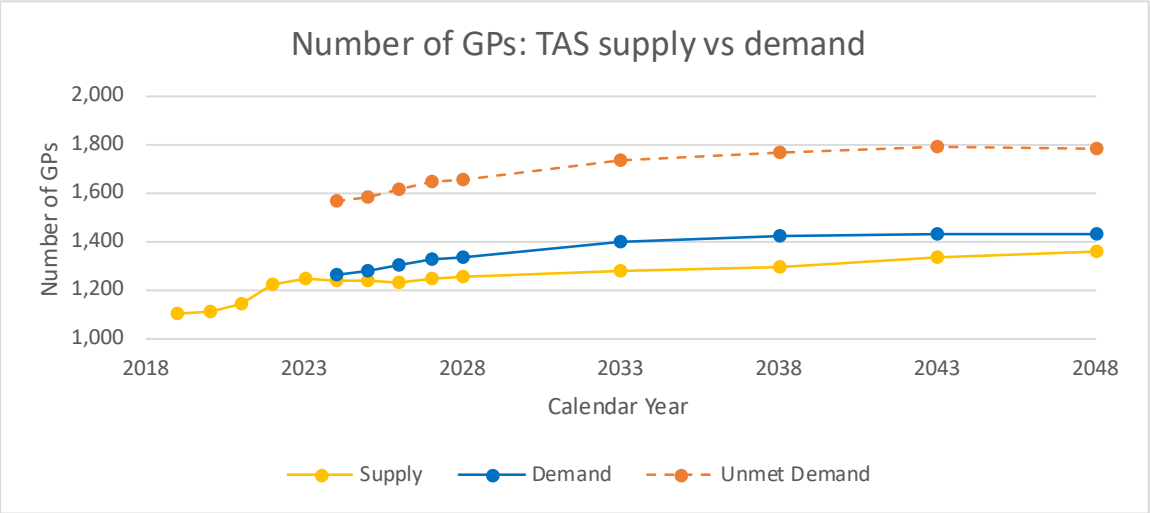
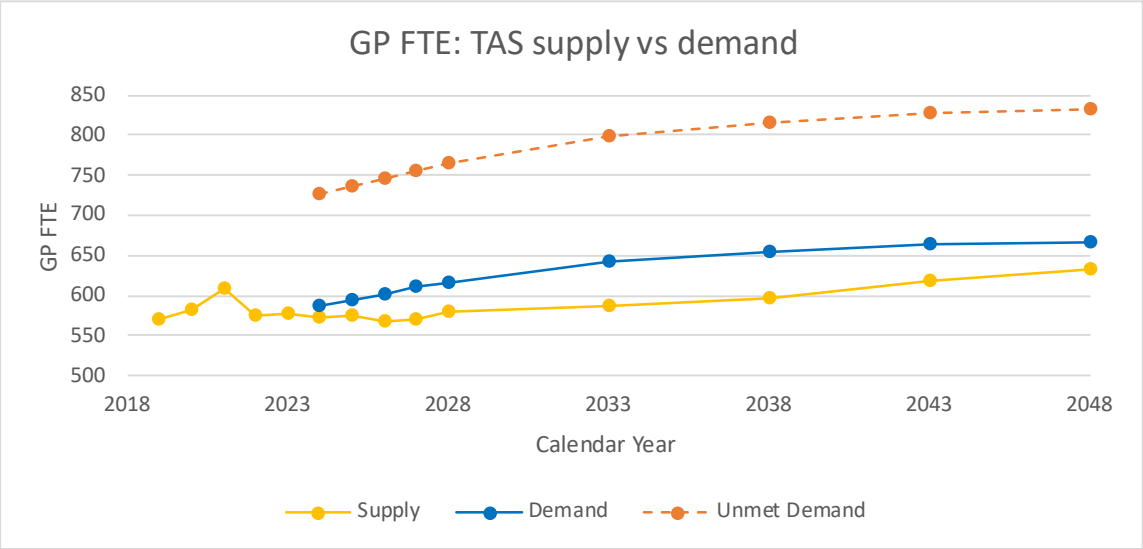


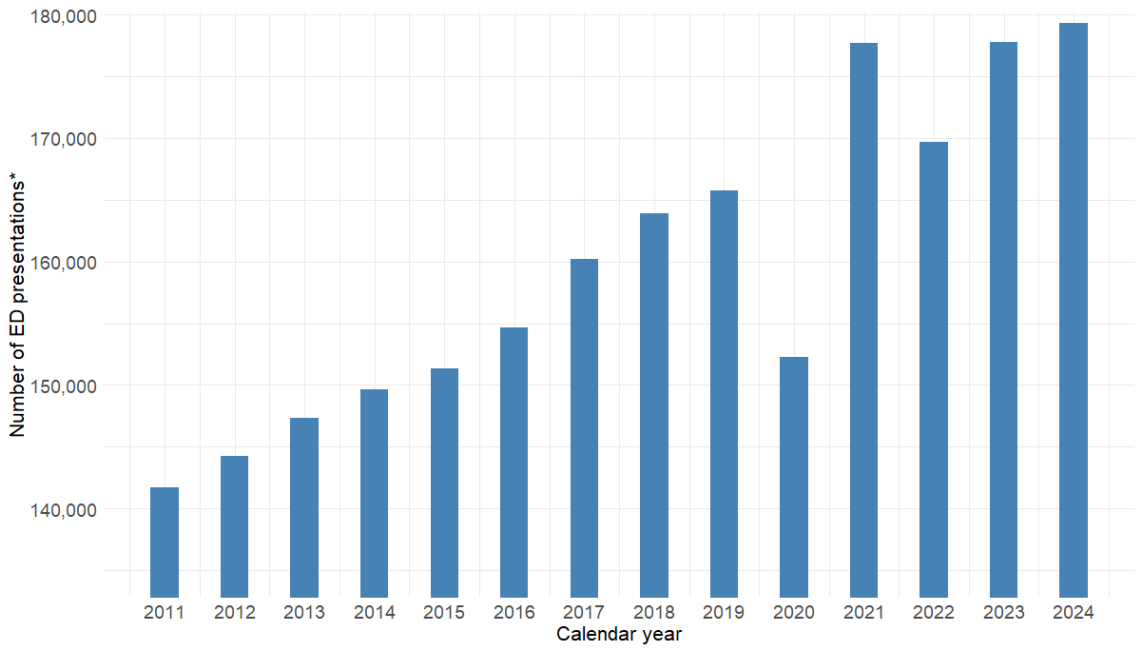
Figure 12. The supply and demand modelling for workforce. GP FTE supply vs demand in Tasmania | 2024



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[59] (Figure 13). There was a decrease in public hospital emergency department presentations during the coronavirus pandemic in 2020. After 2020, public hospital emergency presentations returned to the pre-COVID-19 trend[60].

Figure 13. Public hospital emergency department presentations, Tasmania | 2011 to 2024

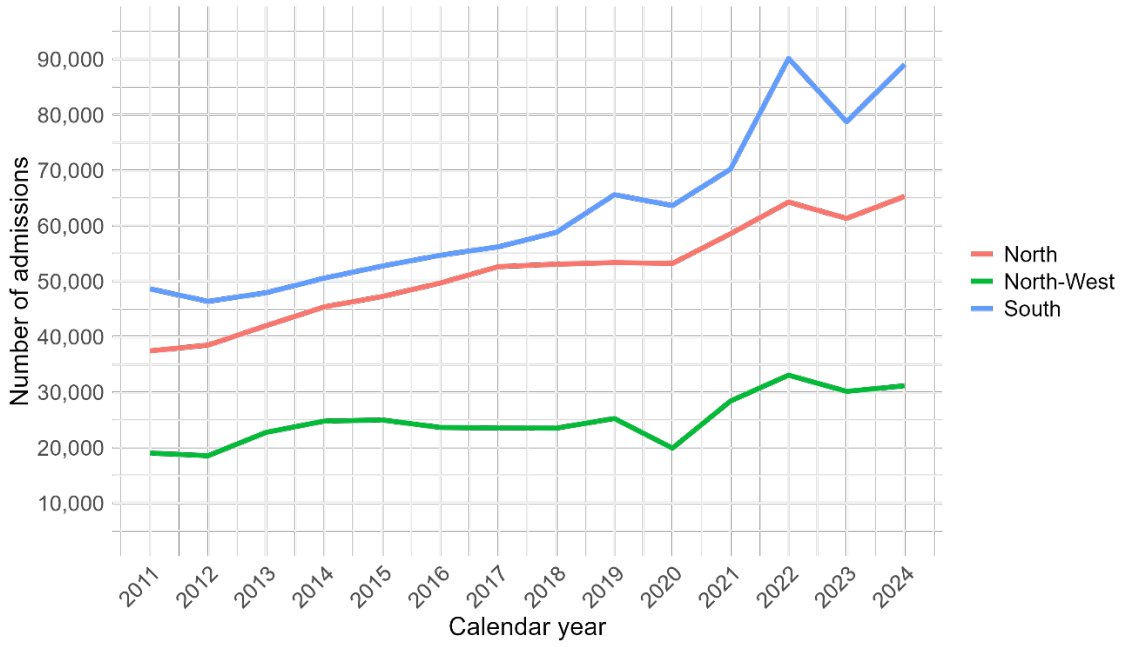


**Estimates reported from Primary Health Tasmania internal data analyses, number reported for all ED presentations*

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 south and north west in 2020 during the COVID-19 pandemic[59] (Figure 14). In 2024, public hospital admissions increased by approximately 9% compared with 2023, after a decrease of around 10% from 2022 to 2023[59].

Figure 14. Public hospital admissions by region of hospital, Tasmania | 2011 to 2024



1.3.3 After-hours primary care services

Tasmanians outside the major centres of Hobart and Launceston have few options to access face to face general practice in the after-hours period, especially in outer regional areas. Despite the availability of telephone based and virtual services, 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 the 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. Healthdirect provides a helpline for consumers requiring health advice after hours, with calls responded to by a registered nurse.

Medicare Urgent Care Clinics (UCCs) have been funded by the Australian Government and commissioned by the Tasmanian state government. There are five Medicare UCCs in Tasmania, open 7 days a week – three located in the south, one in the north and one in the north west, with the first Medicare UCC established from July 2023. The working hours of each clinic varies, covering some of the busiest times for the EDs both in-hours and after-hours 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.

From July 2024 to June 2025, the UCCs data shows a total of 56,119 visits from patients who consented to share their data. Of 56,119 visits, 59.6% occurred during business hours and 40.4% after-hours. The number of visits is showing an increasing trend, reaching the highest peak in March 2025 (n=5410). Mondays showed the highest number of visits during the weekdays, while Sundays recorded the most visits over the weekends, with the busiest time between 2 PM and 6 PM. The most common reasons for visits were acute illnesses, followed by acute injuries and routine management of known conditions. Additionally, 43.5% would have sought help at a local emergency department if they hadn't come to the clinic, while 37.0% of patients reported that they would have visited a GP[61]. The UCCs have contributed to providing care, especially after-hours, and may have helped alleviate some pressure on emergency departments.

1.3.4 Palliative care service demand is increasing

Palliative care is the 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[62].

Palliative care is provided in a range of settings, including in a person's home, residential aged care homes, hospitals, hospices, respite care and after-hours services. Palliative care is not limited to specialist care services but includes primary and secondary level of care, and it is provided at three different levels[63].

- a 'palliative care approach', adopted by health professionals
- end of life 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[63].

In Tasmania it is estimated that most palliative care is delivered outside 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[63].

In the next 25 years, the number of Australians who die each year will double[64]. More than 60% would prefer to die at home, yet currently only 14% do so[64]. 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[65].

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.

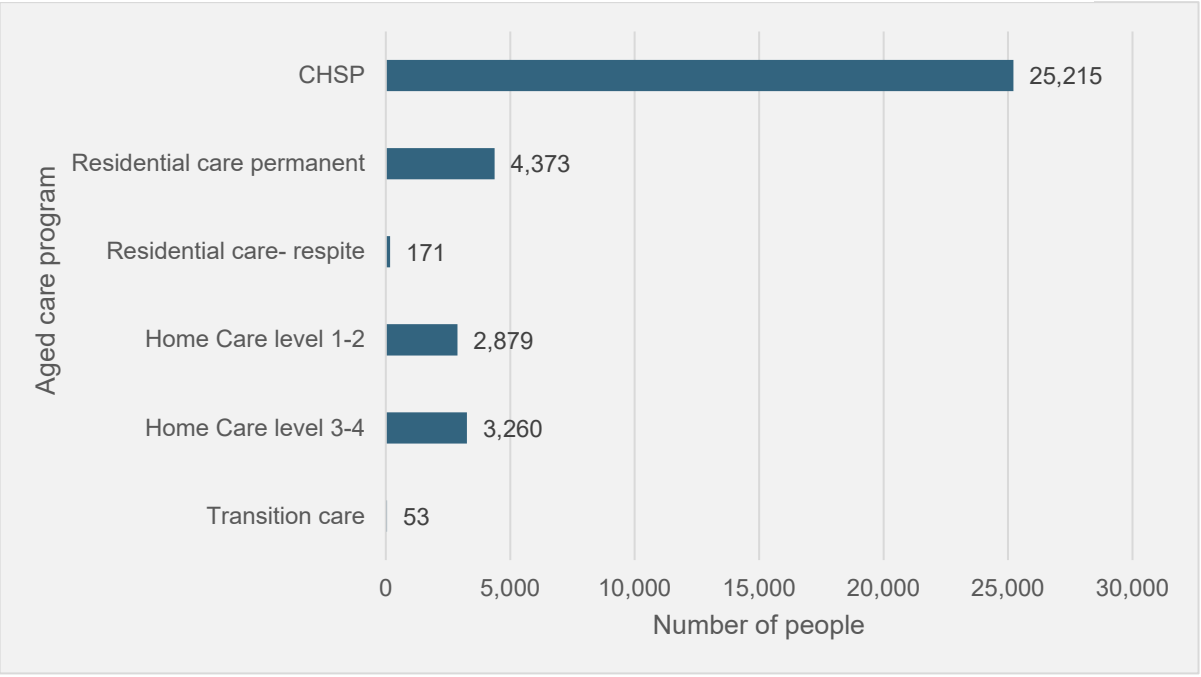
1.3.5 Aged care service demand is increasing

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

There are 3 mainstream types of aged care, including residential aged care, home support (Commonwealth Home Support Programme), and home care (Home Care Packages Program). Additionally, there are several types of flexible care services available that extend across the spectrum from home support to residential aged care (such as transition care which provides short-term care to restore independent living after a hospital stay)[67].

Most aged care services are provided to people in their home or in a community setting. In June 2024, 25,215 Tasmanians aged 65+ and Aboriginal people aged 50+ accessed the Commonwealth Home Support Programme (CHSP), which helps older Australians with daily tasks, transport, social support and nursing care[68]. In addition, more than 6,000 Tasmanians were enrolled in a Home Care Package Program on 30 June 2024[68] (Figure 15).

Figure 15. People aged 65+ and Aboriginal people aged 50–64 years who received aged care services, by program type, Tasmania | 30 June 2024



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. At 30 June 2024, there were 73 aged care services in Tasmania that offered a total of 5294 residential places[69]. 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, there is a waiting time between ACAT approval and entry into residential aged care.

The waiting time for a residential aged care place in Tasmania has shown significant fluctuation over the years. In 2015-16, the median wait time was 63 days. However, this increased substantially to a median waiting time of 150 days in 2020-21 and 139 days in 2021-22[70]. While there has been progress in reducing the wait time from its peak in 2020-21 and 2021-22, to a median wait time of 95 days in 2022-23, the waiting time remains notably long. This reflects ongoing challenges and variability in accessing residential aged care services[68]. There were 2,221 people approved for a home care package who were waiting to be allocated one at the end of December 2024; of these, a majority (1,725) had not been offered a lower level package in the interim[71].

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, most unwell 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[71]. As older people are also generally higher users of health services than younger people, demand is expected to increase with our ageing population[32].

The average wait time for a residential aged care place in 2022-23 was 95 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[32].

GP attendances for people using permanent residential aged care homes (RACHs) in Tasmania are lower than for all of Australia[72]. In 2022–23 the number of GP attendances in residential aged care facilities per patient was 14.8, lower than the Australian average of 17.4 attendances[72].

One in 10 hospitalisations are from residential aged care

Hospitals and residential aged care homes (RACHs) experience frequent patient transfers between the two types of homes for continuous management of chronic conditions, and for acute care following an injury or deterioration in their health. In Tasmania, the most recent quarterly data from October to December 2024 indicated that 10.0% of residents of RACHs had one or more emergency department presentations, while 11.7% of residents had an emergency department presentation or a hospital admission.

Nationally, 12.4% of RACF residents had at least one emergency department presentation and 15.3% had either an emergency department presentation or a hospital admission.

This shows a lower emergency department presentation or hospital admission rate in Tasmania compared with the national average[73] .

Infections are among the most common causes of hospitalisation of residents of RACHs in Australia. Up to 25% of all hospitalisations from RACHs are for infections, most commonly respiratory, urinary tract, gastrointestinal and skin infections[74].

Older people who live in RACHs experience more infections than people who live in other settings[75]. 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[76].

Medical support and diagnostic capability can be limited in RACHs which can result in transfer of residents to hospitals for medical assessment and care[77].

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 may 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 departments in public hospitals)
- 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
- limitations in consumer access to information that supports 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 may also 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

Some consumers can have limited awareness of the services available to them, the cost of services, and how services can be accessed due to the inherent complexity and accessibility barriers of the health system. This can result 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 urgent care centres, telephone-based services or community clinics.

Stakeholders describe concerns related to low consumer health literacy and a focus on seeking help through hospitals as a first option. This may contribute to reports of 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 living 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, supported, 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 aged care and end-of-life care can be improved

GP stakeholders reported that the complex systems in many aged care homes make it difficult to deliver general practice services efficiently. These challenges include complicated documentation processes, difficulty finding nursing staff to support the visiting GP, and electronic systems for resident records that don't integrate with GP record-keeping.

Consumers and carers report being confused about the palliative care and aged care services that are available to them. This includes 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 2024-25, 79 events were provided, including health educational training, clinical decision support sessions, and culturally appropriate care webinars. A total of 2,330 participants attended these events and actively engaged in these learning opportunities. Primary Health Tasmania also facilitated 15 practice manager networking breakfasts that were attended by 174 participants.

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 Support general practices in identified communities through collaborative planning

Primary Health Tasmania undertook a statewide thin markets analysis to identify geographic areas across Tasmania where access to primary healthcare is most limited. Based on this analysis, five priority local government areas (LGAs). These LGAs include Brighton, Central Highlands, Southern Midlands, Huon Valley, and Derwent Valley and experience high level of social disadvantage, a high burden of chronic diseases, mental health issues, and limited GP availability.

Primary Health Tasmania is committed to working with health and social care services to co-design innovative care models, focusing on workforce solutions. Primary Health Tasmania will consult with providers and consumers, organise working groups, and assess the community needs to guide a place-based approach.

1.5.4 Manage 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 alcohol, being overweight, not being physically active, and poor nutrition. 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. 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.

1.5.5 Support 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.

1.5.6 Support 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 will 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

Priority populations

2 Priority populations

2.1 Overview

Assessing need and determining local priorities is a key part of Primary Health Tasmania's work. We achieve this by gathering and analysing data, particularly through our annual health needs assessment activities. We consult experts, including service providers and consumers, to ensure our decisions are well-informed and resources are allocated to achieve the greatest impact for those most in need.

Tasmanians still rank poorly compared with other Australian states and territories on many health measures. In addition to this, Tasmania is home to a regionally dispersed population of over 557,000 people and socioeconomic disadvantage is prevalent across the state. Access to health care is problematic for many - particularly for people with a disability, older Tasmanians, those people experiencing homelessness, Aboriginal and Torres Strait Islander people, LGBTIQA+ people, and people who are from culturally and linguistically diverse backgrounds.

Primary Health Tasmania is committed to addressing the diverse health needs of our community. In this chapter, we present health data and information for the following priority population groups:

- older people
- Aboriginal and Torres Strait Islander people
- multicultural communities
- people experiencing or at risk of homelessness
- people with disability
- people living in rural and remote areas
- people experiencing socioeconomic disadvantage
- children and young people
- LGBTIQA+ people

This chapter will support the understanding of the current population-specific health data and information. It also highlights activities that Primary Health Tasmania is involved in to support these priority populations.

2.2 Older people

This section focuses on older Tasmanians — defined as people aged 65 years and over. For Aboriginal and Torres Strait Islander people, the age range 50 years and over is used, reflecting the life expectancy gap between Aboriginal and non-Aboriginal Tasmanians.

The median age of Tasmanians in 2021 was 42 years, compared with 38 years for the rest of Australia. Our higher median age is associated with a high population disease burden of chronic health conditions such as cancers, diabetes, heart disease, and dementia[78]. Further, as of June 2021, the number of people with dementia in Tasmania was 4,395 (0.8%) which exceeded the national average (0.7%)[78].

Falls, a significant health concern for older people, have the highest incidence and burden among those aged 65 years and over. This age group is significantly more likely to be hospitalised or experience fatal outcomes from a fall compared with younger populations[79].

Despite these challenges, 75% of older Tasmanians feel they have good, very good, or excellent health[80].

Tasmania's population is remaining healthier for much longer than previous generations.

The population of people aged 65 years and above in Tasmania reached 116,630 in 2021, or 19.2% of the population, compared to 17.5% in 2016.

2.2.1 Growing aged care needs in Tasmania

Tasmania's growing older 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 years and over (1 in 5 people) and the highest proportion of people aged 50 years and over (2 in 5 people)[81].

Most Tasmanians aged 65 years 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 years or over (around one third of the population)[82]. This means demand for aged care services is high statewide and will continue to increase.

2.2.2 What does Primary Health Tasmania do?

Primary Health Tasmania commissions services to:

- connect older people with aged care services via the care finder program
- deliver psychological treatment services for older people with mental illness who are living in aged care homes
- support older people with chronic health conditions who are living in rural areas.

2.2.3 What does Primary Health Tasmania also support?

- Increased access to and use of telehealth care options for people living in aged care homes.
- Access to after-hours support for residential aged care, including the Yellow Envelope initiative and shared transfers of care.
- Primary health professionals in caring for older people, through initiatives such as electronic medication management resources, and emergency decision guidelines.
- Improved quality of palliative and end-of-life care for Tasmanians through collaboration under the Greater Choice for At Home Palliative Care Measure.

2.2.4 Primary Health Tasmania's website offers resources to improve aged care for individuals and their carers

- Shared planning checklist
- Information about managing medications
- Passport to better health
- Primary Health Tasmania dementia resources for consumers.

2.3 Aboriginal and Torres Strait Islander people

In Tasmania, 30,186 people identified as Aboriginal and/or Torres Strait Islander in the 2021 Census, representing 6% of the state's population. In 2021 the median age of Aboriginal and Torres Strait Islander people was 25 years, up from 24 years in 2016 and 22 years in 2011. The proportion of the Aboriginal and Torres Strait Islander population aged 65 years and over in 2021 was greater than in 2016 (6.2% compared with 5.9%)[3].

The local government area with the largest Aboriginal and Torres Strait Islander population was Launceston City (2,873 or 9.5% of the total Aboriginal and Torres Strait Islander population), followed by Glenorchy (2,725, 9%) and Clarence (2,623, 8.7%). Circular Head had the greatest proportion of Aboriginal and Torres Strait Islander people (17.3% of the local government area's total population)[3].

A remarkable strength lies at the heart of the Palawa (Tasmanian Aboriginal people) and culture. With the oldest continuing culture in the world, connection to lands and community, resilience and adaptability over thousands of years has been demonstrated.

Aboriginal people experience health inequalities in comparison with non-Indigenous Australians, leading to a reduction in life expectancy. Higher rates of smoking contribute to increased incidence of a number of diseases, including chronic diseases and mental health conditions[83].

2.3.1 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[84]. Improving the health and wellbeing of Tasmanian Aboriginals includes ensuring access to culturally appropriate healthcare services that practice clear and respectful communication, respectful treatment, inclusion of family members, and empowering Aboriginal people to make their own decisions about care.

Additional details on the health status and needs of Aboriginal people in Tasmania will be explored further in Chapter 3.

2.3.2 What does Primary Health Tasmania do?

Primary Health Tasmania works with local communities, organisations and healthcare providers to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples. We turn to our local Aboriginal community organisations and healthcare providers to find out what is needed to inform designing, commissioning and monitoring services to meet those requirements. Primary Health Tasmania has commissioned organisations across the state to deliver:

- integrated team care services to support chronic conditions management
- social and emotional wellbeing services.

Primary Health Tasmania also provide a "passport to better health" resource specifically designed for Aboriginal people in Tasmania.

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

2.4 Multicultural communities

Australia's population includes many people who were born overseas, are not from Anglo-Celtic backgrounds, have a parent born overseas, or speak a variety of languages. Together, these groups of people are known as multicultural communities. Multicultural communities are also known as cultural and linguistically diverse populations (CALD) and this terminology is still widely used in public reports when referencing data. In this document we have used the acronym CALD when referencing data from original sources.

The rich cultural diversity is one of Australia's greatest strengths and is central to our national identity.

Three out of 20 people living in Tasmania were born outside Australia. The proportion of people born outside Australia increased to 15.3% in 2021 from 12% in 2016. Multicultural communities comprise a smaller proportion of the population in Tasmania than elsewhere in Australia. In 2021, the top five countries of birth in Tasmania were: Australia (79.1%), England (3.5%), China (1.2%), Nepal (1.1%), and India (1.1%)[85].

People from migrant backgrounds often experience health disparities leading to lower quality health care, poorer health outcomes, delayed diagnoses, and disempowerment. Barriers to health care include stigma, language barriers, discrimination and racism, perceived lack of cultural safety, limited understanding of the Australian health system, visa status, associated medical costs, and social, cultural and spiritual health beliefs[86, 87].

2.4.1 We have less cultural diversity

Tasmania has a less diverse multicultural community than Australia as a whole. Around 15% of Tasmanian residents were born overseas, compared with 28% of the Australian population as a whole. Only 9.4% of Tasmanian households speak a language other than English at home, compared with 24.8% nationally[4,] and tend to be concentrated in the population centres of Launceston and Greater Hobart.

2.4.2 What does Primary Health Tasmania do?

Primary Health Tasmania commissions services to:

- reduce suicide risk and increase the capacity to respond to suicide crises within multicultural communities
- provides a program to connect older multicultural Tasmanians with aged care services.

Primary Health Tasmania provides access to a range of resources through its Services Portal, and information such as dementia resources for consumers, available in multiple languages. Primary Health Tasmania also develops resources and tools for use by general practitioners, health professionals, and interpreters when interacting with people from multicultural backgrounds.

Health professionals can also access multicultural specific pathways on Tasmanian HealthPathways, ensuring that care is tailored to meet the needs of diverse communities.

Culturally and linguistically diverse -specific data is difficult to obtain for Tasmania.

2.5 People experiencing or at risk of homelessness

Homelessness means a person has no suitable alternative accommodation. A person is considered homeless if their current living arrangement is inadequate, has no tenure or only short, non-extendable tenure, or does not allow control of, and access to, space for social relations.[88] Homelessness has multiple, intersecting causes, including discrimination, a shortage of affordable, available housing, domestic and family violence, intergenerational poverty, long-term unemployment, and economic and social disadvantage[12, 14, 89].

2.5.1 Homelessness affects people of all ages, and in all regions of Tasmania

In 2023–24, 6,672 people in Tasmania were experiencing homelessness or living in marginal housing[8]. Homes Tasmania's September 2025 release reports that more than 5,300 households are seeking social housing[90]. From December 2017 to June 2025, the number of people seeking support from Specialist Homelessness Services in Tasmania rose by 127 people (5.6%), from 2,270 to 2,352[89]. Of the 2,352 people who received assistance, 1,250 were female, 1,066 were male, and 432 identified as Aboriginal.

Homeless people often experience multiple vulnerabilities, with 1,844 clients who accessed specialist homelessness services in Tasmania during 2023-24 identified as having a current mental health issue[91].

In 2021, the number of people experiencing homelessness was highest in Launceston (n=442) and Hobart (n=441) LGAs[92]. Regionally, 51% of people experiencing homelessness were located in the south, 26.9% were located in the north, and 22.1% were in the north west[14].

Most homelessness is hidden from view - people staying temporarily with others "couch surfing", in precarious or substandard accommodation, emergency shelters, overcrowded dwellings, cars and tents[14].

Homelessness can be a full-time job. Finding a safe place to sleep and food to eat are the main priorities for people who are homeless and can take up much of any given day. Contacting housing providers or other welfare agencies that can meet immediate needs for shelter, food, warmth and safety will come ahead of healthcare appointments and can consume a great deal of time.

2.5.2 What does Primary Health Tasmania do?

Primary Health Tasmania commissions health outreach services to people experiencing homelessness. These services include:

- vaccinations
- basic health checks
- wound care
- referral to specialist services
- support to access health care
- a program to connect vulnerable older people with aged care services.

Primary Health Tasmania provides access for health professionals to homelessness specific pathways on Tasmanian HealthPathways.

2.6 People with disability

People with disability include those who have long-term physical, mental, intellectual or sensory impairments which may hinder their full and effective participation in society on an equal basis with others[93].

In Tasmania, there were about 170,400 people in 2022 with reported disability – this was 30.5% of the population compared with 21.4% nationally[94].

In 2021, 38,023 Tasmanians needed assistance with core activities on a daily basis. The prevalence of disability generally increases with age. Two in five people with disability are 65 years or over. In 2015, half of all people with disability used aids or equipment to help them with their disability. In 2018, Tasmania had the highest rate in Australia of people with psychosocial disability at 8.3%[94].

"People with disability lead meaningful lives. We work. We have families. We contribute to our community in myriad ways. We are entitled to respect. Many of us are proud of being people with disability and we want that identity to be affirmed in our private lives as well as in the public sphere." PWDA Language Guide: A guide to language about disability

National Disability Insurance Scheme (NDIS) data for 2025 show there were 15,332 NDIS participants in Tasmania, of which 2,767 lived with intellectual disability. Tasmania had 3% of all NDIS participants with intellectual disability in Australia[95].

2.6.1 Rates of disability grow with increasing age

As people age, the likelihood of developing a disability significantly increases, resulting in a greater concentration of disability-related burden among older age groups[93] (Figure 16).

Everyday self-care activities become increasingly difficult to manage as we age and as our function declines[93] (Figure 17).

Figure 16. People aged 65+ who need assistance with personal activities, by age and activity type, proportion of age group | 2022

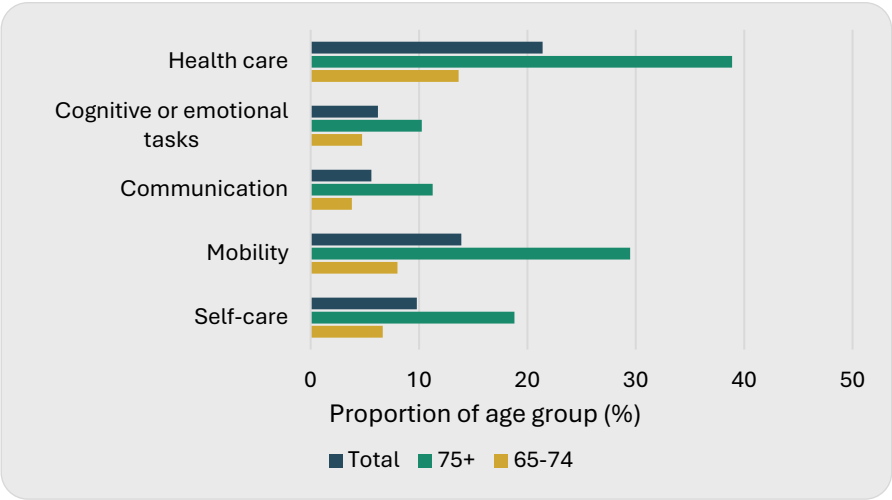
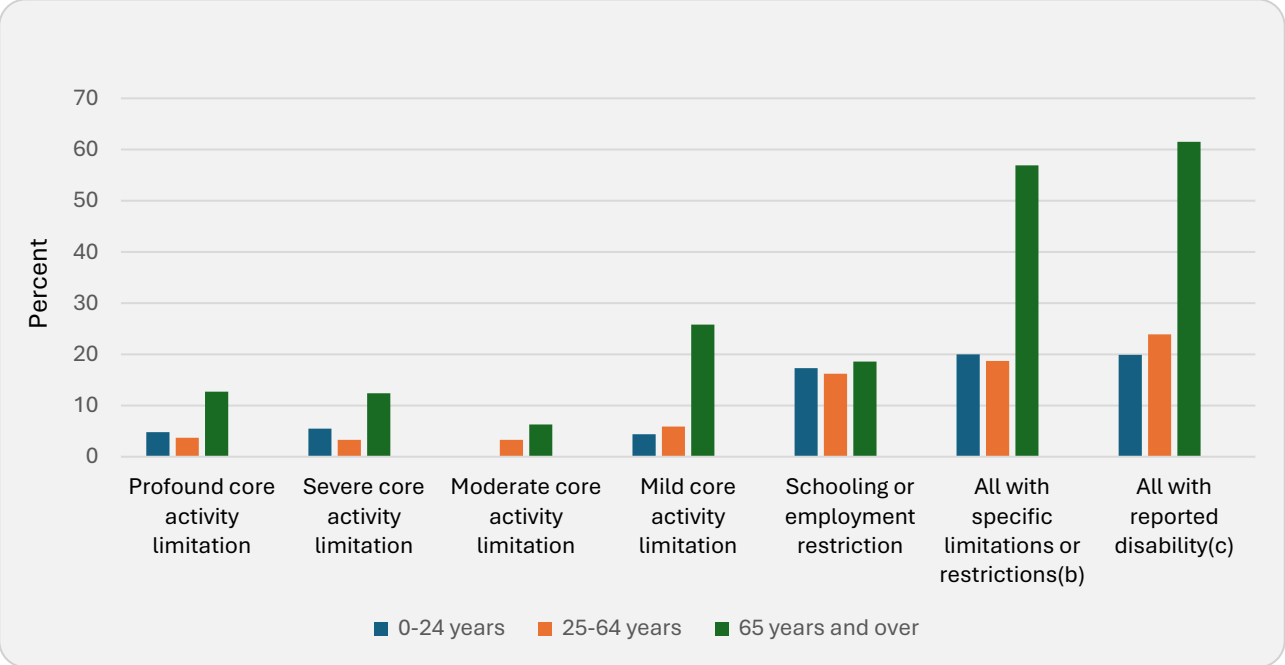


Figure 17. Disability status by age group, Tasmania | 2022



In 2018, 43% of all Tasmanians aged 65+ needed help with everyday activities. About 80% of Tasmanians living with 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[96].

In 2022, over 15% of Tasmanians aged 15 years and over report that they experience discrimination due to their disability. Discrimination is more likely for females, younger people, and those with intellectual or psychosocial disabilities[97].

2.6.2 What does Primary Health Tasmania do?

Primary Health Tasmania commissions psychosocial support services (non-clinical support services) for adults with a severe mental illness that impacts their daily life. Primary Health Tasmania provides access for health professionals to find disability-specific pathways on Tasmanian HealthPathways.

Primary Health Tasmania has implemented a national pilot program to enhance primary care for people with intellectual disabilities. This program aims to provide workforce training for primary healthcare professionals, develop and promote resources for people with intellectual disabilities, and establish stakeholder networks that support the program.

2.7 People living in rural and remote areas

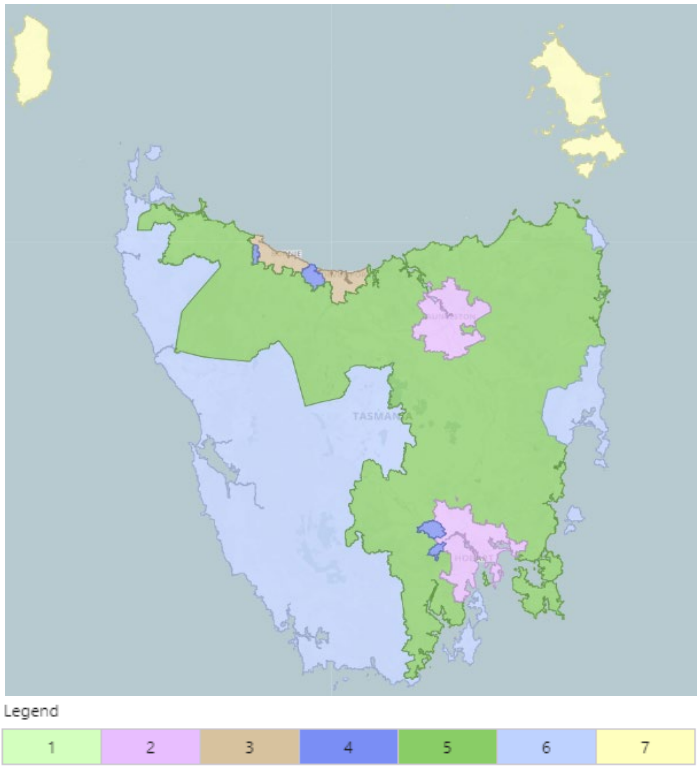
People living in rural and remote areas face unique challenges due to their geographic location, often experiencing poorer health outcomes compared with those living in metropolitan areas. People in rural and remote areas have higher rates of hospitalisations, deaths, and injuries, and limited access to and utilisation of primary healthcare services, in comparison with people living in major cities[98].

To define whether a location is metropolitan, regional, rural, remote or very remote, the Modified Monash Model (MMM) is used. This model assigns a scale of categories ranging from MM 1 to MM 7, with MM 1 representing a major city and MM 7 representing a very remote area. Tasmania's geographical areas are classified as MM 2 to MM 7, falling under the categories of regional, rural, or remote. People living in these areas can find it harder to get medical help and accessing doctors can take longer and cost more compared with Australians living in MM1 geographical areas (Figure 18)[98].

The poorer health outcomes of many people living in rural and regional Tasmania can be associated with barriers to accessing health care, including lower socio-economic status, lower levels of literacy, including health and digital literacy, and higher costs associated with accessing health care.

Consequently, many Tasmanians in rural and regional areas delay seeking healthcare and have more complex healthcare needs. Nearly 50% of rural or regionally based Tasmanian adults reported having three or more chronic health conditions[99]. However, the notable prevalence of chronic conditions is a statewide phenomenon and will be expanded upon in 3 – Chronic Conditions.

Figure 18. Tasmania’s areas classification as regional, rural and remote, according to the Modified Monash Model. MM 1 representing a major city and MM 7 representing a very remote area



2.7.1 What does Primary Health Tasmania do?

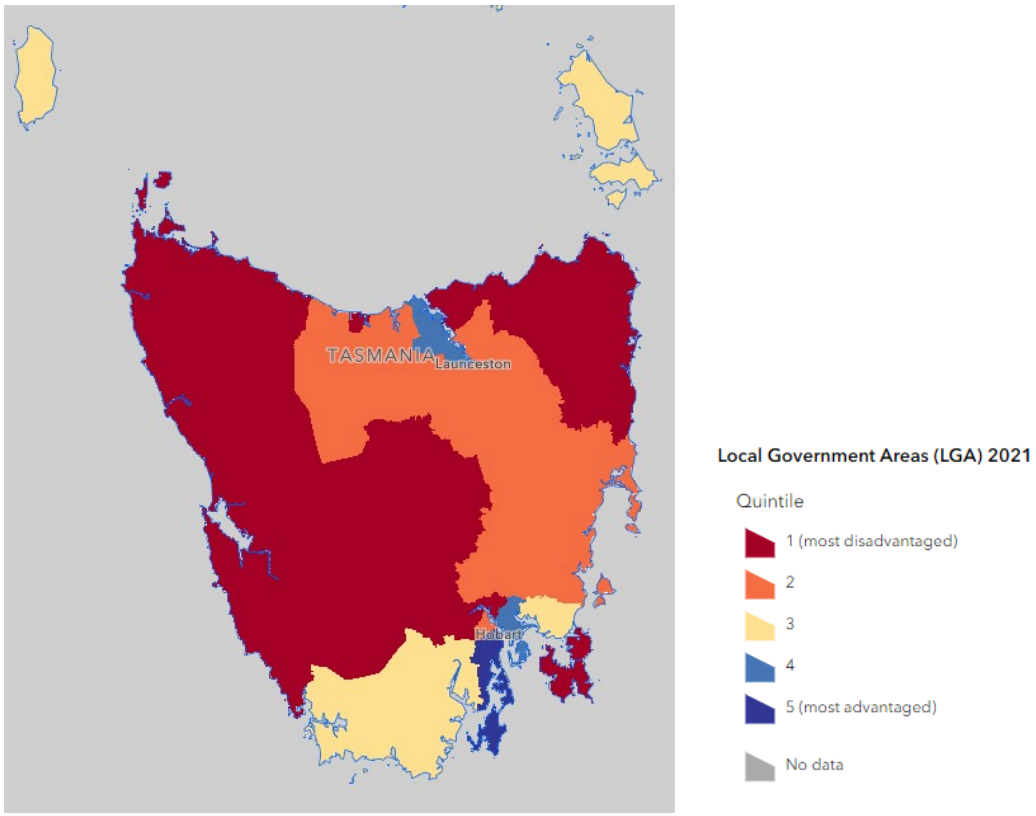
Primary Health Tasmania commissions services using its rural primary health care resources to improve health outcomes for people living with chronic conditions through integrated service delivery approaches across 21 rural local government areas.

2.8 People experiencing socioeconomic disadvantage

Tasmanians experience significant socioeconomic disadvantage. To understand the distribution of socio-economic status of population in Tasmania, the Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) was used (Figure 19). The IRSAD is part of the Socio-Economic Indexes for Areas (SEIFA), developed by the ABS. SEIFA indexes summarise various census data related to population, family, and household characteristics that reflect socio-economic advantage and disadvantage. This means areas with a lowest index score, represented by the red shade, are most disadvantaged compared with areas with the highest index score, shown in dark blue[100].

People experiencing socio-economic disadvantage are more likely to delay or not use health services when needed due to cost of service compared with those who are least disadvantaged[101, 102]. This issue has become more pronounced in 2023-24 compared with the previous year (8.8% vs 7.0%)[10]. Challenges in accessing healthcare can, in turn, negatively impact overall health and wellbeing and reduce life expectancy[102].

Figure 19. Distribution of socioeconomic disadvantage across Tasmania's Local Government Areas through one of the Socio-Economic Indexes for Areas (SEIFA), using the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD), Census data| 2021



2.8.1 What does Primary Health Tasmania do?

Primary Health Tasmania does not commission services specifically targeting people with low socioeconomic status. However, Primary Health Tasmania is committed to addressing the needs of people experiencing socioeconomic disadvantage by removing or reducing cost barriers to accessing care through its commissioned services. This initiative is particularly focused on rural areas by commissioning services for chronic conditions and mental health that are free and accessible through self-referral.

2.9 Children and young people

The first 2000 days of life, from conception to age five, are widely acknowledged as a critical period for shaping long-term health. This time sets the foundation for physical, cognitive, and emotional well-being, offering a key opportunity to reduce health risks and promote positive outcomes for individuals and communities[103]. In 2021, the census data indicated that Tasmania had 28,277 children under the age of 5, with nearly 17% of the population under the age of 15[78].

Youth is a crucial phase in life. The health and well-being of young people can affect their education, work transition, adult lifestyles, and forming families. The Australian Institute of Health and Welfare defines youth as the age range between 12 and 24 years[104]. According to the 2021 census data, 28% of Tasmania's population was under the age of 24[78].

"Provide supports, lifelines, and contacts so that young people always feel they have someone or somewhere they can turn to in tough times"

CHILD AND YOUTH WELLBEING STRATEGY 2024

2.9.1 Health status of children and young people

An infant's health at birth plays a vital role in shaping their future health and wellbeing. As they grow, vaccinations protect them from serious and potentially life-threatening diseases. Infant and child mortality rates are decreasing, and survival rates for certain cancers are improving. However, perinatal conditions, injuries, and cancer continue to be the leading causes of death among children[105].

In 2023, the primary contributors to the health burden for Australian youth aged 15–24 were mental health conditions, substance use disorders, and injuries. This burden differed by gender, with suicide and self-inflicted injuries being the leading cause among males, and anxiety disorders were most common among females[104]. Additionally, the self-reported data from the 2022 national health survey revealed that nearly three-quarters of young people aged 15–24 years experienced one or more chronic conditions[106]. Injuries were the leading cause of death among young people, accounting for 809 (69%) of the 1,200 deaths for 15–24-year-olds. In 2021, half (50%) of all injury deaths were caused by intentional self-harm, followed by land transport accidents (28%) and accidental poisoning (8%)[104].

2.9.2 What does Primary Health Tasmania do?

Primary Health Tasmania has worked with the Tasmanian Health Service and other experts to develop Moving on Up – a practical framework to support the transition of young Tasmanians with chronic conditions to adult care.

Primary Health Tasmania commissions mental health services for young people aged 12 to 25 years. These services include early intervention, psychological therapies for mild to moderate conditions, free case management for severe mental health problems, and free statewide telephone service also offers mental health advice and support.

Children and Young People are Loved, Safe and Valued

CHILD AND YOUTH WELLBEING STRATEGY 2021

2.10 LGBTIQA+ people

LGBTIQA+ is an acronym that stands for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual/ agender/aromantic. There are many other terms (such as non-binary and pansexual) used by people to describe their experience of their gender, sexuality and physiological sex characteristics[107].

The LGBTIQA+ Tasmanians: Telling us the Story report states that LGBTIQA+ Tasmanians value the predominantly welcoming, progressive, and accepting socio-cultural environment in contemporary Tasmania and acknowledge that LGBTIQA+ inclusion has increased over the years. However, people still routinely experience abuse and discrimination and carry the legacy of abuse and discrimination from the past. This means the LGBTIQA+ Tasmanians may have poorer mental and physical health outcomes compared with the general population[107].

The Tasmanian LGBTIQA+ community is 'close knit' and supportive of its members, offering many opportunities for socialising, recreation, and advocacy. LGBTIQA+ Tasmanians are proud of their community and all they have achieved together. They are eager to share and celebrate these strengths with the community at large.

In Tasmania, 4.2% of the population identify as LGBTIQA+, and 0.7% of the population identify as trans and gender diverse[107].

In 2021, an online survey of 825 LGBTIQA+ Tasmanians revealed several key insights into the community's experiences and challenges. Approximately, 40% of respondents work in healthcare or education, and 53% were born in Tasmania, with 69% living in the Hobart region. Additionally, 5.4% identified as Aboriginal or Torres Strait Islander. A total of 97% of respondents reported being told that their sexuality or gender identity was the result of trauma or pathology that needed to be "changed" "fixed" or "healed." Furthermore, 75% of participants stated that they always or sometimes hid their identity in public out of fear of abuse[108].

The survey also highlighted the higher prevalence of disability and chronic illness among LGBTIQA+ people, with 43% of respondents reporting feeling they cannot do the things they want due to their health. Additionally, access to mental health support was identified as particularly challenging in rural and regional areas for LGBTIQA+ people[108, 109].

2.10.1 What does Primary Health Tasmania do?

Primary Health Tasmania does not commission LGBTIQA+-specific services.

Our mainstream commissioned services seek to be inclusive and supportive of all people regardless of ethnicity, faith, age, disability, language, gender identity or sexual orientation.

Additionally, Primary Health Tasmania provides access for health professionals to care pathways specific to LGBTIQA+ people on the Tasmanian HealthPathways portal.

LGBTIQA+-specific health data is difficult to obtain for Tasmania. According to the 2016 Australian Census, approximately eight per 100,000 Tasmanians identified as sex and/or gender diverse. However, there is yet to be questions embedded in the Census that explicitly record health data about the lives of LGBTIQA+ people.

2.11 Health needs

2.11.1 Priority population groups have greater primary care needs

Priority 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.

Comprehensive and accessible primary care is needed by people in all priority population groups.

People from multicultural backgrounds could experience language and cultural barriers to accessing mainstream services[110].

LGBTIQA+ people may experience stigma and discrimination when accessing primary care. They have a greater burden of chronic conditions and mental health problems[111].

2.11.2 Our immunisation coverage rates are high

Tasmania has high immunisation rates with nearly 94% of Tasmanian children being fully vaccinated by the age of 5 years[112]. 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[113].

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 2023, 84.0% of Tasmanian females and 80.3% of Tasmanian males were fully vaccinated for HPV by age 15, compared with 85.3% of females and 83.1% of males nationally[114].

Until recently there has been no regular or nationally consistent source of data from which to estimate vaccination coverage in adults in Australia. Population surveys have been used to estimate vaccination coverage in the adult population or in selected population groups. In 2021, data on adult vaccination coverage from the Australian Immunisation Register were reported for the first time. In 2023, recorded zoster vaccine coverage among adults turning 71 years of age was slightly higher in Tasmania, compared with Australia as a whole: 45.4% vs 41.0%[114]. Coverage among Aboriginal adults turning 71 years of age was higher in Tasmania, compared with Australia overall, with rates of 52.7% and 36.1% respectively[114].

Coverage of seasonal influenza vaccine in 2023 was 26.8% of 20-49 year old people, rising to 45.0% of 50-64 year olds, and 71.4% of those aged 65 and over. This is a slight decrease compared to 2022 where the vaccination rates were 34.6%, 55.3%, and 76.5% respectively. These percentages are higher for Tasmanians than for Australians overall in every age group. Vaccination coverage among Aboriginal Tasmanians is only higher for age groups 50-64 years and age 65 and over with 51.1% and 76.9% coverage respectively compared to non-Aboriginal Tasmanians[114].

2.11.3 Homelessness contributes to health problems

People experiencing homelessness experience significantly higher rates of premature death, disability and chronic illness than the general population[12]. Homelessness and the disadvantages associated with it can contribute to premature ageing and mortality through early onset of health problems more commonly associated with later life[115].

Mental illness is one factor that contributes to the level of homelessness in Australia[116]. In March 2025, specialist homelessness services in Tasmania assisted 967 clients having a current mental health issue[89], highlighting the prevalence of mental illness among the homeless.

There is also a strong link between problematic alcohol or other drug use and experiences of homelessness. This is supported by the fact that 246 clients with problematic drug or alcohol use were assisted by specialist homelessness services[89].

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

2.11.4 There are barriers to accessing primary care in rural populations

People in remote and very remote communities can experience barriers to accessing primary care services[117]. General practice, allied health and community nursing services are generally 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[117].

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. Internet connectivity may limit the accessibility of telehealth services and low information technology literacy may be a barrier to accessing telehealth for some people.

2.11.5 Older people and their carers have greater primary care needs

Most older people have long-term health conditions. Older people living in residential aged care have higher rates of multiple long-term health conditions or 'multimorbidity' than older people living in the community[118].

There is also 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[119]
- 49% have a diagnosis of depression[119]
- 54% have a diagnosis of dementia[120].

More older people in our community are living with dementia. Over 10,302 people in Tasmania were estimated to be living with dementia in 2022[121]. Dementia is a major health issue, causing substantial illness, high levels of disability, and premature mortality. [24, 122]. 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[123].

The needs of carers are an important part of primary care and aged care service provision. In 2022, more than 10.5% (11,900) of Tasmanians aged 65+ provided care as a primary carer[124] (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 | 2022

	0–64 years	65+ years	All ages
Estimated number	28,000	11,900	39,000
Estimated proportion	6.4%	10.5%	7.0%

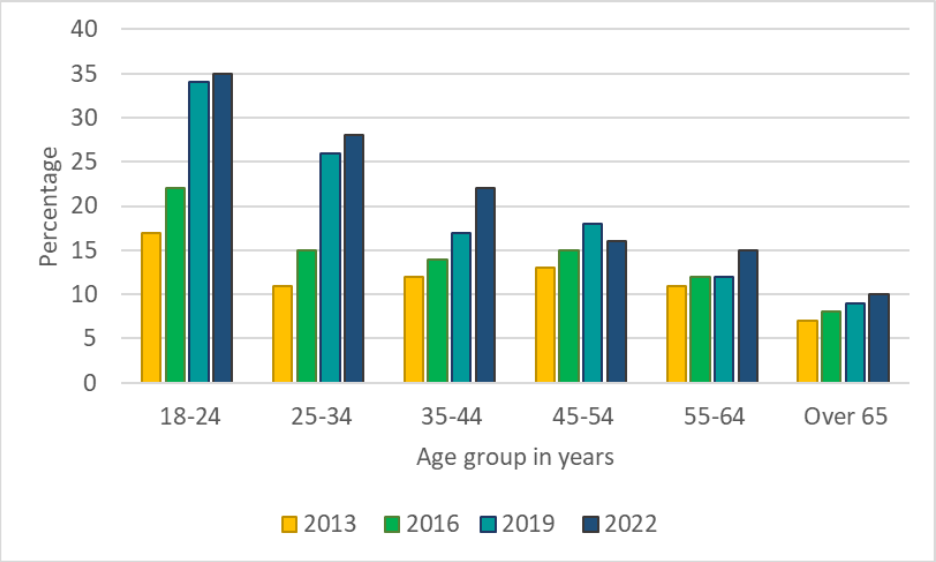
Nearly half of primary carers provide care because they feel they could give better care than the available options (46.6%). For Australians aged 65 years and over, approximately 3 in 10 primary carers provide care because they feel they have no other choice or there are no other care arrangements available, and approximately 7 in 10 felt they had a family responsibility to provide care[125].

2.11.6 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 in people aged 18 to 24 years[126] (Figure 20).

Figure 20. 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 inactivity are more prevalent in the over-12 age group when compared with the under-12 age group[126].

Mental health conditions have a gendered distribution, with depression or anxiety in adolescents being more likely to affect females than males (43% vs 30%)[126].

2.12 Service needs

2.12.1 Priority groups in aged care

In 2022-23, aged care recipients from multicultural communities were overrepresented for ACAT assessments (7.6%), Home Care levels 1-2 (11.8%), Home Care levels 3-4 (12.2%), and Transition Care (10.4%), and slightly underrepresented for residential aged care (7.2%). This suggests there may be a need to enhance residential aged care access for the multicultural community, particularly those with higher rates of disability[127].

Use of the Commonwealth Home Support Program (CHSP) by people from multicultural communities was similar to other CHSP users[127]. Among the total Tasmanian CHSP client group, approximately 900 individuals primarily speak a language other than English at home. Of these, 492 reside in the greater Hobart region, while 408 reside across the rest of Tasmania. After Hobart, the Central Coast LGA has the second-largest cohort of non-English speaking CHSP clients, with 170 individuals[128].

Older people in rural and remote areas made up 36.7% of the target population for aged care in Tasmania as of June 2023. They were, however, underrepresented for all aged care services, including, ACAT assessments (31.5%), residential aged care (24.6%), CHSP (34.7%), Home Care levels 1-4 (12.1%), and Transition Care (1.2 %)[129].

2.12.2 After-hours primary care service for priority groups

Vulnerable Tasmanians are supported to receive care in the after-hours period through Primary Health Tasmania commissioned services. These services are provided via a mobile health clinic, to improve access to after-hours medical care for people experiencing 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.

For multicultural communities there is a need to establish a dedicated multicultural workforce. This should include an after-hours liaison to bridge the gap between primary care and hospitals, and address the unique challenges faced by the multicultural community in accessing healthcare outside standard operating hours.

2.12.3 Demand for general practice services in rural areas is increasing

People living in rural and remote areas these areas face greater healthcare needs due to high-risk behaviours including smoking and alcohol consumption, and higher rates of chronic diseases. Areas with higher socioeconomic disadvantage, including George Town, Devonport, and the West Coast, experience the highest demand for primary care health services.

2.12.4 Multicultural Tasmanians living with disability

In March 2025, there were 384 active NDIS participants in Tasmania who identify as being from multicultural backgrounds, accounting for 2.5% of the total Tasmanian NDIS cohort.

The average committed funding support for active CALD NDIS participants over a six-month period (Q3 FY24/25) stands at $43,326, consistent with the national average. However, the average payment received for Tasmanian CALD NDIS participants is $33,782, lower than the Australian average of $35,813[130, 131].

2.13 Stakeholder perspectives

2.13.1 Primary healthcare and support services for end-of-life and aged care for priority populations

Stakeholders report some priority populations have more difficulty accessing end of life care that is appropriate for their needs.

These populations include:

- LGBTIQA+ people
- Multicultural communities
- Aboriginal and Torres Strait Islander people
- people with disability
- people experiencing or at risk of homelessness.

Other population groups also facing similar difficulties include:

- veterans
- refugees
- prisoners
- care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations) and people affected by forced adoption or removal.

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

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

People receiving aged care services, particularly residential aged care, also report having trouble accessing timely general practice care. Some residential aged care homes are unable to attract medical practitioners to care for their residents. Gaps in visiting allied health services are widespread across allied health disciplines.

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

2.13.2 General practice access challenges for multicultural communities in Tasmania

A general practice working group developed by the migrant support network has identified significant challenges in accessing GPs in Tasmania, particularly for multicultural communities. While GP access is an issue for all, barriers are heightened for multicultural patients due to limited collaboration between practices, outdated service referral information, and the underutilisation of interpreter services.

Additionally, financial disincentives for GPs, particularly when treating refugees with complex care needs requiring longer consultations, exacerbates the issue. Stakeholders in Launceston and Hobart have reported GP access as the top equity issue for their communities.

2.14 Priority actions

2.14.1 Increase support for priority populations particularly in managing chronic conditions

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 and Torres Strait Islander people
- people who receive aged care
- people with disability
- people with low socioeconomic status.

Primary Health Tasmania is committed to supporting priority populations to reduce the impact of chronic conditions on health outcomes.

2.14.2 Strengthen health data collection to improve services for priority populations

Primary Health Tasmania will continue to enhance the collection of meaningful data to gain a deeper understanding of healthcare needs across the state. Primary Health Tasmania aims to refine and expand these efforts, particularly for priority populations, by working closely with local communities, service providers, and stakeholders. This approach ensures that our service design, commissioning, and monitoring, are culturally appropriate and effectively meet the unique needs of our priority populations.

2.14.3 Support primary care delivery for people living in residential aged care

Primary Health Tasmania will continue 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 living in residential aged care. Diabetes also contributes to the infectious disease burden in residential aged care. Primary Health Tasmania understands the importance of supporting the delivery of diabetes educator services to people living in residential aged care.

High rates of depression affect residents of aged care homes. Primary Health Tasmania will continue to support the delivery of mental health care within residential aged care, access to multidisciplinary mental health care where possible, 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[122]
- supporting GPs in assessing, screening, managing and referring those who have mental health problems[123]
- providing access to alternatives to medication to manage mental health problems.

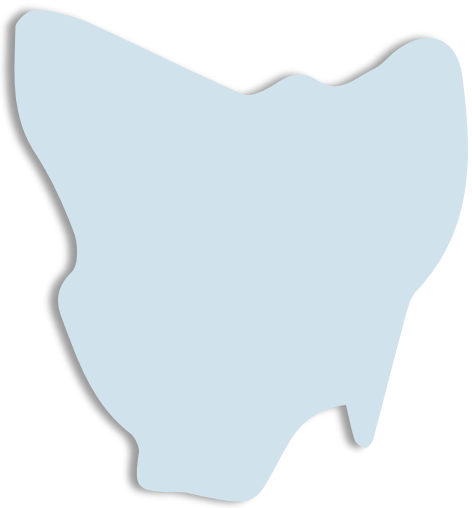
2.14.4 Enhance health professional skills for better care of people with intellectual disability

Primary Health Tasmania is working actively to improve the knowledge and skills of health professionals to support and enhance healthcare for people with intellectual disability through the Primary Care Enhancement Pilot. This initiative has led to increased knowledge, confidence, and skills among primary care providers and stakeholders who participated in the training and support provided by Primary Health Tasmania. Additionally, this pilot has also raised awareness of valuable resources shared within the network of engaged stakeholders.

2.14.5 Promote integrated healthcare for people living in rural and remote areas

Primary Health Tasmania will continue to co-design and implement sustainable and integrated care models in targeted rural local government areas, ensuring that healthcare services are tailored to local needs. This work will focus on strengthening core primary healthcare services in the most rural and remote parts of Tasmania which are facing service system fragility, while also supporting surrounding primary care services to address the specific health priorities of local populations.

By integrating care and working closely with communities, these efforts aim to improve access, coordination, and overall health outcomes in rural and remote areas.



3

Chronic conditions

3 Chronic conditions

3.1 Overview

3.1.1 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.

3.1.2 What are chronic conditions?

The National Strategic Framework for Chronic Conditions describes chronic conditions as a broad range of long health conditions, including chronic and complex health conditions, mental illness, trauma, disability, and genetic disorders[132].

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.

3.1.3 Most Australians have a chronic condition

Chronic conditions are very common. Half of all Australians have at least 1 of the 10 major chronic conditions that are reported on regularly by the Australian Institute of Health and Welfare. These are arthritis, asthma, back problems, cancer, cardiovascular disease, chronic kidney disease, COPD, diabetes, mental health conditions, and osteoporosis[133]. These 10 common conditions have a significant impact on Australians, as:

- 6 in 10 Australians (61%) have at least one long health condition[134]
- the top 5 leading causes of disease burden in 2023 were chronic conditions
- 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[134].

3.2 Health needs

3.2.1 Many Tasmanians have chronic conditions

More than half of all Tasmanian adults (58.4%) report having at least one chronic condition – the highest proportion of all jurisdictions in Australia[135]. 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[136].

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.

3.2.2 Cancer affects a significant proportion of Tasmanians

Tasmanians experience higher rates of cancer, contributing to our overall burden of chronic disease. The most common forms of cancer in Tasmania (excluding non-melanoma skin cancer) are prostate, bowel, breast, skin, and lung cancers[137]. 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[137].

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:

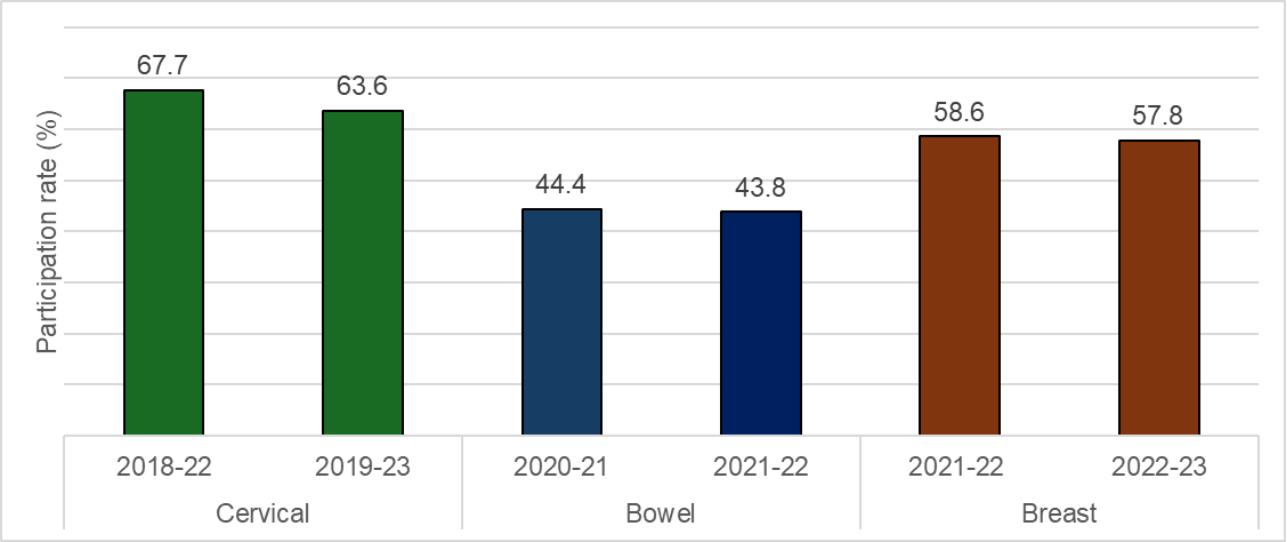
- breast cancer
- bowel cancer
- cervical cancer.

Breast Screen 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 years[138].

The *National Cervical Screening Program*, established in 1991, targeted women aged 20–69 years 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[139].

The *National Bowel Cancer Screening Program*, established in 2006, invites eligible Australians to screen for bowel cancer using a free faecal occult blood test every two years. Until recently, the program targeted those aged 50 to 74 years. Following a 2023 update to national guidelines, screening is now recommended from age 45 years. From 1 July 2024, people aged 45–49 years can request their first kit. The most recent figures show that around 2 in 3 people among the eligible population participated in the cervical screening program and more than half of the eligible population for breast cancer screening whereas less than half of eligible people participate in bowel cancer screening[140] (Figure 21).

Figure 21. Participation rates in cancer screening by type, Tasmania



Surveys report that the following population groups either avoid, or have difficulty in accessing or understanding cancer screening[138-140]:

- Aboriginal and Torres Strait Islander people
- Multicultural communities, 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[141]
- men.

3.2.3 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.

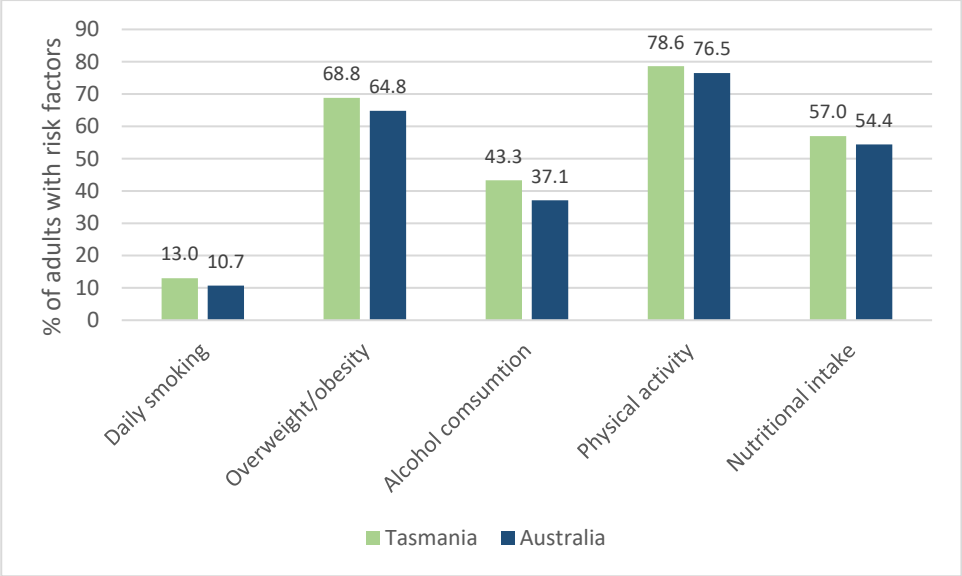
The major preventable behavioural risk factors for disease are tobacco smoking, excess alcohol consumption, physical inactivity, poor diet and nutrition and overweight and obesity[142].

Many risk factors are less favourable in Tasmania compared with Australia overall. Daily smoking and adult overweight-obesity rates are higher, more adults exceed the 2009 NHMRC single-occasion alcohol consumption risk guidelines, more adults did not meet the 2014 physical activity guidelines, and a higher proportion of adults did not meet the recommendation of fruits and vegetable consumption (nutritional intake)[126, 135, 136] (Figure 22).

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 22. Percentage of adults with lifestyle risk factors, Tasmania compared with Australia | 2022



Rates of tobacco smoking are high in Tasmania

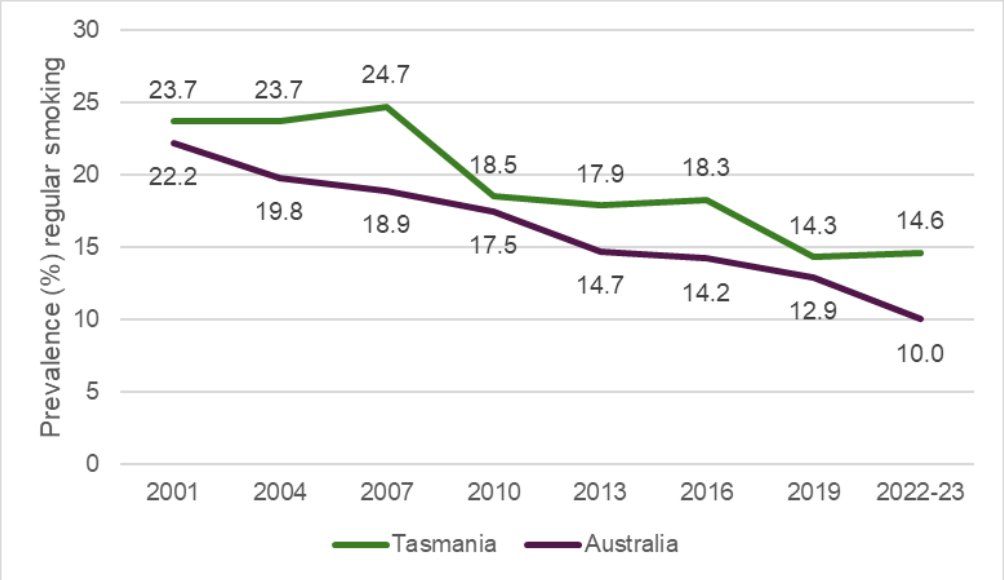
Tobacco smoking is a leading cause of preventable disease and death in Australia[143, 144]. More than three-quarters of this disease burden is accounted for by lung cancer, COPD, and ischaemic heart disease, among other chronic diseases[145, 146].

Many other diseases are also associated with smoking, including[146]:

- other cancers
- respiratory and cardiovascular diseases
- dementia and other neurological conditions
- pregnancy complications
- hip fractures and low bone density
- peptic ulcers and gastrointestinal problems
- infectious diseases
- dental problems.

Smoking rates in Tasmania have declined in recent years but remain higher than the national average. Around 14.6% of Tasmanians (age-standardised) smoke regularly (daily or weekly), compared with 10.0% nationally (Figure 23)[147]. While more recent mortality data is not yet available, between 2013 and 2017 an average of 559 Tasmanians died each year due to tobacco use, up from 502 per year between 2008 and 2012[145]. It is unclear whether the recent decline in smoking prevalence has translated into reduced mortality.

Figure 23. Trends of regular smoking Tasmania and Australia 2001-2023*



*(*Note: adapted from Greenhalgh, EM, Bayly, M, Kalitsis, L and Scollo, M. 1.13 Smoking by Australian states and territories. In Greenhalgh, EM, Bayly, M and Scollo, MM [editors]. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2025. Available from https://www.tobaccoinaustralia.org.au/chapter-1-prevalence/1-13-smoking-states-territories)*

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[126].

Adult vaping in Tasmania remains among the lowest in Australia (about 3% of men and 1% of women), and Tasmania was the only jurisdiction without a significant rise from 2019 to 2022–23 (current use about 4% vs up to ~8% elsewhere)[148]. Nationally, current use has grown and is concentrated in young people, with about 1 in 5 aged 18–24 vaping in 2022–23[148].

Excess alcohol consumption

Excess alcohol consumption falls into two main categories – single-occasion risk and lifetime risk[149].

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[150, 151]:

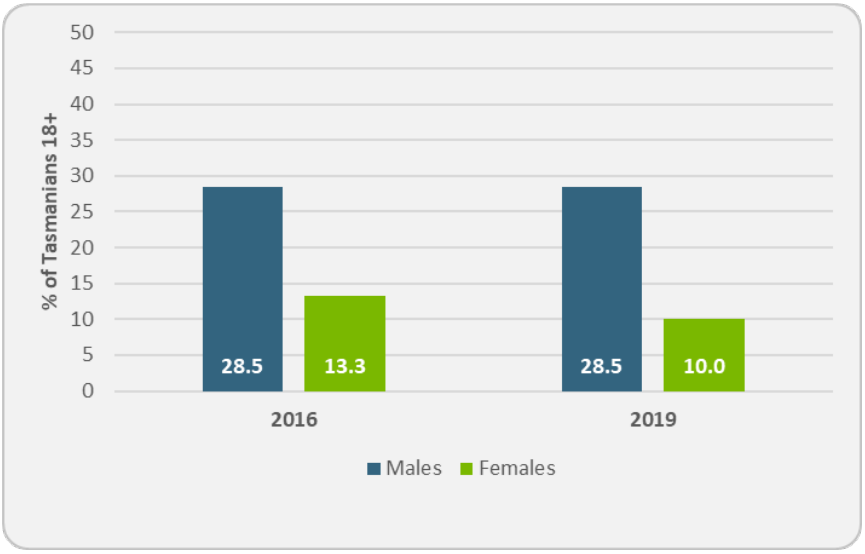
- liver cirrhosis
- mental health problems
- pancreatitis
- foetal growth restriction
- several types of cancer[136].

Males are at significantly greater risk of lifetime harm from alcohol, compared with females[152]. 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)[126] (Figure 24).

In 2022:

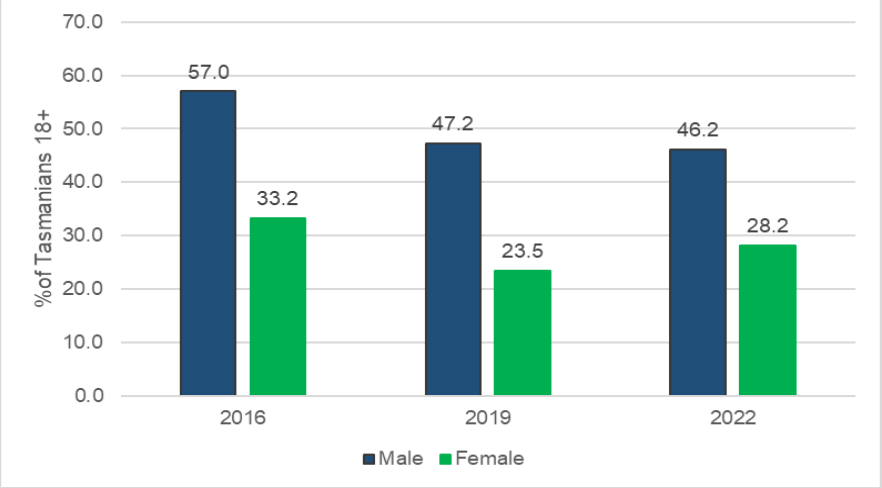
2 in 5 Tasmanians exceeded single-occasion alcohol use risk guidelines.

Figure 24. 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 relatively stable for males and increased for females[126] (Figure 25).

Figure 25. 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 with 6.0 deaths per 10,000 population in Australia as a whole[21]. Around 1 in 5 Tasmanians with dependent children drank more than the recommended amounts[126].

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[126].

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%)[126].

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[126].

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[126].

Three in 5 Tasmanian adults are overweight or obese

Two in three adult Tasmanians reported being overweight or obese in 2022[23]. The data suggests the proportion of overweight adults has decreased slightly from 36.2% in 2007-08 to 33.6% in 2022, but the proportion of obese adults has increased from 26.5% in 2007-08 to 35.3% in 2022[153]. More men reported an overweight BMI than women, however slightly more women reported an obese BMI[126].

In addition, the proportion of Tasmanians at increased or substantially increased risk due to waist circumference rose from 60.1% in 2007–08 to 70.9% in 2022[153].

Self-reported estimates often underestimate the magnitude of the problem, so it is likely that the obesity problem is greater than reported in the National Health Survey and 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.

One in four Tasmanians have high blood pressure

High blood pressure or hypertension, defined in Australia as a systolic blood pressure reading of 140 mmHg or higher and/or a diastolic reading of 90 mmHg or higher, is a major risk factor for cardiovascular diseases including heart attack and stroke[154]. Healthy behaviours, such as regular physical activity, a balanced diet, maintaining a healthy weight, and avoiding smoking and excessive alcohol, are essential for preventing and managing high blood pressure.

High blood pressure is a significant health concern in Tasmania, with rates higher than the other Australian states and territories. In 2022, 26.1% of Tasmanian adults had measured high blood pressure, compared with the national average of 21.7%[153].

3.2.4 The growing burden of chronic conditions in Tasmania

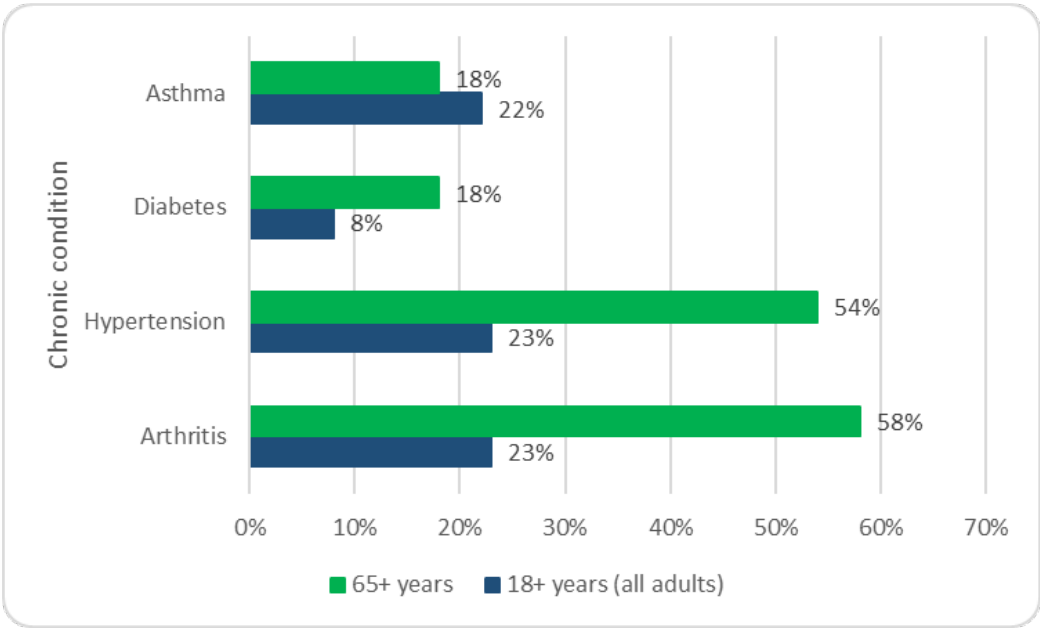
In Tasmania, over 2 in 3 people have at least one common chronic condition, and 1 in 4 Tasmanians has three or more conditions[126]. Rates of chronic conditions in Tasmania are generally higher than Australia as a whole, in part because our population is older and chronic conditions are more common as we age.

In Tasmanians aged 65+ years, self-reported rates of most chronic diseases are higher than in the younger population[126] (Figure 26).

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

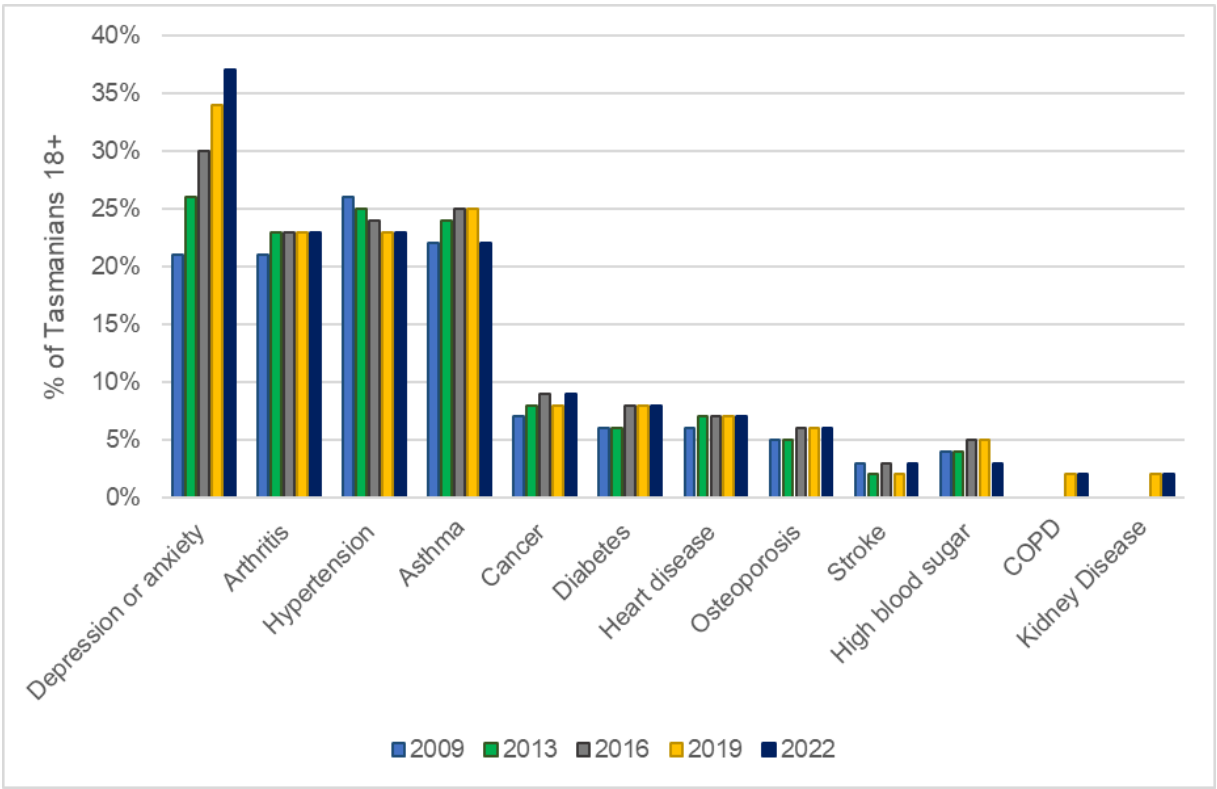
Figure 26. Self-reported ever-diagnosed chronic conditions (age standardised) in all adults aged 18+ and 65+ years, Tasmania 2022



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[126] (Figure 27).

Figure 27. Self-reported ever-diagnosed chronic conditions (age standardised) in people aged 18+, Tasmania | 2009 - 2022



3.2.5 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[155].

Many chronic conditions are made worse by mental health problems. Compared with the general population, people experiencing mental health problems experience nearly three times the rate of arthritis (19% vs 8.2%), almost twice the rate of diabetes (8.6% vs 4.8%) or heart disease (7% vs 4%), around three times the rate of other long-term health condition (20% vs 7.6%) and die 12–15 years earlier[156].

The health needs and service priorities for people experiencing mental health problems is discussed in detail at Chapter 5 Mental Health.

3.3 Service needs

Health services play a crucial role in helping people living 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.

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

Primary Health Tasmania has identified 177 general practice type services in Tasmania. This includes 135 usual general practices, plus Aboriginal Medical Services, as well as those that may provide specialised services such as skin clinics, women's health, or aged care general practice services.

There are 1035 GPs working only in Tasmania and 213 GPs working in multiple states including Tasmania. Many GPs work part-time- the full-time equivalent number of GPs in Tasmania is 578.3. This is 101.3 FTE of GPs per 100,000 Tasmanian population, compared with 112.3 per 100,000 population nationally[157].

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

Nationally, the most frequent chronic problems managed in general practice are mental health problems, musculoskeletal problems, endocrine and metabolic conditions, cardiovascular diseases and respiratory problems[158].

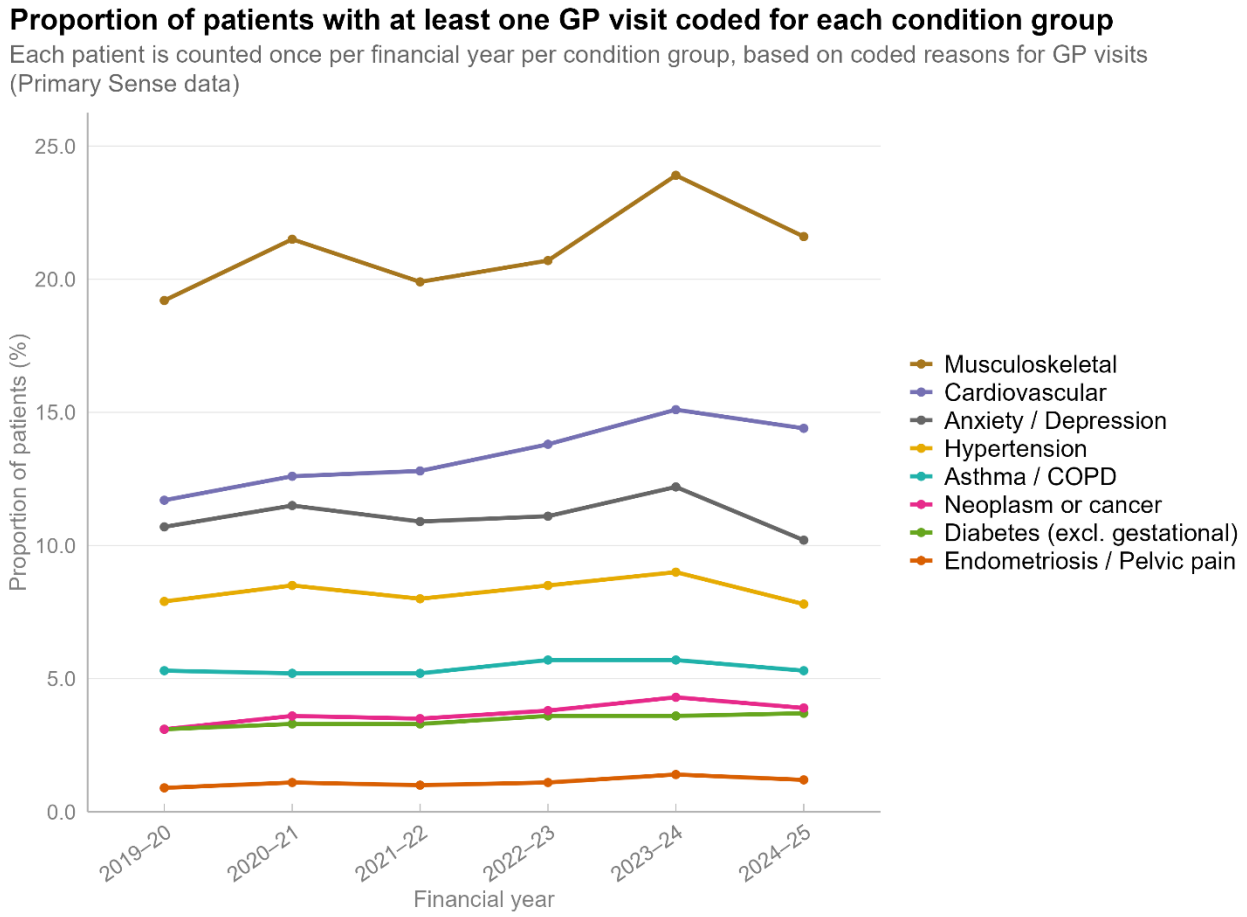
In Tasmania, most general practices contribute data to Primary Health Tasmania through Primary Sense to inform our understanding of care delivered to people in general practice. An internal analysis of the Primary Sense data for the financial year 2023-24 revealed the prevalence of reasons for visiting related to several chronic conditions among patients who attended their General Practitioner (GP) during that financial year. The percentages of patients with active records for selected chronic conditions are as follows:

- musculoskeletal conditions (44.9%)
- cardiovascular conditions (37.1%)
- hypertension (exclusively) (22.5%)
- psychological conditions (33.1%)
- anxiety and depression (exclusively) (31.6%)
- asthma (14.8%)
- diabetes (7.5%)
- COPD (3.6%).

It is important to note that the presence of an active record for a condition in the Primary Sense system does not necessarily mean that the patient visited the GP due to that condition during the year. The active records represent conditions that are being managed or monitored, but they may not be the primary reason for a patient's visit to the GP. These numbers may be an underestimate of the true prevalence of chronic conditions in general practice as other patients may have these chronic conditions, but this has not been recorded in the GP's clinical record.

Figure 28 displays an analysis of the reasons for visiting a GP for specific conditions over the last six financial years from Primary Sense information (GP data). The figure illustrates an increasing trend in the proportions of patients who visited due to musculoskeletal, cardiovascular, and anxiety/depression conditions. These proportions are calculated by dividing the number of individual patients who visited a GP due to specific conditions at least once by the total number of individuals who visited a GP at least once during the respective period[159] (Figure 28).

Figure 28. Trends in visit reasons estimates from active and inactive patients in general practice with a coded diagnosis, Tasmania | 2019/20-2023/24

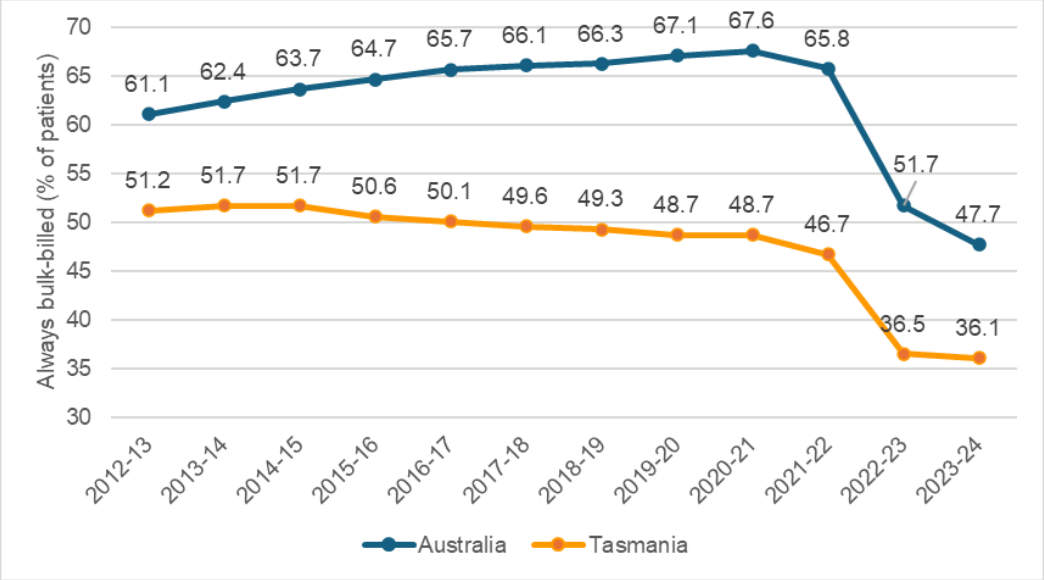


***Note**: The figure shows the proportion of patients who had at least one GP visit coded for a specific condition group during each financial year from 2019–20 to 2024–25. The data come from Primary Sense (general practice records) and use the ICPC-2 and ICPC-2 PLUS classification systems. Primary Sense does not use ICD-10 codes. Any differences compared with previous Primary Health Tasmania reports (where Primary Sense data were not used) may be due to the use of different disease classification systems. Discrepancies with other reports may also reflect changes over time in the number of general practices contributing data to Primary Sense, as well as differences in data cleaning methods and billing standardisation processes. Each line in the figure represents a condition group based on the coded reason for a patient's visit. Patients are counted once per condition group per financial year, regardless of how many visits they had. The proportion is calculated as the number of unique patients with at least one visit coded for a given condition group, divided by the total number of unique patients who had at least one GP visit that year (across all conditions). This reflects the distribution of reasons for seeking care, not the frequency or total number of visits. The "Cardiovascular" group excludes visits coded exclusively for hypertension. Although hypertension is part of the cardiovascular chapter in ICPC-2, it is treated as a separate condition group in this analysis. Specific condition groups such as "Neoplasm or cancer", "Hypertension", "Anxiety / Depression", "Asthma / COPD", "Diabetes (excl. gestational)", and "Endometriosis / Pelvic pain" were defined using selected ICPC-2/ICPC-2 PLUS codes and separated from their broader ICPC chapters for analytical purposes. **Source**: Primary Health Tasmania general practice data (Primary Sense – SQL server). Accessed 9 Jul 2025 – Internal analysis.*

3.3.2 Tasmanians visit their GP less often than other Australians but visit after-hours services more often

Medicare data from 2023-24 show that Tasmanians had 13.8% fewer routine GP consultations (item 23) per 100,000 population and 52% more after-hours urgent consultations (item 585) per 100,000 population compared with Australia as a whole[160]. Tasmania has the second lowest 'always' bulk-billing rate in the nation (excluding COVID-19 vaccine) for GP services and is consistently below the national average[161] (Figure 29).

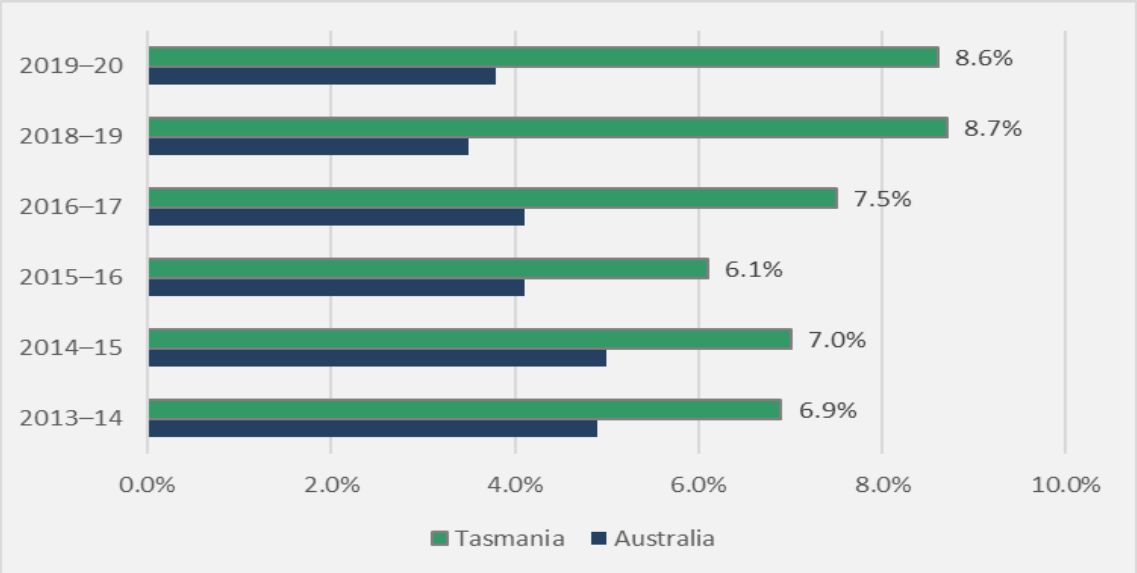
Figure 29. GP non-referred attendances, per patient 100% bulk billing (% of patients) Tasmania and Australia | 2012–24



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.

Tasmania reported the highest proportion of adults among all 31 Primary Health Networks who either delayed or did not see a GP due to cost, with 8.6% affected in 2019–20. This was significantly above the national average at the time (3.7%)[162] (Figure 30).

Figure 30. 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



While updated figures are not available, other evidence suggests that affordability remains a concern. According to the 2023–24 ABS Patient Experience Survey, the proportion of Australians who delayed or avoided seeing a GP due to cost, has increased in recent years, from 3.5% in 2021-22 to 8.8% in 2023-24[163]. In regional areas like Tasmania, where bulk billing rates are lower and median incomes are also lower than the national average, these barriers are likely to persist or worsen.

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.

Out-of-pocket costs continue to be a key driver of inequity in access to primary care across Tasmania, particularly for people living with chronic conditions, those without concession cards, and residents of rural and remote areas.

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

GP Management Plans (GPMP, MBS Item 721) and Team Care Arrangements (TCA, 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[164].

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%).

Medicare data updated in 2022 reported that in 2019 Tasmania had a lower rate of patients who had a GPMP (item 721) or TCA (item 723) per 1,000 population (82.3 and 66.8, respectively) compared with Australia as a whole (104.2 and 88.4 respectively)[165].

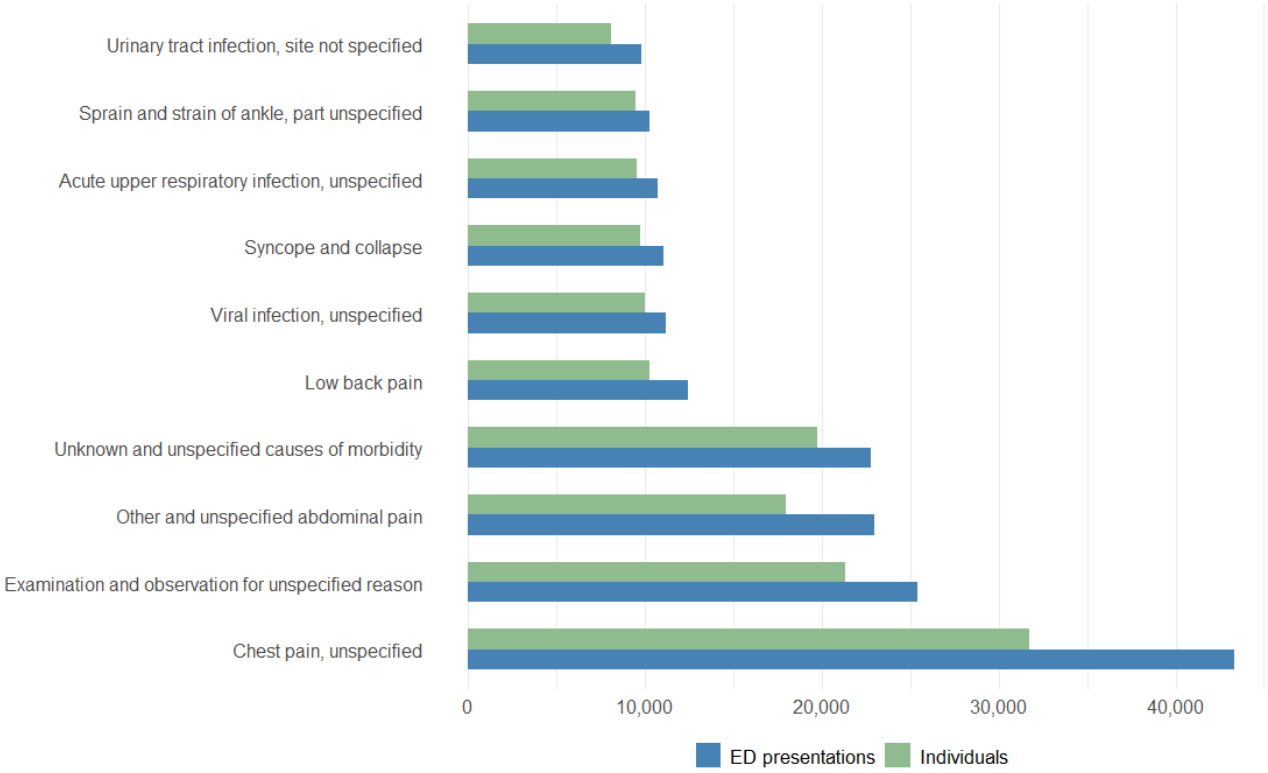
There is currently inadequate data to assess whether the high proportion of patients with chronic disease who do not have a GP Management Plan or Team Care Arrangement is due to low allied health professional availability across Tasmania, or other reasons.

3.3.4 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[166].

The main reasons Tasmanians access public hospital emergency departments are for treatment of pain in chest, abdomen, and back, examination and observation for unspecified reasons and the assessment and management of unknown and unspecified conditions [167] (Figure 31).

Figure 31. 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



3.3.5 More than 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[168].

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.

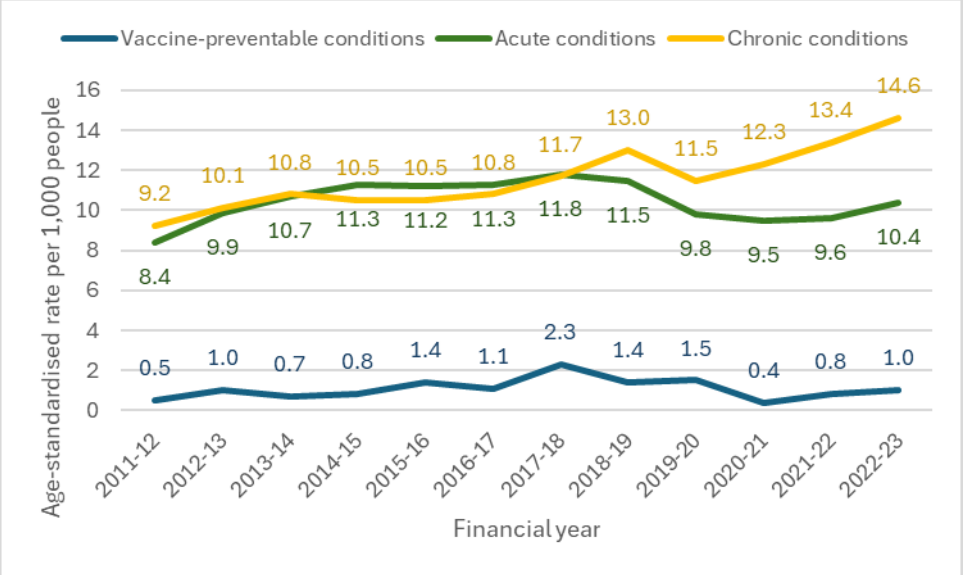
Diabetes is a priority chronic condition that contributes to preventable emergency department presentations and hospital admissions for people in residential aged care.

In Tasmania, during 2023-24, approximately 52% of avoidable admissions were for chronic conditions and 44% were for acute conditions[59]. The largest chronic disease avoidable admission burden was from COPD, diabetes and heart failure, and the largest acute disease burden is from cellulitis and urinary tract infections[59].

Between 2020 and 2024 there were 47,850 potentially preventable hospital admissions to Tasmania's four largest public hospitals - Royal Hobart Hospital, Launceston General Hospital, Northwest Regional Hospital and Mersey Community Hospital. The largest number of potentially preventable hospitalisations overall were for COPD[59].

In Tasmania during 2022-2023, 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[169] (Figure 32).

Figure 32. Rate of separations of potentially preventable hospitalisations for vaccine-preventable, acute, and chronic conditions in Tasmania, from 2011-12 to 2022-23



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[170].

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

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

Between 2020 and 2024 there were 1,085 Tasmanians admitted to hospital 10 or more times for acute public hospital management of their chronic conditions. These people experience multiple chronic conditions including cardiovascular disease, chronic lung disease, diabetes and chronic kidney disease, musculoskeletal problems such as back pain and osteoarthritis and spent an average of 154 days in hospital, comprising almost 5% of all public hospital bed days[59].

Many needed rehabilitation and other non-acute types of care, which can be delivered in the community if services are available.

3.3.7 Services have been announced to address gaps in care for endometriosis and pelvic pain

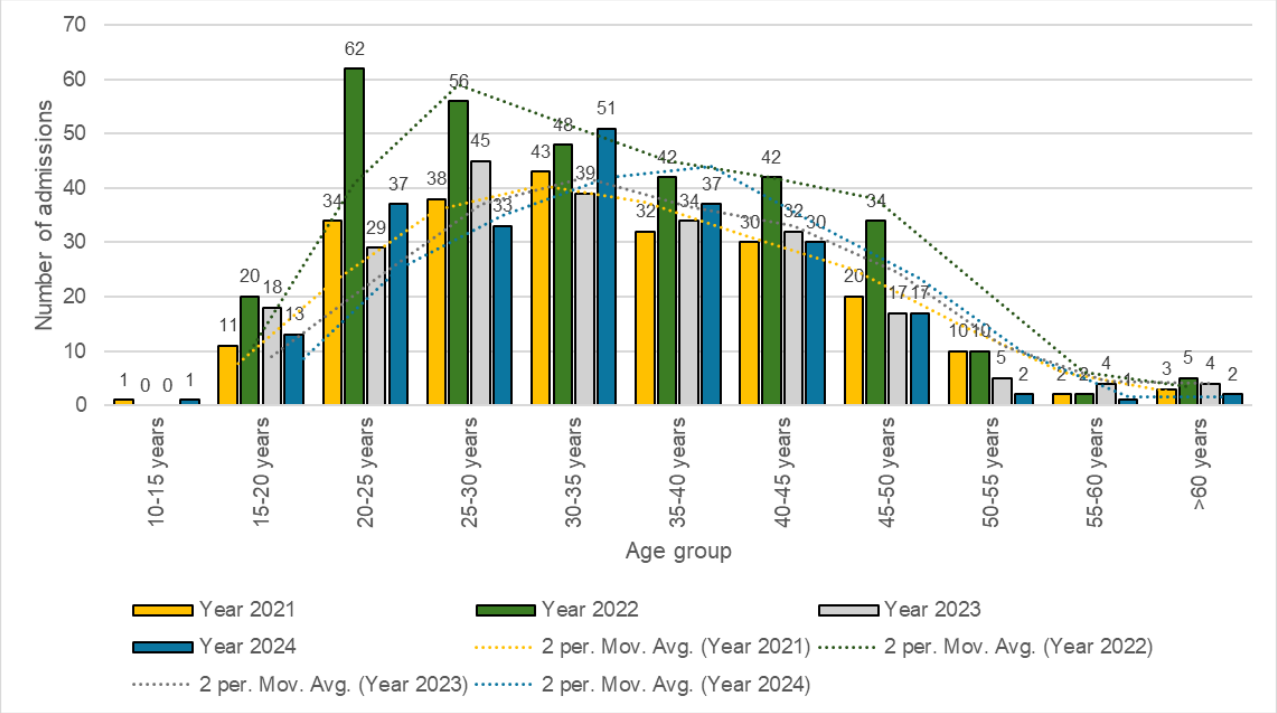
In March 2023, the Commonwealth government announced funding for multidisciplinary services for women with endometriosis and pelvic pain.

Endometriosis is a progressive chronic condition which causes a substantial disease burden among Australian women[171]. In Tasmania's public hospitals, there were 111 endometriosis-related emergency department presentations in 2024, (38.4 presentations per 100,000 females[60], higher than the national rate of 35.1 ED presentations per 100,000 females in FY 2023-24[171]).

Rates of endometriosis-related hospitalisations in public hospitals where endometriosis was the principal diagnosis are lower in Tasmania (using the estimated resident population in September 2024) than in Australia as a whole (crude rate of 38.9 per 100,000 population in Tasmania in 2024 vs 57.8 per 100,000 population in Australia during FY 2022-23)[60, 171]. The reasons for this discrepancy are unclear, but the Tasmanian figures do not include Tasmanian women who travel to the mainland for treatment.

Hospital admissions for endometriosis were highest among women aged 20 to 35 years, with a clear peak in 2022 followed by a slight decline in 2023 and 2024. Most cases occurred in the 20–25 and 25–30-year-old age groups, consistent with the typical reproductive years when symptoms are most pronounced. Admissions among adolescents (10–20 years) remained very low across all years, which may indicate underdiagnosis or delayed recognition in this group. Although less frequent, hospitalisations were still observed in women over 40 years, including those over 60 years, highlighting that endometriosis can continue to affect women beyond the reproductive years. The reduction in admissions post-2022 could reflect changes in clinical pathways, reduced access to elective procedures, or increasing use of outpatient and non-surgical management options[59] (Figure 33).

Figure 33. Endometriosis (any diagnosis) admissions in Tasmanian public hospitals by age group in three calendar years from 2021 to 2024 (Admitted Patient Care data)



3.4 Stakeholder perspectives

According to consumers and clinicians, people living 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.

3.4.1 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 homes.

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.

3.4.2 Management of people with complex chronic conditions can improve

Some people living with 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.

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

People living 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.

3.4.4 People with chronic conditions need access to affordable care

People living 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[148].

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

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

3.5 Priority actions

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

3.5.1 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 living 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.

3.5.2 Facilitate comprehensive care for people with chronic conditions

Primary Health Tasmania is committed to supporting 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:

Health pathways

- Continue to 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 living with chronic conditions.

New models of care

- In partnership with Tasmanian public hospital partners, Primary Health Tasmania implemented innovative models of primary care for people with chronic, complex conditions who are high users of inpatient hospital services. The Healthcare Connect Service, initially established in northern Tasmania, aimed to reduce preventable hospitalisations among patients most at risk of poor health outcomes. The initial service outcomes showed a significant reduction in hospital services use, including hospital admissions, emergency department presentations, as well as a decrease in bed days within 12 months of patients entering the Healthcare Connect model of care. The initial implementation of the service concluded on 30 June 2024, with final evaluation results pending to fully assess the impact and effectiveness of this service.

3.5.3 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 is committed to 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 is committed to:

- partnering with consumers to design, implement and evaluate innovative primary care services, programs and activities for people living with chronic conditions, particularly those who are frequently admitted to Tasmanian public hospitals
- supporting a team-based approach to delivery of care through our commissioned services
- supporting delivery of multidisciplinary primary care to people in rural areas as close to home as possible through our Rural Primary Health Services commissioning
- working with ACCHOs to care for community members with chronic health conditions through our integrated team care (ITC) program
- 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 homes by providing an after-hours support plan toolkit to plan for the after-hours care of their residents.

3.5.4 New workforce roles

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

4

Aboriginal people

4 Aboriginal people

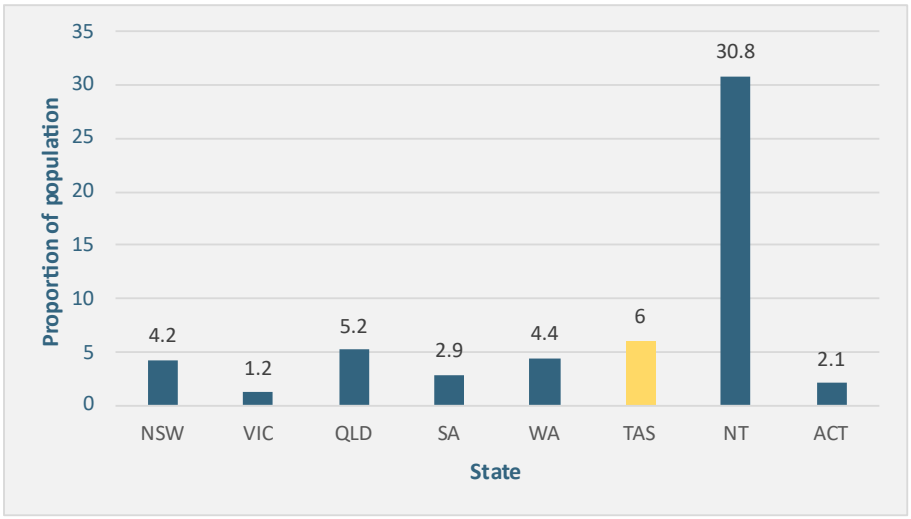
4.1 Overview

Aboriginal and Torres Strait Islander Australians are descended from the people who lived in Australia and surrounding islands prior to European colonisation[172]. Primary Health Tasmania recognises that Tasmanian Aboriginal community members have their own way of expressing their cultural identity. Some people call themselves an Aboriginal person, while others say they are Palawa, Pakana, First Nations or other variations. In this report, we respectfully use the term 'Indigenous' to refer to Aboriginal and Torres Strait Islander peoples nationally, and use the terms 'Aboriginal people', 'Tasmanian Aboriginal people' and 'Aboriginal Tasmanians' to refer to Aboriginal and Torres Strait Islander people living in Lutruwita/Tasmania[173, 174].

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

According to the 2021 Australian census data, Tasmania was home to more than 33,894 Aboriginal people, of whom 2,302 were aged 65 years or over, and 6,589 were aged 50 years or over[175]. At 6% of the total Tasmanian population, this is the second highest proportion of Aboriginal people of any other state or territory after the Northern Territory[175] (Figure 34). Similar to the previous census, about one-quarter of Tasmanian Aboriginal people live in the greater Hobart region[176].

Figure 34. Estimated resident population by Indigenous status, Australia | June 2021



4.1.2 Indigenous people experience health inequities

Indigenous people face significant health inequities, compared with other Australians. Nationally, they have lower life expectancy, higher chronic disease and mental health disease burden, poorer self-reported health, and higher rates of smoking and obesity[32].

Indigenous people also face ongoing challenges associated with racism, stigma, environmental adversity and social disadvantage[177].

4.2 Health needs

Providing a clear health profile for 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.

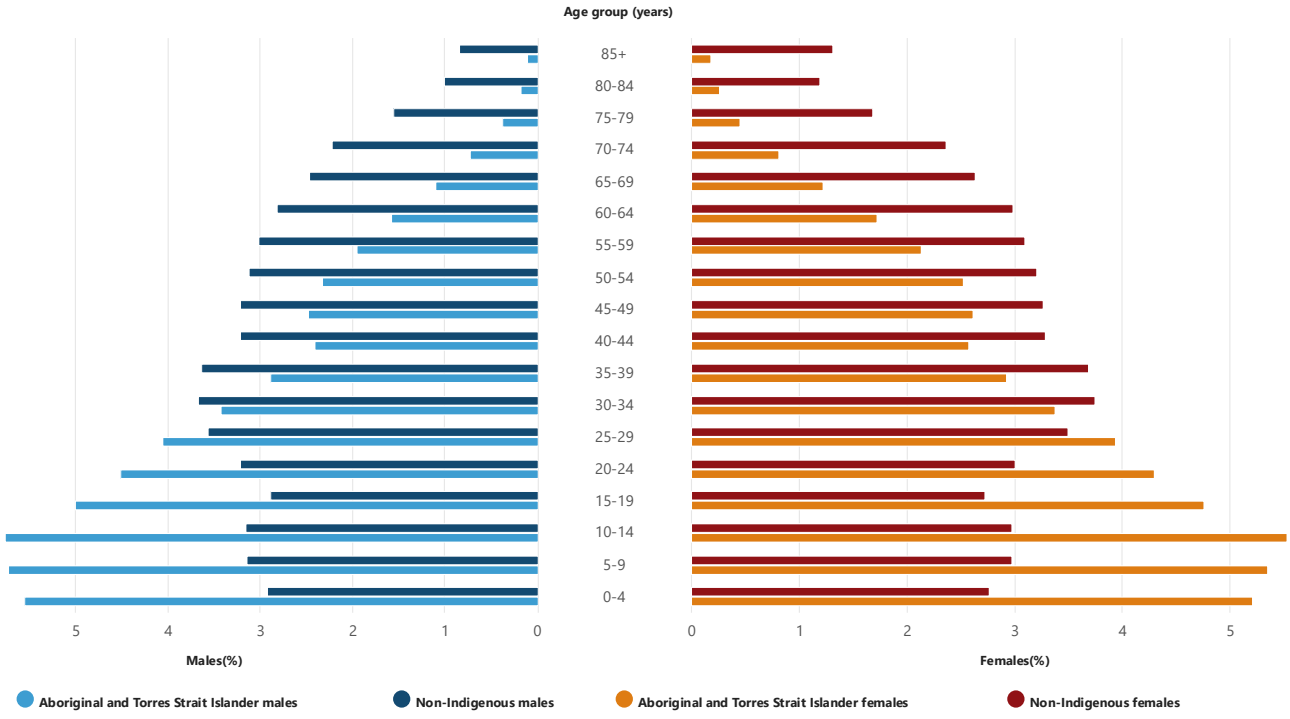
In general, compared with non-Indigenous Australians, Indigenous people in Australia have[178]:

- a younger age structure
- a higher chronic disease burden
- a higher mental health disease burden
- higher rates of health risk factors[178].

4.2.1 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[175]. Figure 35 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[175].

Figure 35. Estimated population distribution by Indigenous status and age group, proportion of Australian population | 2021



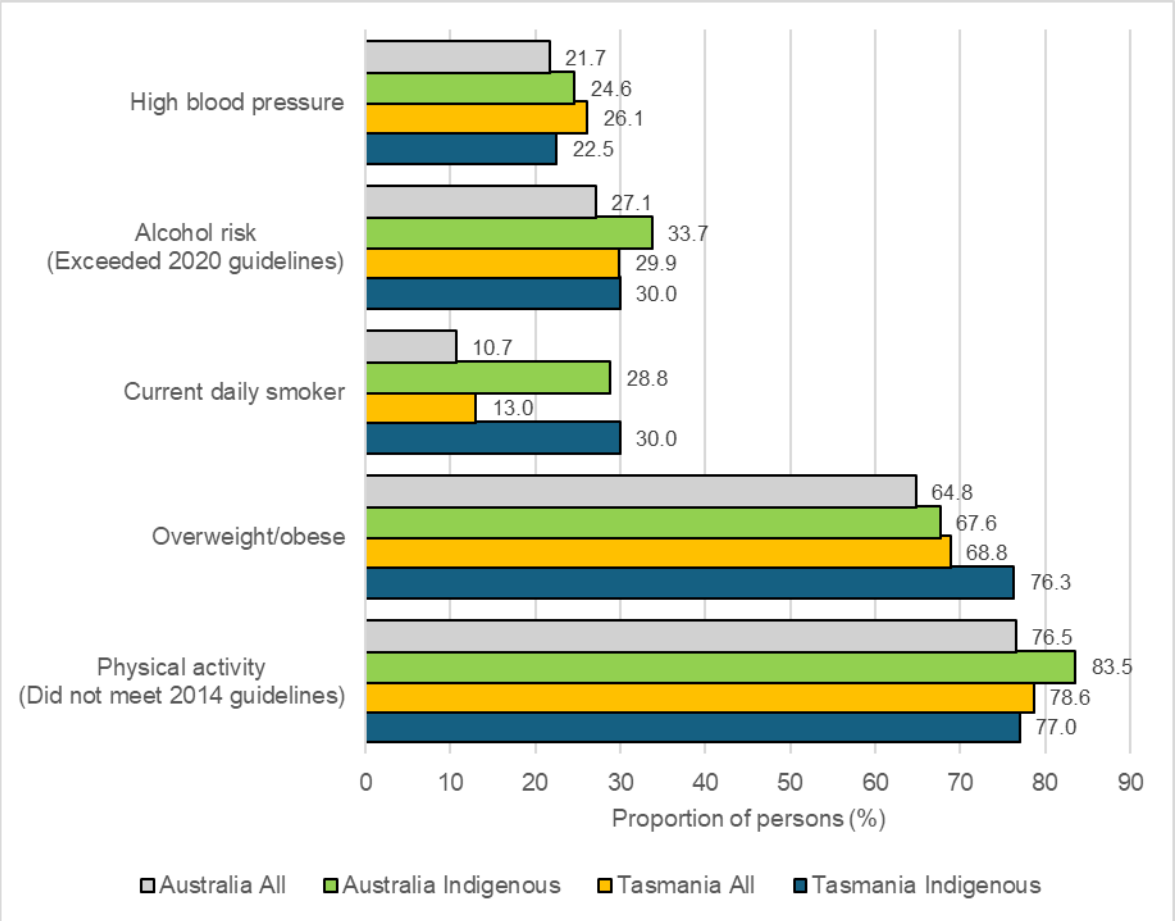
4.2.2 Indigenous people have poorer health status and higher health risk factors

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[178].

Recent data highlight that Aboriginal and Torres Strait Islander people in Tasmania continue to experience a higher prevalence of key health risk factors compared to the general population. In Tasmania, 30% of Indigenous adults are current daily smokers, nearly three times the national average

for all Australians (10.7%)[153, 179]. Risky alcohol consumption is also more common among Indigenous Tasmanians (30.0%) than among the overall Australian population (27.1%). Additionally, 76.3% of Indigenous adults in Tasmania are overweight or obese, and 77.0% do not meet physical activity guidelines[179] (Figure 36).

Figure 36. Age-standardised prevalence of selected health risk factors by Indigenous status, Australia | 2022–23

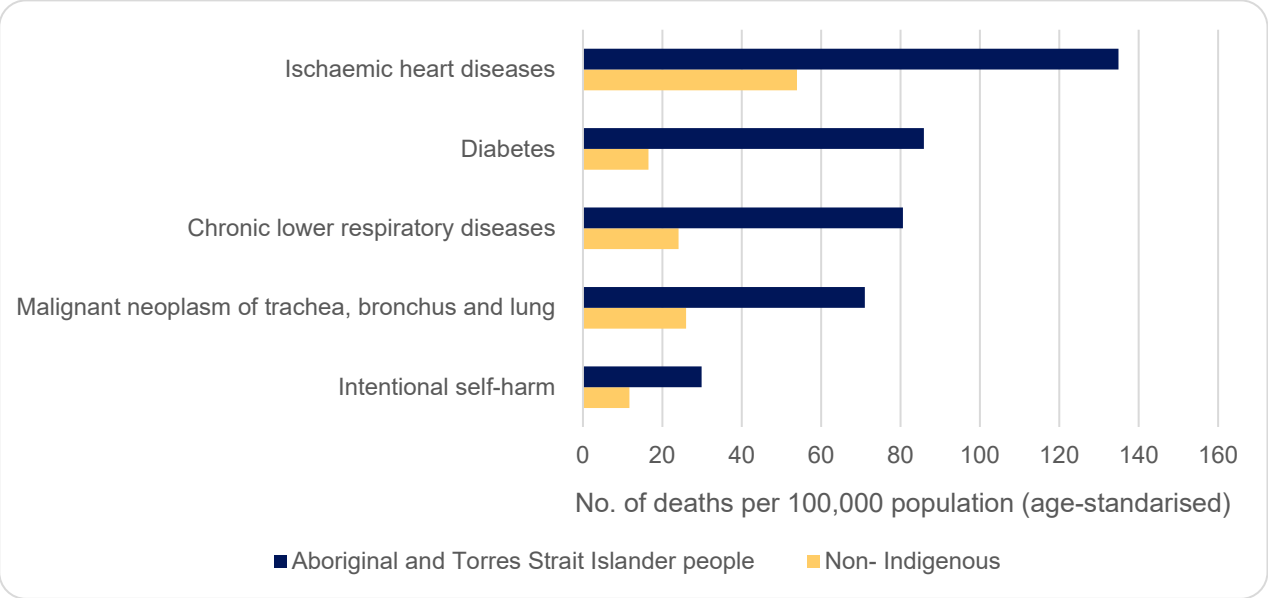


4.2.3 Indigenous Australians have a higher chronic disease burden

Chronic diseases cause most of the burden for Indigenous people[83]. In 2022, the national age-standardised rates of death from diabetes were more than five times as high for Indigenous people, compared with non-indigenous Australians (85.9 deaths per 100,000 compared with 16.5 deaths per 100,000, respectively).

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 (Figure 37).

Figure 37. 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.

4.2.4 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 with 19% of Tasmanian adults overall[126].

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[180].

Age-standardised rates of Indigenous deaths by suicide have increased nationally over the past ten years from 22.7 per 100,000 people in 2013, to 29.9 per 100,000 people in 2022, while for non-Indigenous Australians there has been a slight increase from 11.1 to 11.7 per 100,000 people in the same time period[181].

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 highest for the 25-44-year age group at 50.0 per 100,000 (compared with 15.9 per 100,000 for the same non-indigenous age group), followed by the 45- 64-year age group at 23.4 per 100,000 (compared with 17.1 per 100,000 for the same non-Indigenous age group) during the period between 2018-2022[181].

4.2.5 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 to health care due to factors such as remoteness, lack of affordability and a lack of cultural safety[177]. Indigenous people also experience discrimination accessing services and may avoid seeking care[177].

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[182].

4.2.6 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 aftermath of the 2023 Voice to Parliament referendum[183, 184].

Recent national data show that more than 70% of Aboriginal and Torres Strait Islander adults reported experiences of discrimination during this period, with over 200,000 estimated to have experienced high or very high psychological distress[185]. These impacts were not limited to the referendum campaign period and may have ongoing consequences for mental health and wellbeing across communities.

Feelings of re-traumatisation, identity threat, emotional exhaustion, and community division have been documented. Providing education for the workforce remains important to ensure culturally safe, trauma-informed responses. In addition, increased access to culturally appropriate mental health care and sustained support for Aboriginal and Torres Strait Islander consumers may be required in the years following the referendum.

4.3 Service needs

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

4.3.1 Avoidable public hospitalisations for Tasmanian Aboriginals

During 2023-24, the rate of episodes of care for an admitted patient that is completed (separations) was about 1.7 times the rate of other Tasmanians (401.2 vs 241.7 separations per 1,000 population)[186].

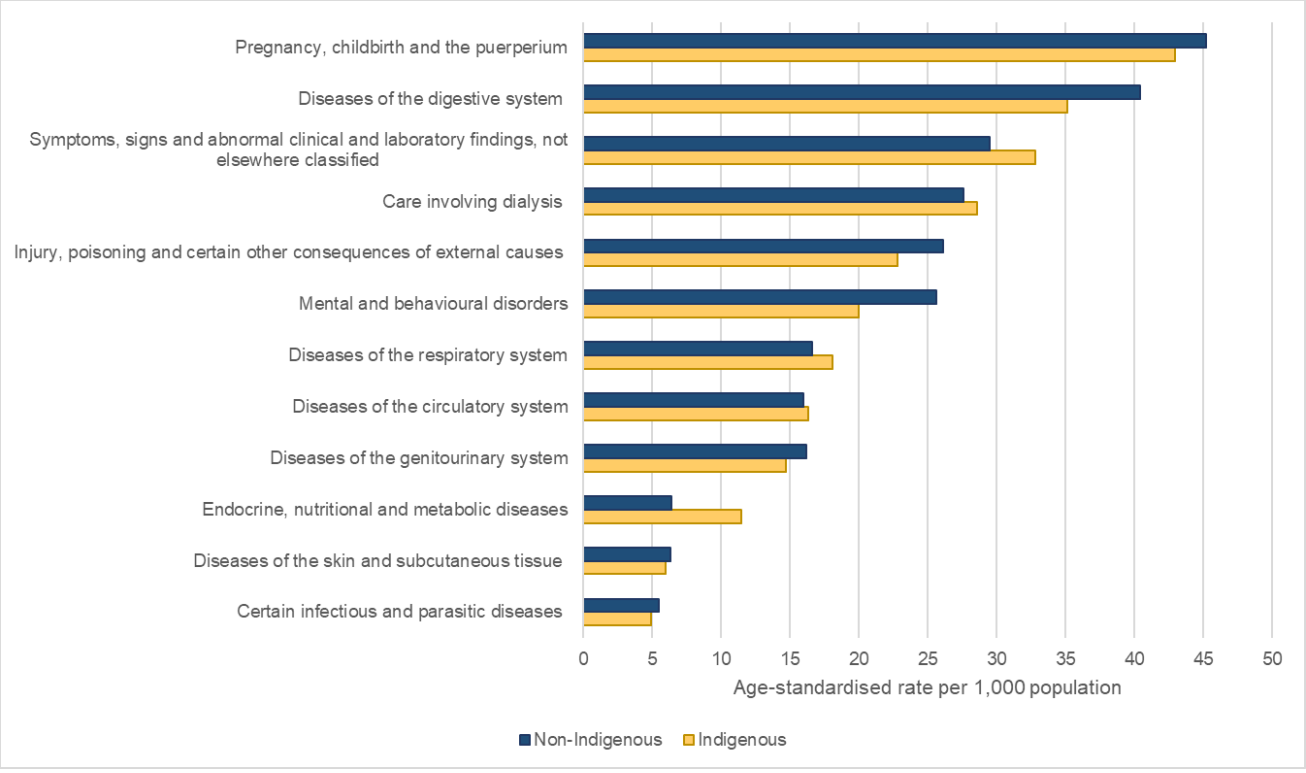
Indigenous people nationally have higher rates of avoidable hospital admissions – or potentially preventable hospitalisations (PPHs) – for chronic conditions than non-Indigenous people. In Tasmania it is estimated that the rate of potentially preventable hospitalisations is 26.4 per 1,000 people, lower than national rates of 65.4 potentially preventable hospitalisations per 1,000 people[187]. The top five potentially preventable conditions in Tasmanian Aboriginal people who were hospitalised during the financial years 2019-20 and 2020-21 were dental conditions, COPD, iron deficiency anaemia, diabetes complications, and urinary tract infections[188].

4.3.2 Public hospital emergency department use

During 2022-23, there were 439.4 emergency department presentations at public hospitals per 1,000 population for Aboriginal Tasmanians – about 1.4 times the rate of non-Indigenous Tasmanians[166].

Among the leading causes of hospitalisations at public hospitals for Indigenous Australians, the age-standardised hospitalisation rate per 1000 population was higher for assessing and managing symptoms, signs and abnormal clinical and laboratory findings, respiratory disease, circulatory system, dialysis and endocrine and metabolic diseases than the corresponding non-Indigenous rate in respective causes[189] (Figure 38).

Figure 38. Age-standardised rates of the leading causes of Indigenous hospitalisations per 1,000 population, by Indigenous status, Australia | July 2017 – June 2019



4.3.3 Primary care service use

Primary health care for Indigenous Australians is delivered by a diverse range of providers, including mainstream primary care organisations and Indigenous specific primary care organisations[190]. In 2022-23, 800.4 per 1,000 Aboriginal and Torres Strait Islander people attended a GP in Tasmania. This rate is higher than the national rate (769.3 per 1,000 Aboriginal and Torres Strait Islander people). In Tasmania, 88.2 per 1,000 Aboriginal and Torres Strait Islander people received chronic disease care under GP Management Plans which is a mutually agreed plan of action between a patient and their GP, while 68.3 per 1,000 received chronic disease care under Team Care Arrangements[191]. Team Care Arrangements give access to Medicare-subsidised care from selected allied health care providers for individual treatment services.

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

4.3.4 Aboriginal-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 culturally appropriate and accessible to Indigenous clients[192].

There are seven Aboriginal-specific primary healthcare organisations in Tasmania, three of which report having fewer than 500 clients[192]. Six of these organisations are ACCHOs and one is a mainstream provider. In 2023–24 these organisations reported seeing more than 7,316 clients, mostly Aboriginal people. These clients received a total of 74,538 episodes of care, approximately 10.2 per person[192]. In 2024-25, 7,913 number of services, including care coordination, supplementary and clinical services, were delivered by Indigenous Health Services and ACCHOs.

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[192].

Influenza immunisation

In 2023, seasonal influenza vaccination recorded coverage in Tasmania was:

- 31.8% for Indigenous children <5 years of age
- 15.9% for Indigenous children aged 5-9 years
- 14.7% for Indigenous children aged 10-19 years
- 24.0% for Indigenous adults aged 20-49 years
- 51.1% among those aged 50-64
- 76.9% for those aged 65 or over.

Influenza vaccine coverage rates among Indigenous people in Tasmania are lower than the national average in every age group except for Indigenous adults aged 50 years or over[193]. Indigenous people 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 people[193].

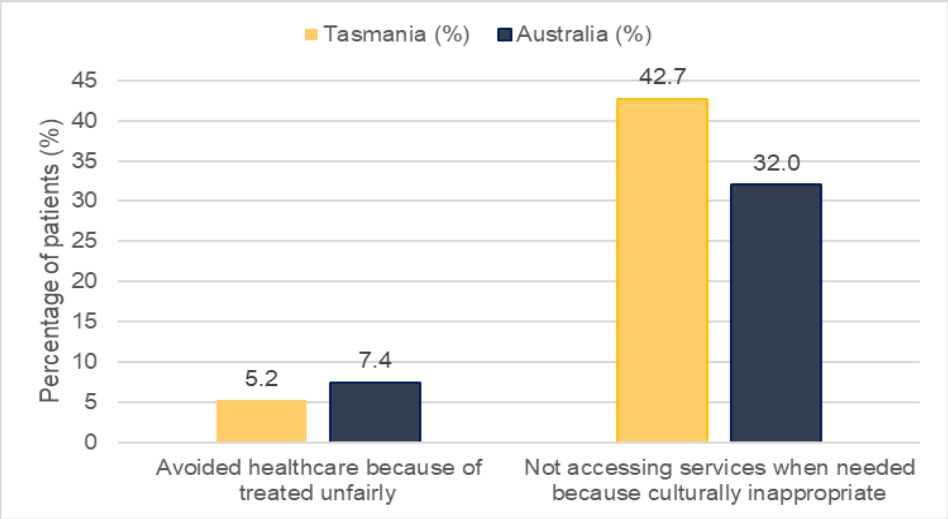
Some Indigenous people avoid healthcare services due to culturally inappropriate treatment

In 2018–19, 30% of Indigenous Australians did not access health care when they needed to. There are a range of reasons for not accessing health care, 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[194].

In Tasmania, cultural appropriateness of most health services remains an issue for more than 40% of Aboriginal people[177] (Figure 39). 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[195]. 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, dislike of services- leading to embarrassment or fear of service usage, and transport problems[196].

Figure 39. Indigenous patient experiences of health care, Tasmania and Australia | 2018–19



4.4 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.

4.4.1 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.

4.4.2 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.

4.4.3 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 AOD 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.

4.4.4 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 AOD 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.

4.5 Priority actions

Primary Health Tasmania is prioritising health outcomes of Tasmanian Aboriginal people. The goals and corresponding actions for 2025–2028 are described below.

4.5.1 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:

- strengthen initiatives to improve culturally safe primary health care across Tasmania by funding cultural capability training and access supports
- increase the capacity of ACCHOs to deliver primary care to meet the needs of their local communities, through existing commissioned services
- support ACCHOs to respond to primary care needs within their communities, with a focus on social and emotional wellbeing, mental health, AOD services, and comprehensive chronic conditions management.

4.5.2 Improve the management of chronic conditions

Many Indigenous people living with chronic conditions experience poorer health outcomes than their non-Indigenous peers. Primary Health Tasmania is committed to improving 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 living 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.

4.5.3 Build the Aboriginal and Torres Strait Islander health workforce

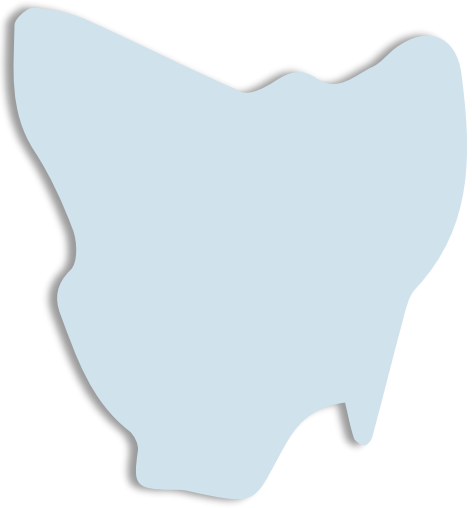
A priority for Primary Health Tasmania is to build workforce capacity and capability of Aboriginal health professionals. We will support ACCHOs to identify gaps in Aboriginal health workforce and support initiatives to address gaps.

Through our commissioning of services and a partnership approach, we will have a long-term commitment to 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.

4.5.4 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.



5

Mental health

5 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.

5.1 Overview

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

5.1.1 Impact of mental illness

Mental illness and substance use disorders contributed 14.8% to Australia's total burden of disease in 2024, making it the second highest disease group contributing to the total burden of disease after cancer[197].

Mental health conditions and mental illness are significant health issues in Tasmania and have a substantial social and economic impact on our community. The challenge of mental illness can make 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.

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

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[198]. This chapter draws substantially from the knowledge in that report.

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

Australian Government, Department of Health

5.2 Health needs

5.2.1 Mental health conditions are a major part of burden of disease in Tasmania

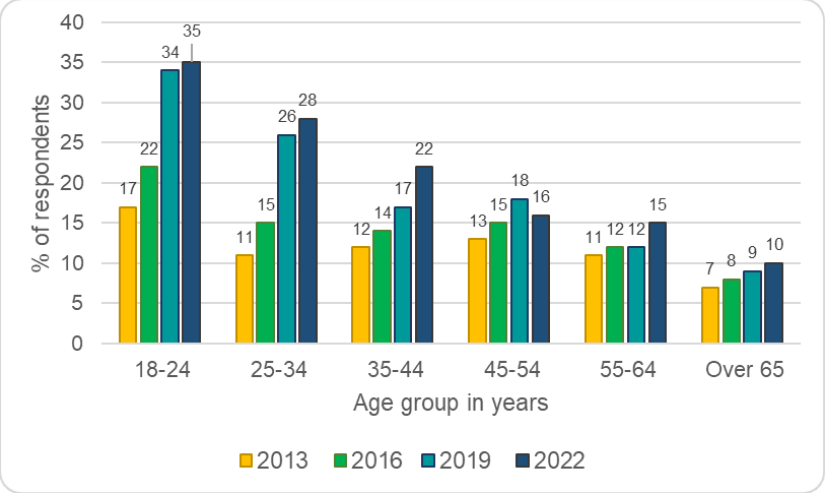
About 1 in 5 people in our community will experience mental health conditions in any year.

In 2020-2022, 19.8% of Tasmanians (88,700 people) reported a mental health disorder in the previous 12 months[199]. Most Tasmanians with mental health conditions 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 in Australia[200].

In Tasmania, in 2024-2025, just over 48,000 people visited a GP due to anxiety and depression (64% women, 35% aged 25-44 years old), and 89,500 people visited a GP due to psychological and mental health issues (59% women, 32% aged 25-44 years old)[36].

Self-reported psychological distress is a measure of the burden of diagnosed and undiagnosed mental health conditions affecting the Tasmanian population. Almost one in five Tasmanian adults (19%), reported very high or high levels of psychological distress in 2022[126]. More female Tasmanians reported high or very high levels of psychological distress than males in 2022, similar to previous years. The highest age-group with self-reported with high and very high level of psychological distress is 18-24 (Figure 40)[126].

Figure 40. Self-reported high and very high level of psychological distress by age group, Tasmanian Population Health Survey: 2013–22



Mental health conditions include mood disorders such as depression, anxiety disorders, psychotic disorders, schizophrenia, 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[126].

The burden of mental health conditions and mental illness is concentrated in people who are most socioeconomically disadvantaged[200].

5.2.2 People with mental illness often experience poorer physical health

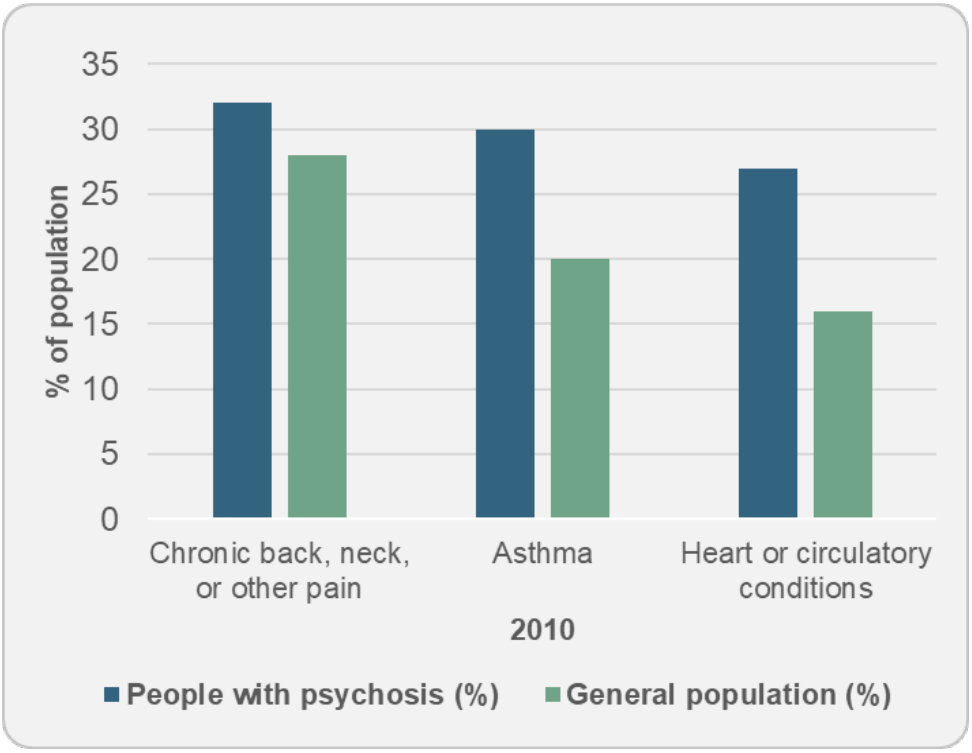
Most people experiencing mental illness also have chronic disease. People living with mental illness have poorer physical health than other Australians, as their physical health needs are often overshadowed by their mental illness. According to results of the 2020-2022 Australian Health Survey, for people who self-reported having a mental illness:

- the most common additional health conditions are other long-term health conditions (20% vs. 7.6%), arthritis, asthma, diabetes, and heart disease[201], and
- people with self-reported mental illness experience significantly more asthma (19% vs 8%), arthritis (19% vs 8%), diabetes (9% vs 5%), and heart disease (7% vs 4%), compared with the general population.

The life expectancy of people living with severe mental illness is reduced by 12–16 years compared with the life expectancy of the general population (15.9 years for men and 12.0 years for women)[201]. The National Study of Mental Health and Wellbeing provide estimates on the physical health of Australians reporting a mental health disorder in the previous 12 months. Between 2020 and 2022, 4.3 million Australians aged 16-85 years experienced a 12-month mental disorder, and 1.7 million had both a 12-month mental disorder and a physical health condition[199]. The second national survey of People Living with Psychotic Illness conducted in 2010[202] indicated 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. Other common conditions included asthma (30% compared with 20% for the general population) and heart or circulatory conditions (27% compared with 16%)[202] (Figure 41). The survey has not been repeated since 2010.

Participants living with a psychotic illness had high levels of smoking (65.9% of participants consumed 21 cigarettes per day on average), intake of 1 or fewer serving of fruit or vegetables daily, and low levels of physical activity. Additionally, 60.8% of those participants were found to have metabolic syndrome which increases the risk of cardiovascular disease, stroke, and diabetes[203]. The heightened risk of developing chronic conditions in individuals with psychosis appears to be largely due to lifestyle choices and factors related to their treatment[204].

Figure 41. 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 10% lower than for people with a physical illness and no concurrent mental illness. This may contribute to physical conditions being undiagnosed and untreated in people with mental illness, which can prove fatal[205].

Nationally, long-term physical health conditions disproportionately impact people with mental illness with 50.6% of people with mental illness having a long-term health condition compared to 33.6% of people without mental illness[206].

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[207].

People with severe and enduring mental illness die 10–20 years earlier than the general population. Eating disorders are also associated with high mortality rates[208, 209].

5.2.3 Psychosocial needs of people with severe mental health illnesses are substantial

The psychosocial support needs of people with psychotic illnesses, including schizophrenia are substantial and largely unmet[210]. According to survey data:

- In 2010, 64,000 Australians aged 18–64 experienced a psychotic illness and were in contact with public specialised mental health services each year. This equates to 5 cases per 1,000 population.
- Schizophrenia accounted for almost half of all psychotic illness diagnosis (47%).
- Nearly one-quarter of people with psychotic illnesses 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% would prefer to be living with someone else.
- The majority have at least one friend (86.5%), however 13.3% have no friends at all, 14.1% had no one they could rely on, and 15.4% have never had a confiding relationship.
- Two-thirds (68.6%) have not attended any social programs, and a similar proportion (69.4%) have not attended any recreational activities. Only 38.6% of people with psychotic illness received evidence-based psychosocial therapies.
- The main income source for 85% of participants came from government benefits.
- Despite this, only 38.6% of people with psychotic illness received evidence-based psychosocial therapies.

Additionally, financial difficulties and employment have been identified as important challenges by participants themselves. Securing employment has been expressed as an expressed goal and advocated by Morgan et al., to help address many challenges facing people with psychotic illness[210].

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

Between 2018 and 2022, 88 Tasmanians on average have died by suicide annually (ranging between 78 and 107 people each year). The age-standardised suicide death rate in Tasmania in 2023 was 14.9 per 100,000 people, compared with 11.8 per 100,000 people nationally[211, 212]. Suicide was the leading cause of death among Tasmanians aged 15–44 years in 2023 and accounted for the highest number of years of life lost[122]. Suicide rates are higher among males than females in all age groups and are highest among men aged 45–54 years[122].

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 psychosocial or economic factors like relationship difficulties, social isolation, loss of a job or income, and financial or housing stress[213].

However, around two-thirds (67%) of people who died by suicide in Tasmania between 2012 and 2020 had at least one previous diagnosis of a mental illness. A similar proportion (66%) of people who died by suicide had received at least one episode of mental health treatment in the 12 months leading to death, and nearly half (48%) received treatment in the 6 weeks leading to death, most commonly by a GP[214].

For people who died by suicide with available toxicology reports, pharmaceutical drugs had been consumed before death by 75% of people, alcohol by 37% of people, and illicit drugs by 13% of people[214].

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[214]. In alignment with that, the *Tasmanian Suicide Prevention Strategy 2023-27* includes a focus on collaboration to prevent suicide in Tasmania[215].

5.3 Service needs

5.3.1 Tasmania's mental health system is complex

A range of mental health related services are provided in Tasmania by various levels of government. Tasmanian Government provides mental health care through their funded services in the Tasmanian Health Service such as public hospitals, including emergency departments, residential mental healthcare services and community mental healthcare services, as well as commissioned mental health services delivered by community service providers. Primary Health Tasmania commissions a range of primary mental health and suicide prevention services.

The Australian Government funds consultations with specialist medical practitioners, GPs, psychologists and other allied health practitioners through the Medicare Benefits Scheme and other commissioned primary mental health services through the Primary Health Networks. The Australian Government will launch the National Early Intervention Services (NEIS) in 2026, a telehealth service focussed on early intervention and self-management.

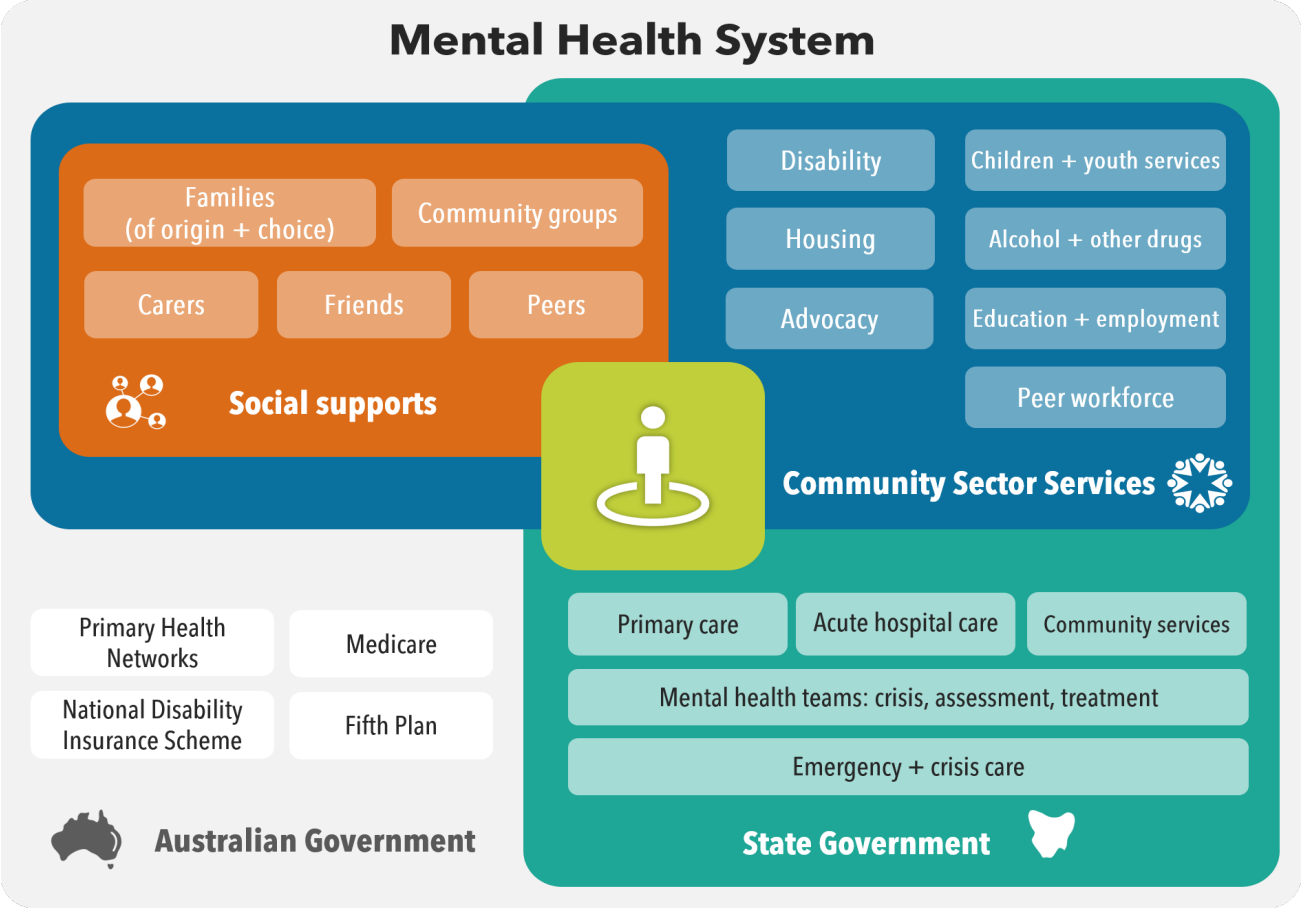
Access to psychologists may be subsidised through Medicare with the preparation of a Mental Health Treatment Plan by a GP, depending on eligibility. Mental health care is also provided in private hospitals.

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 (rebranded to Universal aftercare). Support for psychosocial disability is also provided through the National Disability Insurance Scheme and by the non-government mental health sector (Figure 42).

General practice plays a central role as the first point of contact for most people living with a mental health condition. GPs prepare Mental Health Treatment Plans, prescribe medication, provide ongoing management, and refer people to psychologists and psychiatrists.

The private sector contributes through private hospitals, private psychiatrists, and psychologists delivering services funded by insurance or out-of-pocket payments.

Figure 42. Tasmania's mental health system



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

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

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

Rethink 2020: Key Reform Directions

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

5.3.2 Hospital service use for mental health conditions

The number of hospital separations for people with mental and behavioural disorders has increased in Tasmania since 2011. There was a slight increase in hospital separations in the south and north west regions in 2021, returning to more normal levels in 2023. In 2024, hospital separations rose sharply in the south, while other regions recorded only a very slight increase[60]. (Figure 43)

Figure 43. Public hospital separations, mental and behavioural disorders, Tasmania | 2011 to 2024

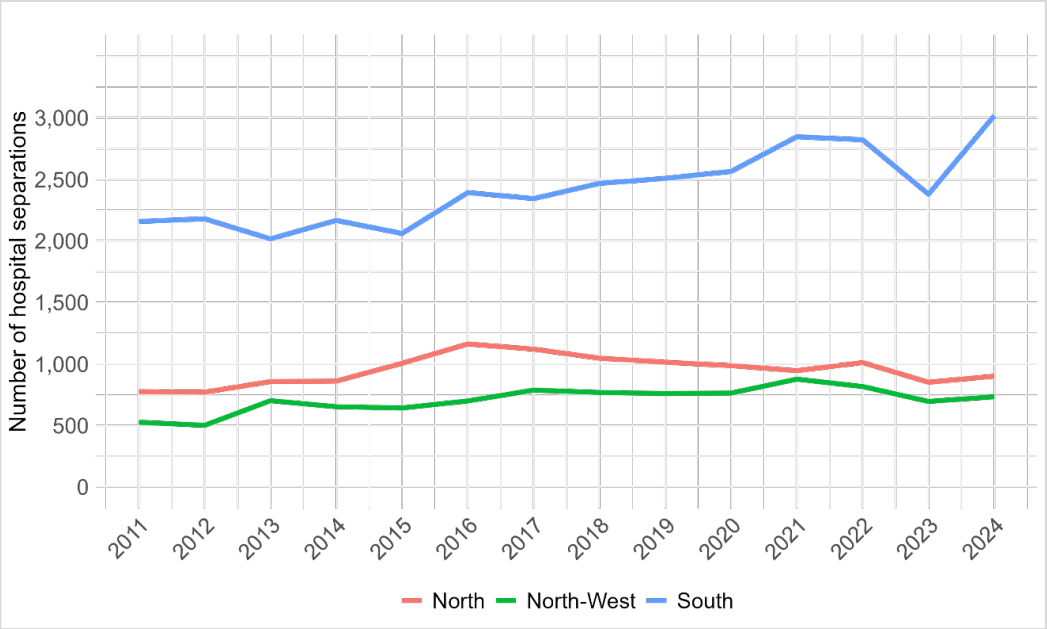
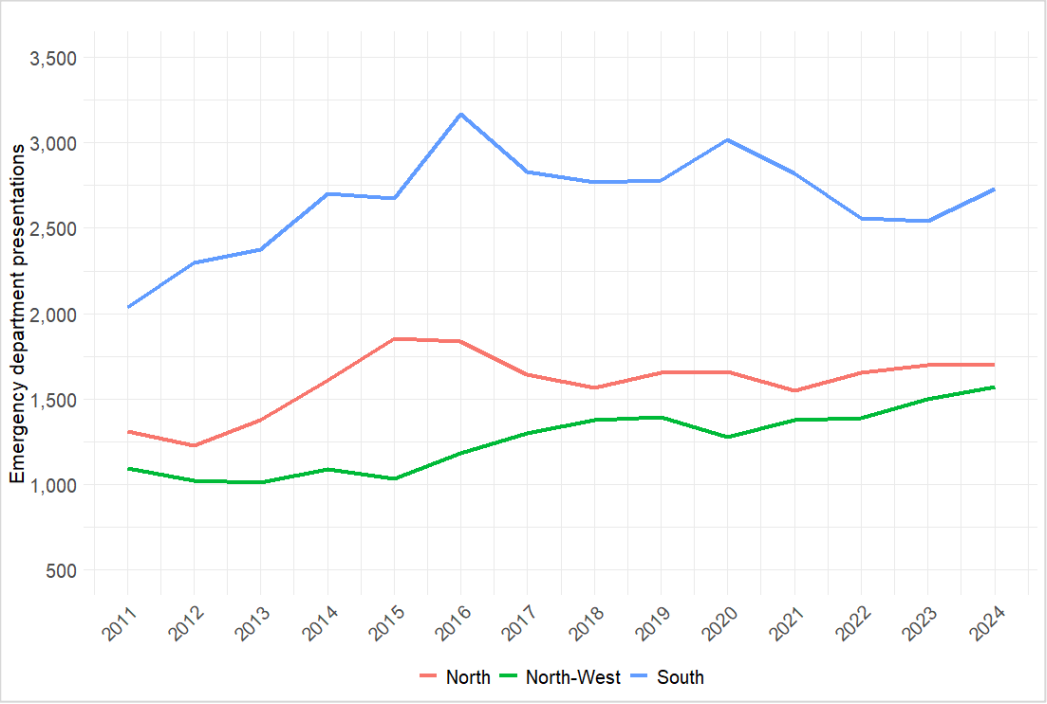


Figure 44. Public hospital Emergency Department presentations, mental and behavioural disorders, Tasmania | 2011 to 2024



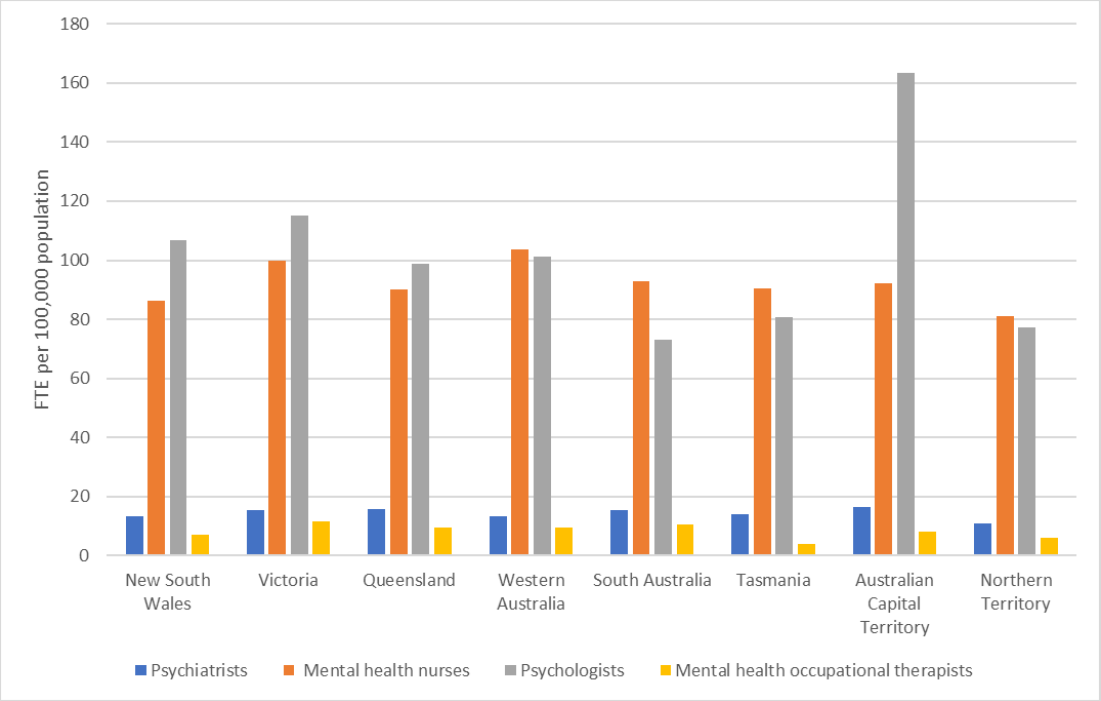
Emergency Department presentations for people with mental and behavioural disorders showed an overall increase across three regions, despite fluctuations, in Tasmania since 2011. Between 2023 and 2024, Emergency Department presentations showed a sharp increase in the south, while the other regions only have a slight increase[16] (Figure 44).

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

Tasmania provides clinical community-based mental services through 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.

The number (full-time equivalent) of psychiatrists and psychologists per 100,000 population is smaller in Tasmania than many other jurisdictions[216] (Figure 45).

Figure 45. Clinical full-time equivalent mental health disciplines per 100,000 population, Australian states and territories | 2021



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

The National Survey of Mental Health and Wellbeing collected data on mental health service access in the preceding 12 months, 2020-2022. From this survey, it was estimated that 17.4% of Australians aged 16-85 years saw a health professional for their mental health, 21.6% of females and 12.9% of males[216]. Among people with a lifetime mental health disorder who had experienced symptoms in the previous 12 months, 9.7 saw a health professional for their mental health: 10.2% of females and 5.0% of males consulted a GP, 6.0% of females, and 3.1% of males consulted a psychologist, and 2.5% of females and 1.7% of males consulted a psychiatrist[216].

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[217].

In 2023-2024, about 2.7 million Australians (10% of the population) received Medicare-subsidised mental health services. Of those who accessed Medicare-subsidised mental health services, 78% received clinical mental health services through a GP, 20% from clinical psychologists, 21% from psychiatrists, 27% from a private psychiatrist, and 4% from other allied health providers (for example, hospital or community care)[218].

In Tasmania, GPs provide most mental health care for people who have mental health issues, with clinical psychologists the second-most common community level service provider in 2023-24[218].

In 2023-2024, 41,232 (72 per 1,000) Tasmanian patients visiting a GP received 60,238 (105 per 1,000) Medicare-subsidised mental health-specific services[218]. Overall, 53,810 Tasmanians (94 per 1,000) received 240,875 (419 per 1,000) Medicare-subsidised mental health-specific services from all service providers[218].

Internal analysis from Primary Sense data showed that in 2023-2024, around 94,000 patients visited GP practices in Tasmania at least once due to psychological reasons (anxiety, depression, dementia, and/or psychological reasons other than anxiety and depression) of whom 37,595 (67%) visited a general practice with a presenting complaint of anxiety and depression. In 2024-2025, this 89,500 patients visited GPs due to psychological reasons of which 48,000 (54%) people visited a GP due to anxiety and/or depression[36].

COVID-19 has further influenced treatment patterns, leading to a significant increase in MBS-subsidised mental health-related services in Australia. Throughout the pandemic, many consumers transitioned to telehealth options, with services being delivered via telephone or videoconference[219].

Medicare data show that Tasmanians use Medicare-subsidised mental health specific services such as GPs and psychiatrists at a lower rate than the national average[218]. However, data from the Pharmaceutical Benefits Scheme (PBS) shows that prescription rates for mental health issues are significantly higher than the national average[220,]

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 psychiatrist
- affordability or out-of-pocket cost of seeing a psychiatrist.

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

5.3.5 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 conditions
- 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 conditions.

Primary Health Tasmania also commissions psychological services for people living 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[221] (Table 5).

Table 5. Profile of Primary Health Tasmania commissioned mental health programs | 2020–21 to 2024-25

Program	Active clients***	Active episodes	Services excluding non-attendees****
Low-intensity psychological interventions	1,473	1,550	8,970
Short-term psychological interventions including aged care (psychological therapies)	7,466	9,694	67,049
Child and youth-specific mental health services	362	375	25,820
Adult severe and Complex services (clinical care coordination and complex care package)	1,570	1,719	30,497
Psychosocial support	1,468	1,511	29,524
Medicare Mental Health Centre* (Head to health)	1,361	1,517	16,227
Way Back*	1,005	1,020	19,006
Bushfires**	119	149	1,172

*Commenced during 2021-22; ** Discontinued during 2021-22; All data is captured from PMHC MDS portal reports - all funding sources included ***active clients attended at least one service; cumulative numbers of previous five financial years; ****services booked but not attended was not considered in the service count.

Primary Health Tasmania's commissioned 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 conditions. 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 score of 25–29 indicates moderate psychological distress and >29 indicates severe psychological distress.

Two thirds of people (67%) accessing commissioned mental health services had severe levels of psychological distress at presentation. For episodes of care where that treatment was concluded, 36% of people had severe psychological distress at the end of treatment[222]. A significant improvement in psychological distress was observed across all commissioned mental health services[221] (Table 6).

Table 6. Percentage changes in psychological distress as per K10 (MDS definition: first and final measurements), Primary Health Tasmania | 2020–21 to 2024–25

Program***	Improved %	No Change %	Deteriorated %
Low-intensity psychological interventions	56.3	40.9	2.8
Short-term psychological interventions including aged care (psychological therapies)	51.8	39.7	8.5
Child and youth-specific mental health services	59.2	32.0	8.8
Adult severe and Complex services (clinical care coordination and complex care package)	71.9	24.1	4.0
Psychosocial support	74.0	23.3	2.7
Medicare Mental Health Centre* (Head to health)	72.3	22.2	5.5
Way Back*	73.2	24.0	2.8
Bushfires**	65.0	35.0	0.0

*Commenced during 2021-22; ** Discontinued during 2021-22 All data is captured from PMHC MDS portal reports – all funding sources included, *** All data is captured from PMHC MDS portal reports - all funding sources included

Primary Health Tasmania also commissions mental health services for young people through headspace centres in Tasmania's three regions. Each year, around 3000 young people received services from four centres located in south, north and north-west of Tasmania[221] (Table 7).

Table 7. Profile of the headspace program in Tasmania | 2021–22 to 2024–25

Centre	2021-22			2022-23			2023-24			2024-25		
	P	E	S	P	E	S	P	E	S	P	E	S
Burnie	172	214	443	129	186	325	203	209	817	230	235	957
Devonport	396	493	1,294	495	652	1,768	537	573	2,260	630	682	2,724
Hobart	1,349	1,634	4,116	1,351	1,684	4,396	1,337	1,465	4,706	1,123	1,234	3,680
Launceston	1,195	1,482	4,936	833	1,107	3,400	948	1,023	4,824	1,078	1,244	5,776
Total	3,112	3,823	10,789	2,808	3,629	9,889	2,905	3,150	12,607	2,863	3,199	13,137

*__P__=Persons; __E__=Episodes; __S__=Services

Data extracted from headspace internal report (Tableau profile accessed 25-Aug 2025). Persons are unique active service users, an episode of care is a defined period during which a client receives services for a particular mental health issue or set of related needs, a service refers to the clinical mental health intervention(s) provided to a client under an episode of care.

Service user outcomes are measured using K10. The majority of young people with K10 measures experience either no significant change in levels of psychological distress over time or experience an improvement in their psychological distress (Table 8).[221]

Table 8. Outcome of services by K10 score, people who received services from headspace, Tasmania | 2020–21 to 2024–25

	Significant improvement	No significant change	Significant deterioration
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
FY 2023-24 (n=829)	41.1	46.2	12.7
FY 2024-25 (n=854)	35.4	53.5	11.1

Tableau profile accessed 25-Aug 2025

5.4 Stakeholder perspectives

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

5.4.1 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 due to fragmented care coordination, with limited formal collaboration between mental health, social, and primary care services. This leads to disrupted continuity of care and suboptimal treatment outcomes, particularly for individuals with complex needs. It is unclear to patients and their families and caregivers which services they should access for specific mental health conditions.

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 conditions 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 living with mental health conditions, 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.

The dynamic nature of mental health conditions requires service users to receive varying levels of care over time, yet the current system lacks robust mechanisms to facilitate smooth transitions for service users stepping up or stepping down in care intensity.

Through the Tasmania Bilateral Agreement for Mental Health and Suicide Prevention, the Tasmanian Department of Health, funded by Primary Health Tasmania, is implementing a Central Intake Referral Service. This service will be a single-entry point for all Tasmanians needing mental health services. The single-entry point will be Medicare Mental Health phone service.

For successful integration, there must also be a clear alignment between national and state policies, strategic frameworks, and local program implementation. This ensures that the services provided reflect overarching goals and objectives while being adaptable to local context and needs.

5.4.2 We need to address gaps in mental health services

People report it is difficult to access urgent mental health care outside working hours. This is a problem for people in crisis, who present to emergency departments for care during this period. Limited options for mental health care during after-hours and weekends periods are also a problem for people with mental health conditions who are at work 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.

Statewide service provision is heavily weighted towards the inner regional areas 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 outer regional, remote, and very remote 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.

The initial assessment and referral- decision support tool (IAR-DST), used to support consistent assessments of mental health needs and help determine the appropriate level of care faces challenges, such as low uptake, lack of integration into existing referral pathways, and incomplete information from referrers.

5.4.3 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.

There is a need for ongoing staff training in community engagement, and multidisciplinary collaboration, to ensure that professionals are well-equipped to meet multiple needs. Staff have also expressed a strong interest in ongoing, targeted training in areas of trauma-informed care, and delivering interventions.

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. There is a critical need for ongoing staff training, particularly in cultural safety, community engagement, and multidisciplinary collaboration, to ensure that professionals are well-equipped to meet diverse needs. Staff have also expressed a strong interest in ongoing, targeted training in areas of trauma-informed care, medications, and cultural competency. However, financial constraints and workforce shortages further limit the capacity to expand services and provide timely, high-quality care.

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

Tasmania has very limited psychogeriatric service availability and a limited psychogeriatrics workforce. As a result, other clinical disciplines care for people with complex psychogeriatric care needs.

Staff retention and shortage is reported as problematic for some mental health service organisations, especially in rural and remote areas. Recruitment, retention, and access to supervision remains a barrier.

5.4.4 There are significant data gaps

There is a need to address the significant lack of LGA-level data about who, how and when people with mental health issues access services from different organisations across the state. Additionally, although current data indicates an average of 66% improvement in distress levels among treatment-concluded episodes across all Primary Health Tasmania commissioned programs, several limitations hinder robust program evaluation. These include the small number of matched pairs within one financial year, largely due to extended episode durations and wait times, creating more ongoing episodes yet to conclude, and the lack of follow-up data after exit. There is limited data on how many Tasmanians use interstate telehealth counselling, even as it becomes more common. Collectively, these factors restrict the ability to draw strong conclusions about the sustainability of improvements and the overall impact of mental health programs on service user's well-being.

Feedback from providers highlights the importance of streamlining reporting processes and ensuring alignment with clinical priorities. There is strong interest in the use of simplified, outcomes-focused measures such as consistent Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) as well as improved digital systems to enable more effective communication and feedback between service providers and commissioning bodies. Strengthening these systems can help reduce administrative burden and support continuous quality improvement across the sector.

Addressing this data gap will provide valuable information about how best to plan targeted services to people with mental health conditions and drive high quality program evaluation.

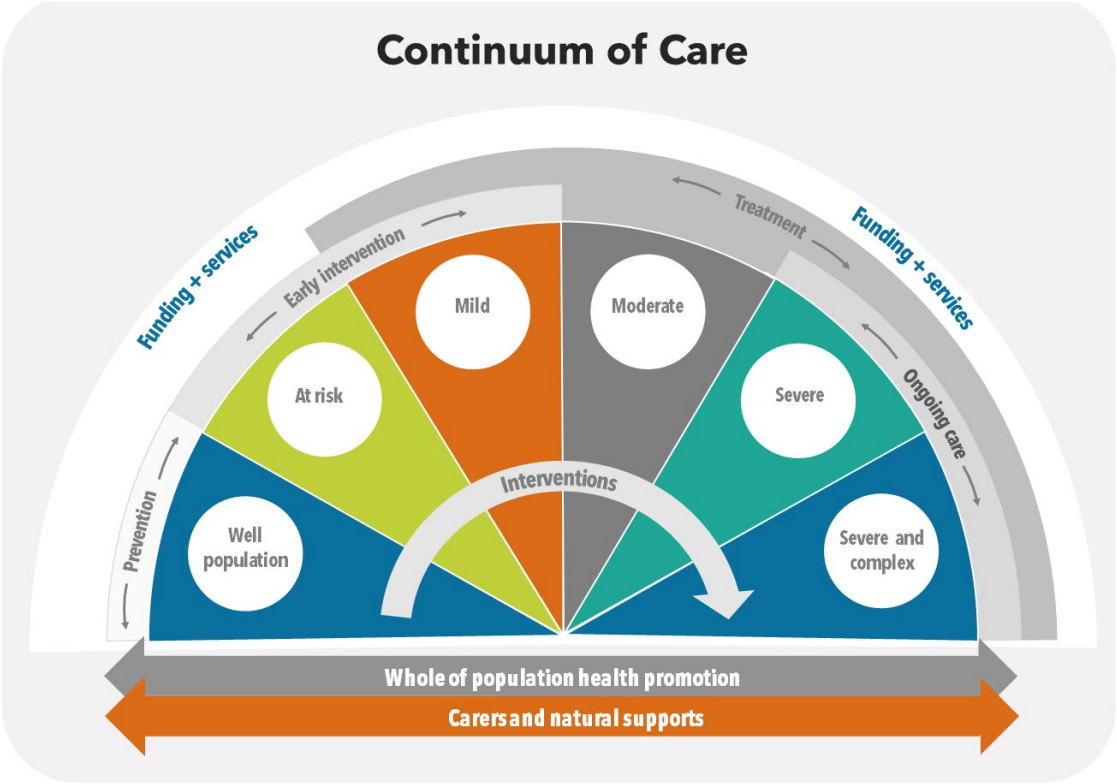
5.5 Priority actions

5.5.1 Commission across spectrum of need and continuum of care

Primary Health Tasmania will continue to commission services that support mental health service delivery across the continuum of mental health care in a stepped care model. 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, as well as service providers, the Tasmanian Department of Health and General Practice (Figure 46).

Figure 46. Tasmanian Mental Health Continuum of Care Model



5.5.2 Establish a primary mental health service gateway in northern Tasmania

People in northern and north-west Tasmania have lower availability of primary mental health services compared with people in the south.

To improve access to mental health care services for people experiencing psychosocial distress and different levels of mental health conditions, Medicare Mental Health Centres for adult mental health 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 northern, north-west Tasmania and outer Hobart.

5.5.3 Address gaps in mental health services

Primary Health Tasmania commissions services to address gaps in primary care. Currently, the largest number of services are provided by headspace, followed by Short Term Psychological Services across all active clients. The largest proportion of aged group serviced are young people age 12-24, which received services mainly from headspace. headspace services receive the highest budget among all commissioned mental health services.

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 services
- primary mental health care and psychosocial support for adults with severe and complex mental health conditions
- mental health care for older people living in residential aged care.

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

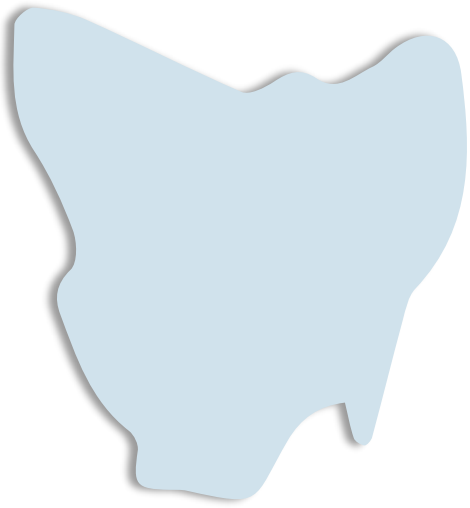
5.5.4 Strengthen suicide prevention and early intervention

An updated National Suicide Prevention Strategy has been released in late 2024 by the Commonwealth Government funded National Suicide Prevention Office[223].

Primary Health Tasmania will continue to work with the Tasmanian Department of Health and other stakeholders on the second implementation plan for the Tasmanian Suicide Prevention Strategy 2023-2027. It outlines Tasmanian priorities for suicide prevention, in alignment with the overarching strategy and community consultation.

The Tasmanian Suicide Prevention Plan presents community-based suicide prevention activity against evidence-based best practice and supports the development and delivery of the Universal Aftercare for people who have attempted suicide.

Primary Health Tasmania commissions community-based suicide prevention and aftercare services, aligned with the National Mental Health and Suicide Prevention Plan and Rethink 2020. This includes efforts to reduce suicide risk, strengthen protective factors, and ensure follow-up support after a suicide attempt.



6

Alcohol and other drugs

6 Alcohol and other drugs

6.1 Overview

Alcohol and Other Drugs (AOD) use is a major cause of preventable disease, illness, injury, 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[224, 225].

'Other drug use' or 'illicit drug use' (used interchangeably) can include[226]:

- 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 AOD 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 AOD 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 AOD 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, including workforce development, trauma-informed practice, and integration with other parts of the health system.

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

6.2 Health needs

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

6.2.1 Alcohol and other drug use in Tasmania

The National Drug Strategy Household Survey collects information on AOD use in Australia and gives us a snapshot of AOD use by state[227].

According to the most recent survey results in Tasmania in 2022-23 among people aged 14 and over:

- 1 in 4 people consumed 5 or more standard 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[227] (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 among people aged 14 and over in Tasmania compared with Australia | 2022-23

	Tasmania (%)	Australia (%)
Drank alcohol in the previous 12 months	85.0	76.8
Consume 4 or more drinks in a single day (at least monthly)	23.4	23.8
Used an illicit drug in the past 12 months	16.4	17.9

6.2.2 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[126]. The rate of Tasmanians drinking any amount of alcohol on daily basis had increased from 4.4% to 7.2% of Tasmanian population. The rate of Tasmanians drinking weekly, monthly or less than monthly, or who are ex-drinkers, did not change significantly between 2019 and 2022-23 [227].

Many of us consume alcohol responsibly for social or cultural reasons. However, excessive alcohol use can lead to harm, resulting in health, social, and economic impacts. In 2022, for 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)[126].

Alcohol misuse has health, social and economic impacts on individuals and communities. In 2022-23, approximately 1 in 4 (23.1%) Tasmanians experienced an alcohol-related incident, and experienced higher rates of alcohol-related harm than the national average:

- verbal abuse (19.2%% vs 17.6% of people)
- physical abuse (7.1% vs 5.3% of people)
- put in fear (13.3% vs 12.1% of people)[228].

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

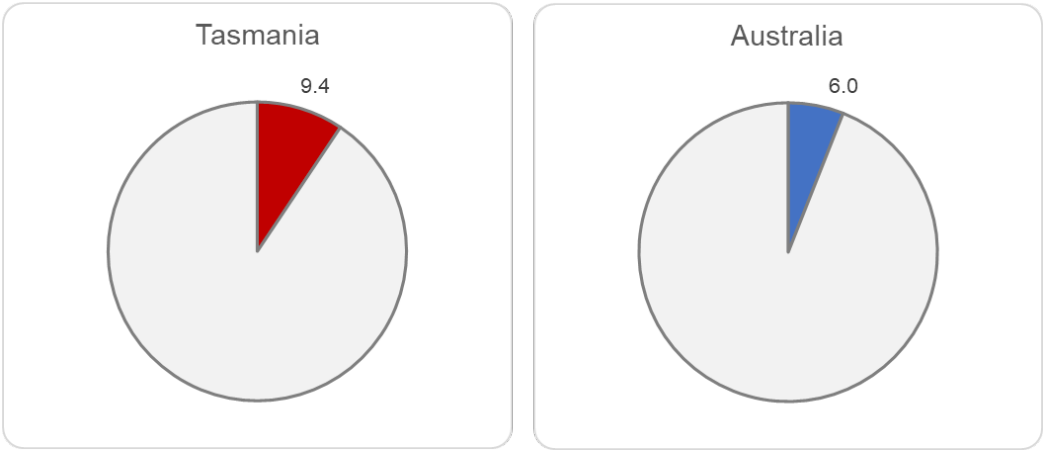
Lifetime risk is drinking more than 2 standard drinks a day.

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[229]. People most likely to die from a cause directly attributable to alcohol are males aged 60–64 years, people with chronic alcoholic liver disease, of lower socioeconomic status, 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 with 6.0 deaths per 10,000 population in Australia as a whole[229] (Figure 47).

Figure 47.Alcohol-induced deaths, rate per 100,000 population (age-standardised), Tasmania and Australia | 2022



Deaths where the underlying cause can be directly attributed to alcohol use are also known as alcohol-induced deaths. However, alcohol-related deaths extend beyond those deaths which are directly attributable to alcohol. Alcohol-related deaths include deaths directly attributable to alcohol use (alcohol-induced deaths) and deaths where alcohol is listed as an associated cause of death (e.g. motor incident with high blood alcohol concentration). Alcohol continues to account for a higher number of deaths than any other drug type and deaths involving alcohol have risen over the last decade. Nationally, in 2023, there were 5,004 alcohol-related deaths, and 1,667 alcohol-induced deaths. Additionally, in 2022-23, alcohol accounted for 60% of all drug-related hospitalisations[230, 231].

6.2.3 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[232].

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 2022-2023, about 1 in 6 Tasmanians had used an illicit drug in the previous 12 months which is less than the national average (16.4% vs 17.9%). Rates of illicit drug use in 2022-2023 (16.4%) were similar to 2016 (17.4%). However, the type of illicit drug used has changed over time. In 2022-23, hallucinogens were the second most commonly used drug in the previous 12 months whereas ecstasy and cocaine usage have decreased compared to 2019. Cannabis remains to be the most used drug. (Table 10)[233].

Table 10. Top 5 illicit drugs used in the previous 12 months, people aged 14+, Tasmania | 2001, 2019 and 2022-23

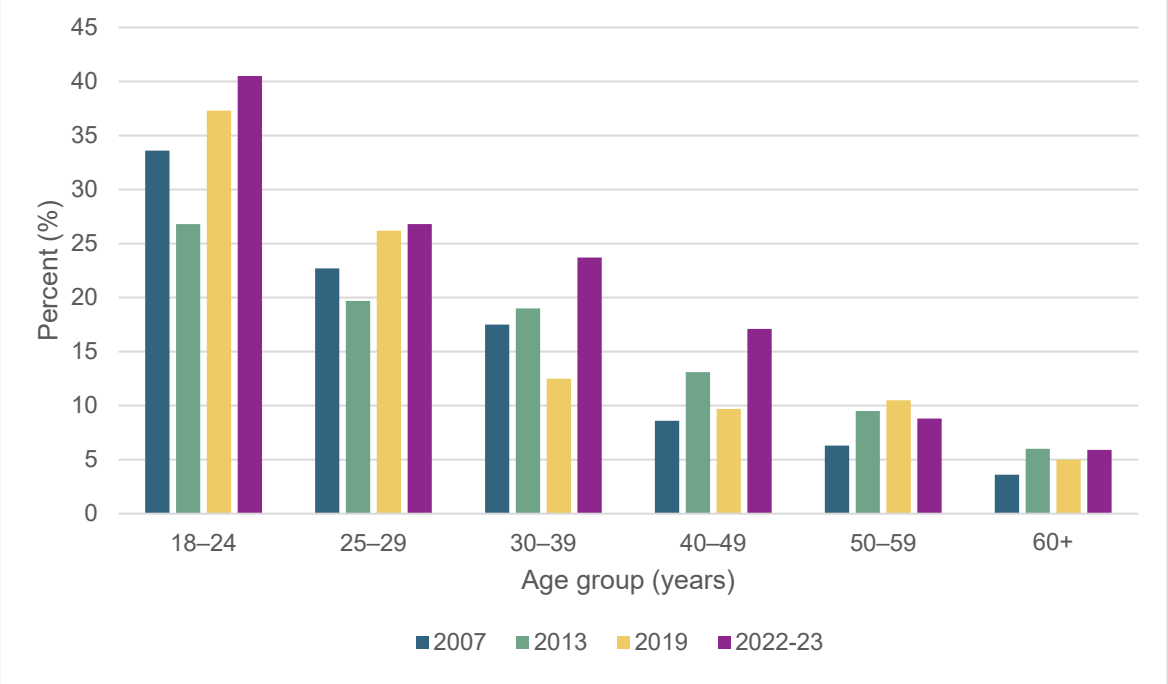
	2001		2019		2022-23	
Rank	**Drug**	**%**	**Drug**	**%**	**Drug**	**%**
1	Cannabis	14.4	Cannabis	10.5	Cannabis	11.5
2	Ecstasy	4.8	Cocaine	3.5	Hallucinogens	*3.0#
3	Hallucinogens	1.7	Ecstasy	*2.3	Meth/amphetamine(a)	*2.2
4	Cocaine	*1.5	Inhalants	*1.7	Ecstasy	*1.8
5	Inhalants	*0.5	Hallucinogens	*1.2	Cocaine	*1.3

*Estimate has a relative standard error of 25% to 50% and should be used with caution
#Statistically significant change between 2019 and 2022-23
(a) Drug category was changed in 2022–2023. Results for 2019 and earlier years are not comparable.

Rates of illicit drug use are the highest among youth aged 18-24 years

Between 2007 to 2023, the highest proportion of recent use of illegal drugs was consistently seen in Tasmanians aged 18-24 years old (Figure 1). This is consistent with the national figures where Australians aged 18-24 recorded the highest proportion of illegal drug use[228].

Figure 48. Illicit drugs used in the previous 12 months, according to age category, age 18+, Tasmania | 2007, 2013, 2019 and 2022-23



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 2022-2023, 1 in 10 (9.8%) Tasmanians experienced an illicit drug-related incident in the past 12 months, similar to the national average of 10.1%. However, Tasmanians experienced slightly higher risk of physical abuse and being put in fear due to illicit drug use:

- verbal abuse (7.2% vs 7.5% of people)
- physical abuse (3.6%* vs 2.3% of people)
- put in fear (7.3% vs 6.6% of people)[228].

*Estimate has a relative standard error between 25% and 50% and should be interpreted with caution

6.3 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 improving social and personal functioning. Assistance may also be provided to support the family and friends of people using drugs.

In 2023-2024, publicly funded AOD treatment agencies provided around 241,000 treatment episodes to an estimated 131,900 clients nationally. The four most common drugs that led clients to seek treatment for their own drug use were alcohol (42% of all treatment episodes), amphetamines (26%), cannabis (16%) and heroin (4.3%). Six in 10 of all clients receiving treatment were male (60%), and 7 in 10 (72%) clients were aged 20-29 years[234].

6.3.1 Tasmania's specialist alcohol and other drug treatment services

In 2023-2024, there were 21 publicly funded AOD treatment agencies (4 government and 17 non-government) in Tasmania that provided 3,703 treatment episodes to 2,757 clients with concluded treatment episodes.

Our rate of treatment episodes is 720 people per 100,000 population, which is lower than the national treatment rate of 1,011 people per 100,000 population[234]. In addition, our rate of clients is 536 clients per 100,000 people, which is lower than the national rate of 553 clients per 100,000 population.

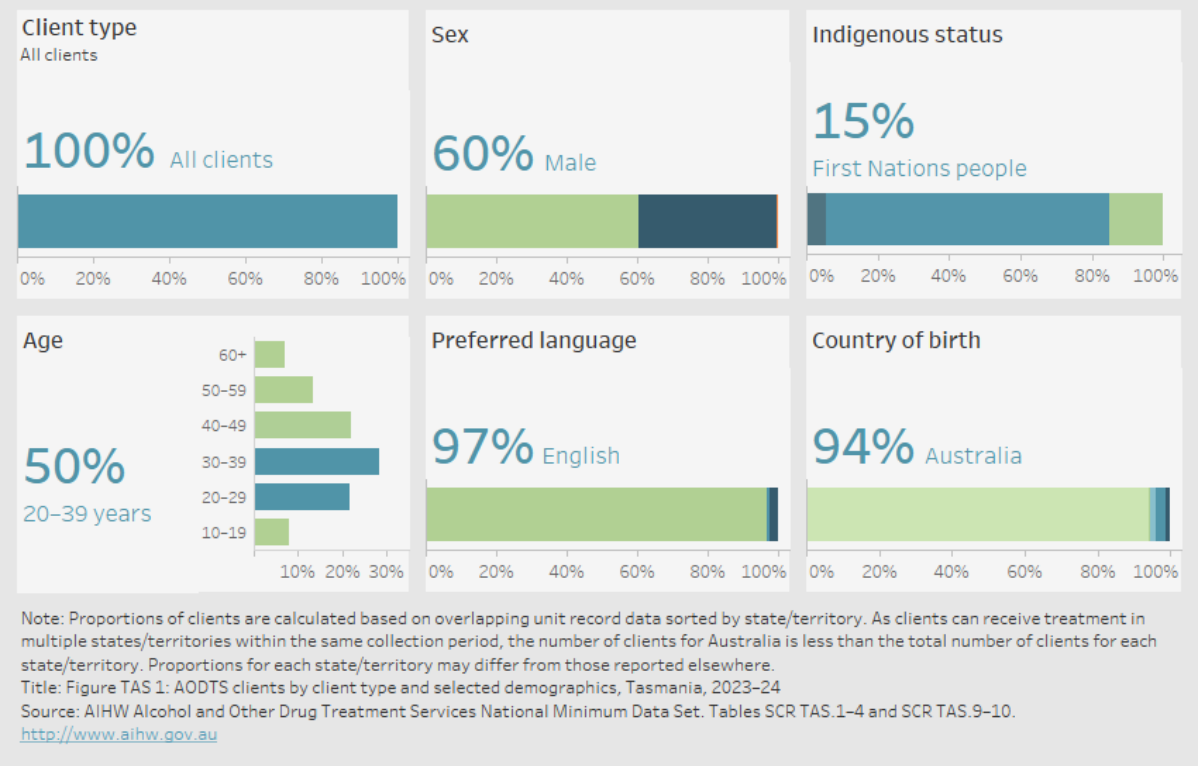
Access to evidence-based, quality alcohol and other drugs information and treatment services should be seen as a basic right of all Tasmanians.

Alcohol, Tobacco and other Drugs Council Tasmania

Based on AIHW AOD services glossary, a client is someone aged 10 or older who receives AOD treatment for their own or someone else's use. A treatment episode refers to a continuous period of contact between the client and provider, with the same main treatment type and drug of concern, and no unplanned break longer than three months.

The data shows that 60% of Tasmanians who received specialist treatment were male and 15% identified as Aboriginal. Tasmanians aged 20–39 years were most likely (50%) to receive specialist services[234] (Figure 49).

Figure 49. Alcohol and other drug treatment services, client demographics (n=2,757), Tasmania | 2023-24



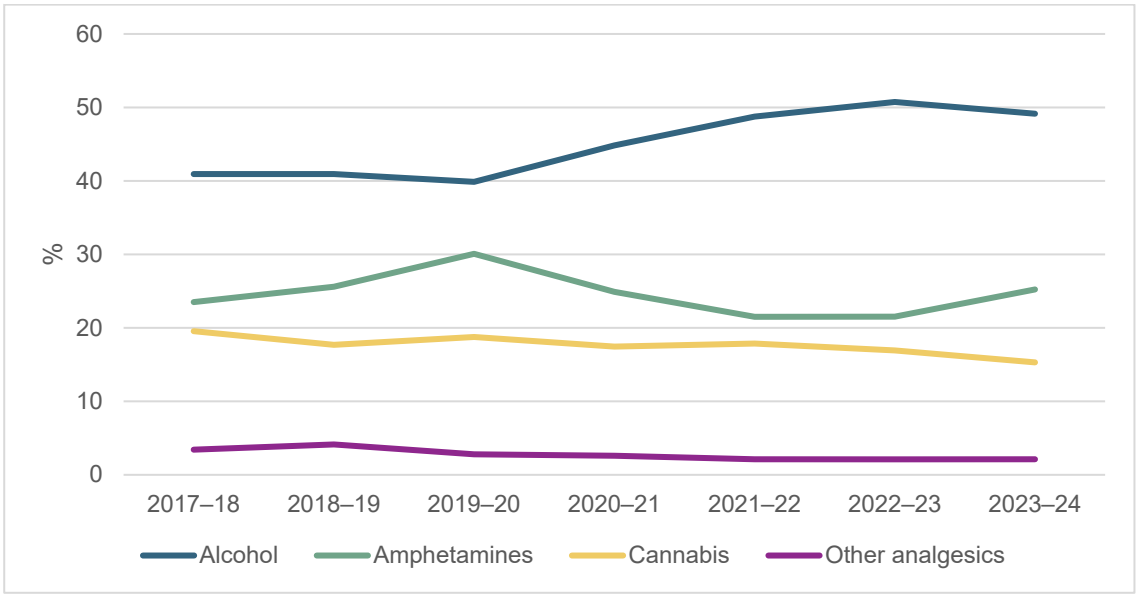
Note: Proportions of clients are calculated based on overlapping unit record data sorted by state/territory. As clients can receive treatment in multiple states/territories within the same collection period, the number of clients for Australia is less than the total number of clients for each state/territory. Proportions for each state/territory may differ from those reported elsewhere.
Title: Figure TAS 1: AODTS clients by client type and selected demographics, Tasmania, 2023–24
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables SCR TAS.1–4 and SCR TAS.9–10.
http://www.aihw.gov.au

Most specialist treatment is provided for alcohol-related concerns

Alcohol is the most common principal drug of concern for Tasmanians who attended specialist AOD treatment services (49.1%), followed by amphetamines (25.2%) and then cannabis (15.3%) (Figure 50)[234].

The proportion of treatment episodes for alcohol as a principal drug of concern have been increasing in Tasmania since 2019-20, peaking in 2022-23 at 50.7%, before starting to decline in 2023-24 (49.1%). In contrast, amphetamine use returned to baseline levels in 2022-23 (21.5%) before increasing to 25.2% in 2023-24. The proportion of treatment concluded episodes for cannabis and other analgesics continued to show a gradual decline since 2021-22 remaining stable over time[234].

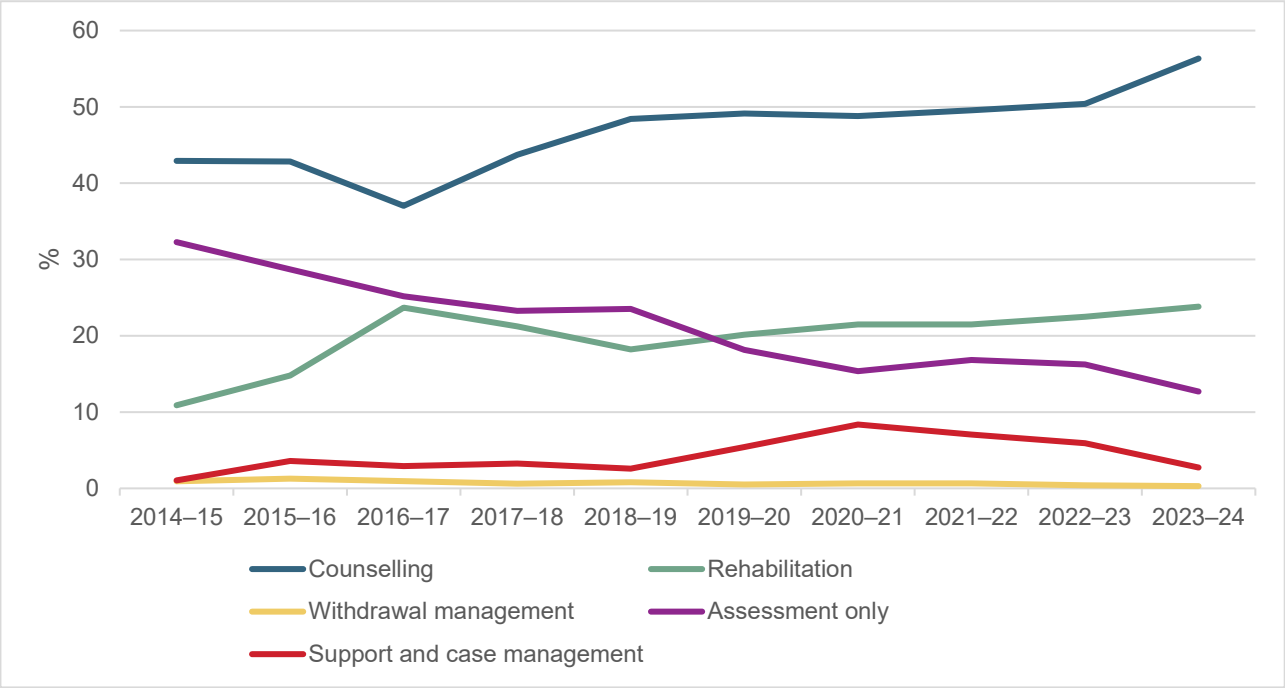
Figure 50. Proportion of closed treatment episodes (n=3,535) for own drug use by drug of concern, and presentation rates for principal drugs of concern Tasmania | 2023-24



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

In Tasmania, counselling remains the most common treatment for treatment concluded episodes used specialist AOD treatment services, with the proportion of episodes falling from 43% in 2014-15 to 37% in 2016-17, before increasing to 56% in 2024-25. Counselling can involve approaches such as cognitive behavioural therapy, brief interventions, relapse prevention strategies, and motivational interviewing. Rehabilitation services are supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of drug use. The proportion of episodes for rehabilitation, as the main treatment type, have increased steadily over time since 2019-20. Expanding rehabilitation support means not only assisting individuals through withdrawal but also addressing the underlying causes of their AOD use. However, other treatment types have been steadily decreasing (Figure 51)[234].

Figure 51. Proportion of main treatment concluded episodes by type provided by specialist AOD services, Tasmania | 2014-15 to 2023-24



6.3.2 Other services that provide care and support

Specialist AOD treatment services are part of a broader health system providing care to Tasmanians with AOD treatment needs. Services delivering treatment include hospitals and acute services, mental health, disability, emergency services, children and youth services, and can also include housing, justice, education and employment providers[235].

Hospitalisations

In 2024, approximately 2.6% of all public hospital separations in Tasmania (4,839 out of 188,439) were for a drug-related diagnosis[59]. Between 2014 and 2024, drug-related hospital separations (principal and additional diagnosis) varied between 4,282 and 5,731 presentations per year (Figure 52). Treatment for alcohol-related problems was responsible for the largest number of separations. Alcohol accounted for the largest share of AOD presentations, confirming its role as the leading driver of AOD-related acute care (Figure 53).

Figure 52. Number of alcohol and drug related hospital separations in Tasmania 2014 to 2024

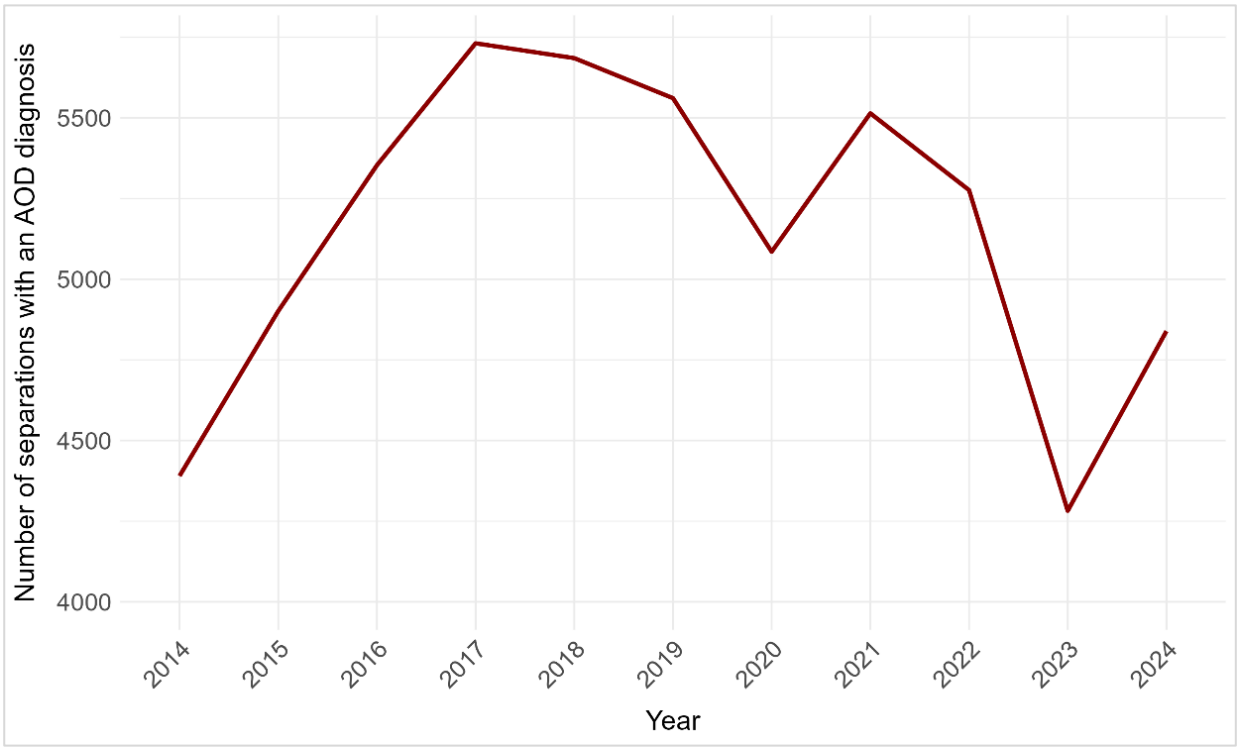
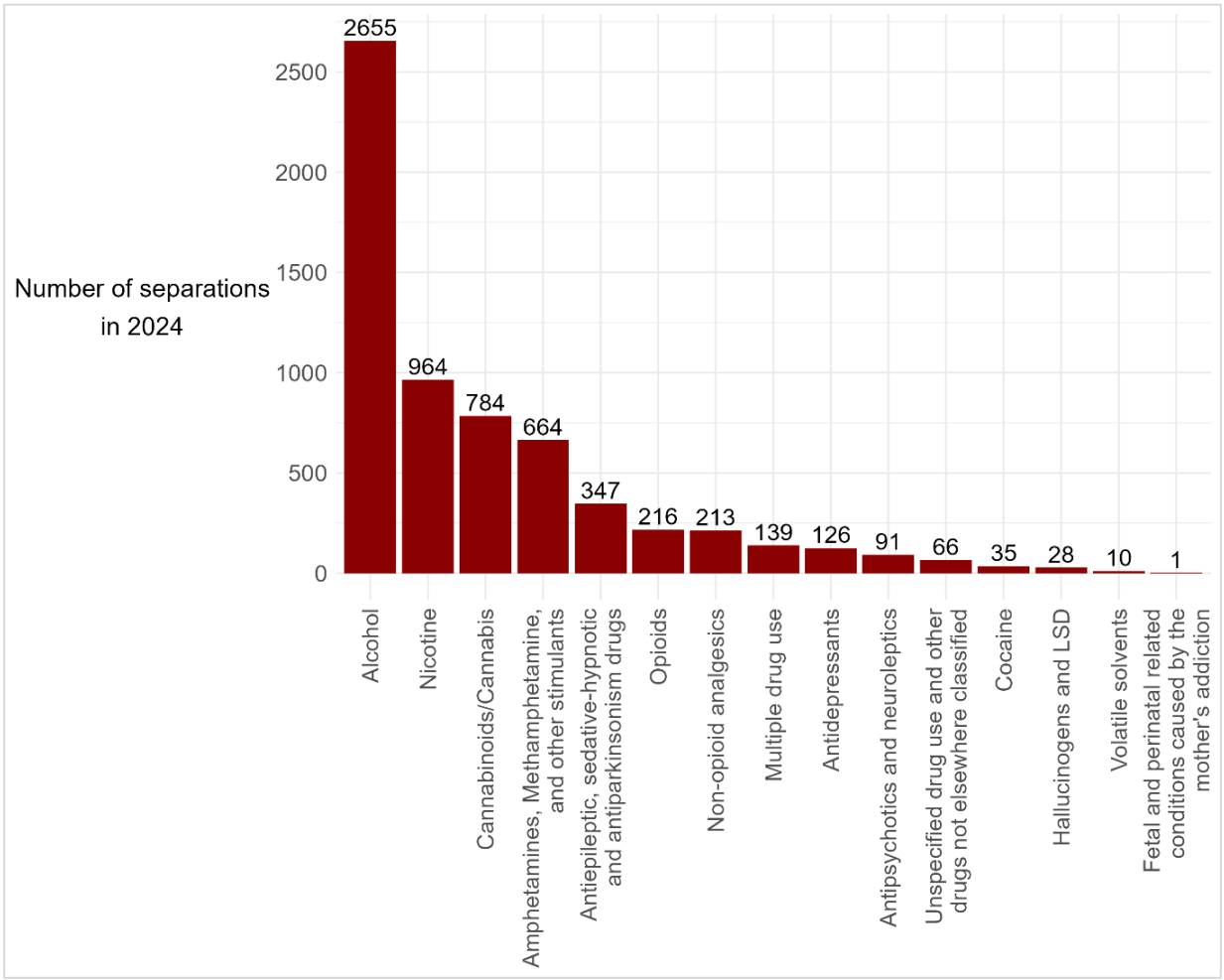


Figure 53. Number of alcohol and drug related hospital separations by reason in Tasmania 2024

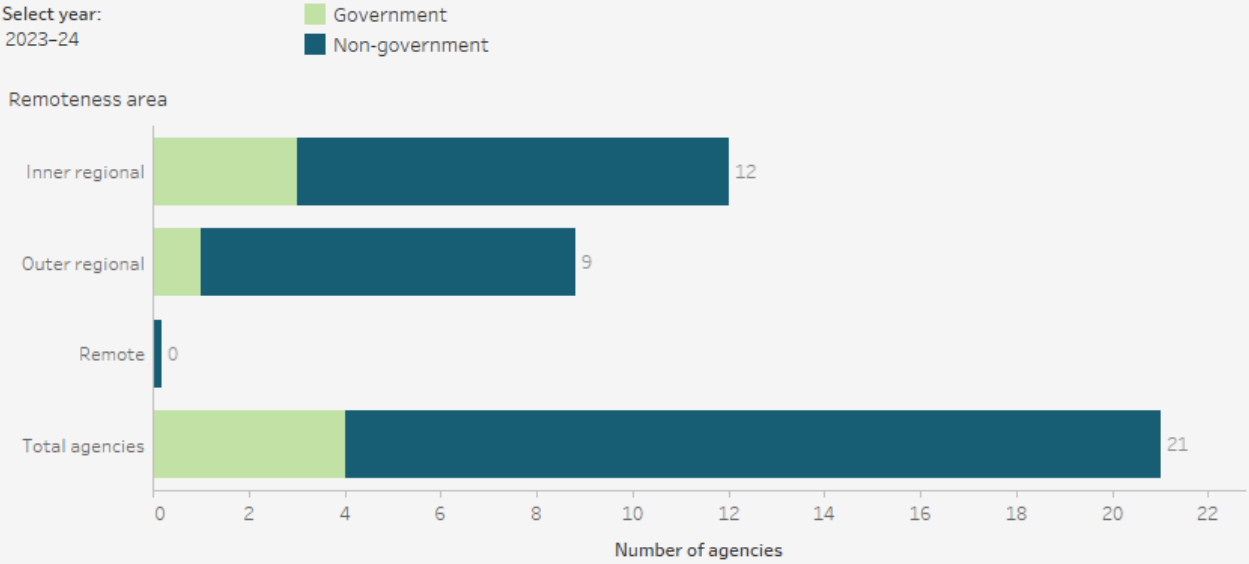


6.3.3 Available AOD treatment services in Tasmania

Figure 54 illustrates the proportion of government and non-government AOD treatment agencies in Tasmania. The total number of AOD treatment services in Tasmania has been stable in the past ten years.

In 2023-2024, 17 of the 21 AOD agencies in Tasmania were non-government treatment agencies that receive public funding; 12 agencies were located in inner regional areas, the remaining 9 were in outer regional areas[234].

Figure 54. Number of AOD treatment agencies by remoteness area and sector, Tasmania | 2023-24



Note: In 2022–23, SA2 of agency was updated from ABS ASGS 2016 to ASGS edition 3 2021. Correspondance mappings may change over time and may differ from what was previously published. Due to correspondance update only 2 years of data has been presented.
Title: Figure TAS 5: Number of agencies, by remoteness area and sector, Tasmania, 2022–23 to 2023–24
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

6.4 Stakeholder perspectives

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

Based on feedback from providers, the number of AOD agencies has remained largely static over the past decade despite increasing demand and complexity, indicating that service capacity has not kept pace with community needs. While most agencies are located in inner regional areas, outer regional communities face long travel distances, limited outreach or telehealth, and unstable workforce coverage. These inequities restrict access for rural Tasmanians.

The highest proportion of service use among youth signals the importance of targeted youth withdrawal services, which are currently lacking. Despite higher prevalence of illicit drug use among young people, Tasmania lacks dedicated residential rehabilitation services and detox programs that focus on youth specific needs. This gap leaves young people without appropriate, tailored treatment options, even though current AOD services accept people over the age of 12 years[236].

6.4.1 Main care need is for managing alcohol-related problems

According to consultations with primary care stakeholder groups, alcohol use is the most commonly managed substance use disorder in primary care settings.

Stakeholders report people experiencing alcohol use issues may also experience homelessness, unemployment, mental ill-health, physical health problems, and harm from involvement with child protection, justice system (including prison, and/or police contact). 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 AOD counsellors to support other primary care providers in the management of alcohol misuse issues. Stakeholders report the lack of family counselling and support services. Moreover, stakeholders report the need to implement prevention and early intervention services, especially for complex cases with mental health diagnosis and AOD issues. These initiatives could potentially address consumers' issues and prevent them from becoming involved with the criminal justice system.

Additionally, stakeholders report difficulties accessing culturally tailored AOD treatment services. Building the Aboriginal health workforce to deliver AOD treatment and support is a priority for stakeholders who participated in consultations.

People affected by alcohol use 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 access and continuity of care.

6.4.2 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 related to methamphetamine use, requires ready access to specialist AOD services and mental health services.

Stakeholders report gaps in specialist services in Tasmania in addiction psychiatry.

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 AOD issues.

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

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
- limited availability of GP bulk-billing creates some barriers for consumers to afford and access AOD care
- stigma related to AOD use, affecting both GP attitudes and consumers' willingness to seek help
- inconsistent access to prescription service for opioid replacement therapy across the state, with significant limitations in rural areas.

6.4.3 Operational gaps

Stakeholders have also reported an increase in the complexity and acuity of client presentations. As complex needs often span both clinical and social domains with clients often presenting with suicidality, trauma histories, or housing and justice system needs. Complex clients often have a high burden of comorbidity (such as mental health conditions/suicidality) and requires a greater degree of support in client management. However, referrals to specialist supports are often delayed or unsuccessful as a result of high demand and limited supply.

6.4.4 There are significant data gaps

Current AOD data systems and reporting frameworks are not designed to capture the client level details required for effective population equity monitoring, system-level risk oversight, or comprehensive service journey mapping. For more comprehensive inferences to be made, additional elements such as priority population flags, geospatial data, risk indicators associated with clients, and service journey data would be necessary for all services.

6.5 Priority actions

6.5.1 Better integration of care across the AOD service system

Primary Health Tasmania is committed to further developing our commissioning approach to encourage integration across the boundaries of primary, community and acute services.

People living with AOD issues often experience co-occurring mental health conditions, creating a significant challenge for service providers. Through our Tasmanian HealthPathways and partnerships with Tasmanian Government stakeholders, Primary Health Tasmania is working on improving streamlined referral pathways into specialist services for people with complex AOD issues.

6.5.2 Build the capacity of the AOD treatment sector

Strengthening the capacity of the primary care system is essential to ensure training and upskilling GPs to provide stigma-free care, and appropriate referral to AOD treatment.

While service provision in Tasmania is currently concentrated at the counselling and rehabilitation stages, there are opportunities to strengthen capacity in other critical areas, particularly in withdrawal management, residential rehabilitation, and structured aftercare. Strengthening cross-sector linkages is also essential, as individuals accessing AOD services often present with complex and overlapping needs. Enhancing integration between health, mental health, housing, and social support systems will be key to delivering more coordinated and effective care.

Through our Practice Incentives Program, and Quality Improvement Incentive Program, Primary Health Tasmania will work with general practices to improve assessment and management of people living with AOD 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 supporting organisations to develop culturally safe Aboriginal health services to respond to AOD issues in their communities.

6.5.3 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. 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 treatment concluded episodes of care and does not provide sufficient information about client-level information.

6.5.4 Harm reduction approaches

Harm reduction is a core element of the National Drug Strategy and Tasmania's AOD Reform Agenda. While Primary Health Tasmania does not directly commission harm reduction programs such as needle and syringe programs, pharmacotherapy, or take-home naloxone, we have an important role in supporting integration.

Primary Health Tasmania will work with commissioned providers to reduce these barriers by embedding harm reduction principles into treatment services, supporting trauma-informed and non-stigmatising care, and facilitating stronger connections with Tasmanian Government-funded harm reduction programs.

References

1. Australian Bureau of Statistics. Census of Population and Housing: Population data summary, 2021. Table 1: Population by sex by State and Territory [Dataset]. Canberra: ABS; 2022 [updated 28/06/2022; cited 2025 June 13]. Available from: https://www.abs.gov.au/statistics/people/population/population-census/2021/Population%20data%20summary.xlsx.
2. Australian Bureau of Statistics. Regional population, 2023-24. Population estimates and components by LGA. Table 6. Estimated resident population and components, Local Government Areas, Tasmania [Internet]. ABS. 2022-23 [updated 27/03/2025; cited 2025 July 02]. Available from: https://www.abs.gov.au/statistics/people/population/regional-population/latest-release.
3. Australian Bureau of Statistics. Estimates of Aboriginal and Torres Strait Islander Australians [Internet]. Canberra: ABS; 2021 June 30 [cited 2025 June 24]. Available from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release.
4. Australian Bureau of Statistics. 2021 Census All persons QuickStats. Language used at home, top responses (other than English) [Internet]. [Internet]. ABS. 2021 [cited 2025 24 June]. Available from: https://www.abs.gov.au/census/find-census-data/quickstats/2021/6.
5. Australian Bureau of Statistics. Regional population [Internet]. Canberra: ABS; 2023-24 [cited 2025 June 24]. Available from: https://www.abs.gov.au/statistics/people/population/regional-population/latest-release.
6. Australian Bureau of Statistics. Regional population by age and sex [Internet]. Canberra: ABS; 2023 [cited 2025 June 24]. Available from: https://www.abs.gov.au/statistics/people/population/regional-population-age-and-sex/latest-release.
7. Department of Treasury and Finance. Tasmanian and Local Government Area population projections – 2023 to 2053; Final report and results, 2024 [cited 2025 June 24]. Available from: https://www.treasury.tas.gov.au/Documents/TasPOPP%202024%20-%20Tasmanian%20and%20local%20government%20area%20population%20projections%202023%20to%202053%20-%20final%20report.pdf.
8. Department of State Growth. Tasmania's population growth strategy; Planning for our future. Tasmania: Department of State Growth; 2024 [cited 2025 June 24]. Available from: https://www.stategrowth.tas.gov.au/__data/assets/pdf_file/0020/526331/ACTIVE_-_Tasmanias_Population_Policy_2_July.pdf.
9. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings.Disability Tables; Table 1.3 proportion of persons with disability 2022, and 4.3 proportion of all persons, living in households, disability status, by age, sex at birth(a) and geographic location [Internet]. ABS. 2022 [cited 2025 June 24]. Available from: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release.
10. Australian Bureau of Statistics. Socio-Economic Indexes for Areas (SEIFA), Australia. Table 1 LGA SEIFA Summary, 2021 [Dataset]. Canberra: ABS; 2023 [updated 11/02/2025; cited 2025 June 24]. Available from: https://www.abs.gov.au/statistics/people/housing/experimental-index-household-advantage-and-disadvantage/latest-release.
11. Department of State Growth. Transport Access Strategy. Tasmania: Department of State Growth; Undated. p. 6.
12. Australian Institute of Health and Welfare. Health of people experiencing homelessness [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 June. 24]. Available from: https://www.aihw.gov.au/reports/australias-health/health-of-people-experiencing-homelessness.
13. Seastres RJ, Hutton J, Zordan R, Moore G, Mackelprang J, Kiburg KV, Sundararajan V. Long-term effects of homelessness on mortality: a 15-year Australian cohort study. Aust N Z J Public Health. 2020 Dec;44(6):476-481. doi: 10.1111/1753-6405.13038. Epub 2020 Sep 21. PMID: 32955766.
14. Australian Bureau of Statistics. Census of Population and Housing: Estimating Homelessness; Estimates of persons who were homeless or marginally housed as calculated from the Census of Population and Housing. Reference period 2021. 2023 [updated 22/03/2023. Available from: https://www.abs.gov.au/statistics/people/housing/census-population-and-housing-estimating-homelessness/latest-release.
15. Australian Institute of Health and Welfare. Chronic conditions [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 24]. Available from: https://www.aihw.gov.au/reports/australias-health/chronic-conditions.
16. Tasmanian Council of Social Service. Hello Tas! A toolkit for developing your community service organisation's health literacy. TasCOSS. 2024. Available from: https://www.hellotas.org.au/sites/default/files/files/HeLLOTas%20Toolkit.pdf.
17. Tasmanian Government, Department of Health. Health literacy action plan 2019–2024. Hobart, Tasmania: DoH; 2019.
18. Australian Bureau of Statistics. National Health Survey: Table 2.3 Summary Health Characteristics, by state and territories — All Persons, proportion. Canberra: ABS; 2022 [cited 2025 June 23]. Available from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/2022.
19. Australian Bureau of Statistics. Life expectancy [Internet]. Canberra: ABS; 2021-2023

[cited 2025 June 23]. Available from: https://www.abs.gov.au/statistics/people/population/life-expectancy/latest-release.
20. Australian Bureau of Statistics. Infant deaths and Infant mortality rates, Year of registration, Age at death, Sex, States, Territories and Australia Canberra: ABS; 2023 [cited 2025 June 23]. Available from: https://explore.data.abs.gov.au/vis?fs[0]=ABS%20Topics%2C2%7CPEOPLE%23PEOPLE%23%7CPopulation%23POPULATION%23%7CDeaths%23DEATHS%23&pg=0&fc=ABS%20Topics&df[ds]=ABS_ABS_TOPICS&df[id]=INFANTDEATHS_REGISTRATIONYEAR&df[ag]=ABS&df[vs]=1.0.0&pd=2009%2C&dq=9.3.IM.
21. Australian Bureau of Statistics. Causes of Death, Australia [Internet]. Canberra: ABS; 2023 [cited 2025 June 23]. Available from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release.
22. Australian Institute of Health and Welfare. Health system: Effectiveness. Potentially avoidable deaths. Potentially avoidable deaths, age-standardised rate (per 100,000 population) [Dataset]. Canberra: AIHW; 2023 [updated 03/06/2024; cited 2024 17 July]. Available from: https://www.aihw.gov.au/reports-data/australias-health-performance/australias-health-performance-framework/tas/tasmania/effectiveness/effectiveness?tab=2.1.6.
23. Australian Bureau of Statistics. National Health Survey: State and territory findings [Internet]. Canberra: ABS; 2022 [cited 2025 June 23]. Available from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-state-and-territory-findings/latest-release.
24. Australian Institute of Health and Welfare. Deaths in Australia [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 June 23]. Available from: https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia.
25. Dementia Australia. Dementia to become leading cause of death, prevention needed [media release]. 2024 Oct [cited 2025 Jun 23]. Available from: https://www.dementia.org.au/media-centre/media-releases/dementia-become-leading-cause-death-prevention-needed.
26. Australian Institute of Health and Welfare. Dementia in Australia [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 Jun. 23]. Available from: https://www.aihw.gov.au/reports/dementia/dementia-in-aus.
27. Dementia Australia. Chronic traumatic encephalopathy (CTE) dementia [updated 24 September 2024 , cited 2025 June 23]. Available from: https://www.dementia.org.au/about-dementia/chronic-traumatic-encephalopathy-cte-dementia.
28. COVID Live. COVID-19 statistics for Tasmania [Internet]. Australia: COVID Live; [cited 2025 August 02]. Available from: https://covidlive.com.au/tas.
29. Health Consumers Tasmania. Health Consumers Tasmania: Concerns and queries regarding COVID-19, 6–9 April 2020. Survey analysis report: Survey closed 30 April 2020. Health Consumers Tasmania; 2020.
30. Van Dam PJ, Caney D, Turner RC, Griffin P, Dwyer M, Prior S. Telehealth experiences of vulnerable clients living in Tasmania. Aust J Rural Health. 2022 Apr;30(2):188-196. doi: 10.1111/ajr.12835. Epub 2022 Jan 25. PMID: 35076149; PMCID: PMC9304290.
31. Australian Institute of Health and Welfare. Australia's health 2022: data insights. Chapter 2: Changes in the health of Australians during the COVID-19 period. Canberra: AIHW; 2022.
32. Australian Institute of Health and Welfare. Australia's health 2024: data insights [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 23]. Available from: https://www.aihw.gov.au/reports/australias-health/australias-health-2024-data-insights
33. Imran N, Aamer I, Sharif MI, Bodla ZH, Naveed S. Psychological burden of quarantine in children and adolescents: A rapid systematic review and proposed solutions. Pak J Med Sci. 2020 Jul-Aug;36(5):1106-1116. doi: 10.12669/pjms.36.5.3088. PMID: 32704298; PMCID: PMC7372688.
34. Australian Institute of Health and Welfare. The mental health impact of COVID-19 [Internet]. Canberra: AIHW; 2021 [cited 2025 August 04]. Available from: https://www.aihw.gov.au/getmedia/6e2c41a8-d849-44ea-ab16-6e7d75503a14/mental-health-impact-of-covid-19.pdf.aspx.
35. Australian Institute of Health and Welfare. Long COVID in Australia – a review of the literature [Internet]. AIHW Catalogue no. PHE 318; 2022 [cited 2025 June 23]. Available from: https://www.aihw.gov.au/getmedia/9592f439-9b96-4589-a55d-6b04e262e5e1/aihw-phe-318.pdf.aspx?inline=true.
36. Primary Health Tasmania. Internal analysis. General practice dataset from July 2024 to June 2025. Accessed 20 August 2025. 2025.
37. Australian Government, Department of health and Aged Care. Pertussis (whooping cough) [updated 12 July 2022, cited 2025 June 23]. Available from: https://www.health.gov.au/diseases/pertussis-whooping-cough?language=en#about-whooping-cough.
38. Australian Government Department of Health and Aged Care. Protect your baby from whooping cough: vaccinate for free when pregnant [Internet]. Canberra: Australian Government Department of Health and Aged Care; 2022 [cited 2025 Jun 23]. Available from: https://www.health.gov.au/sites/default/files/documents/2022/06/protect-your-baby-from-whooping-cough-vaccinate-for-free-when-pregnant-brochure-

brochure-protect-your-baby-from-whooping-cough-pamphlets.pdf.
39. Tasmanian Department of Health. Vaccine preventable diseases in Tasmania: Surveillance report 2024. Hobart (Australia): Department of Health; 2025 Jul. Available from: https://www.health.tas.gov.au/sites/default/files/2025-07/vaccine_preventable_diseases_in_tasmania_final_2024_accessible.pdf.
40. Australian Government Department of Health and Aged Care. Influenza (flu) vaccine [cited 2025 June 24]. Available from: https://www.health.gov.au/topics/immunisation/vaccines/influenza-flu-vaccine.
41. Australian Institute of Health and Welfare. Family, domestic and sexual violence: family and domestic violence [Internet]. Canberra: AIHW; [cited 2025 Jun 24]. Available from: https://www.aihw.gov.au/family-domestic-and-sexual-violence/types-of-violence/family-domestic-violence.
42. Australian Institute of Health and Welfare. Family, domestic and sexual violence Canberra: AIHW; 2023 [Available from: https://www.aihw.gov.au/reports/domestic-violence/family-domestic-and-sexual-violence.
43. Australian Bureau of Statistics. Recorded Crime - Victims. 5. Victims of family and domestic violence related offences. Table 35 Victims of family and domestic violence related sexual assault, Selected characteristics, States and territories, 2023 (Dataset). Canberra: ABS; 2023 [updated 27/06/2024, cited 2025 June 24]. Available from: https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-victims/latest-release.
44. Australian Bureau of Statistics. Personal Safety, Australia [Internet]. Canberra: ABS; 2021-22 [cited 2025 September 9]. Available from: https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release.
45. Tasmania Police. Corporate Performance Report June 2024 [Internet]. Hobart: Tasmania Police; 2024 [cited 2025 June 24]. Available from: https://www.police.tas.gov.au/uploads/Corporate-Performance-Report-June-2024.pdf.
46. Australian Institute of Health and welfare. Risk factors [updated 2024 June 13, cited 2025 June 24]. Available from: https://www.aihw.gov.au/reports-data/behaviours-risk-factors/risk-factors/overview.
47. Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century. Understanding population health and its determinants. The Future of the Public's Health in the 21st Century. 2002 Jun 1:2.Available from: https://www.ncbi.nlm.nih.gov/books/NBK221225/.
48. Australian Government, Australian Institute of Health and Welfare. Climate change and environmental health indicators: reporting framework [cited 2025 June 24]. Available from: https://www.aihw.gov.au/getmedia/d249dc5d-7c5f-47ec-9b78-da765d00a2fe/aihw-phe-343-climate-change-and-environmental-health-indicators.pdf?v=20240515111427&inline=true.
49. Thomson MC, Stanberry LR. Climate Change and Vectorborne Diseases. N Engl J Med. 2022 Nov 24;387(21):1969-1978. doi: 10.1056/NEJMra2200092. PMID: 36416768.
50. Australian Government, Department of Health and Aged Care. Environmental toxins and contaminants [cited 2025 June 24]. Available from: https://www.health.gov.au/topics/environmental-health/about/environmental-toxins-and-contaminants.
51. Australian Institute of Health and Welfare. Head injuries in Australia 2020–21 [Internet]. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2025 June 24]. Available from: https://www.aihw.gov.au/reports/injury/head-injuries-in-australia-2020-21.
52. National Institute of Neurological Disorders and Stroke (NINDS). Traumatic Brain Injury (TBI) [Internet]. Bethesda (MD): NINDS; published 8 months ago [cited 2025 Jun 24]. Available from: https://www.ninds.nih.gov/health-information/disorders/traumatic-brain-injury-tbi.
53. Gardner, R.C., Burke, J.F., Nettiksimmons, J., Goldman, S., Tanner, C.M. and Yaffe, K., 2015. Traumatic brain injury in later life increases risk for P arkinson disease. Annals of neurology, 77(6), pp.987-995.
54. Johansson, E., Alfredsson, L., Strid, P., Kockum, I., Olsson, T. and Hedström, A.K., 2024. Head trauma results in manyfold increased risk of multiple sclerosis in genetically susceptible individuals. Journal of Neurology, Neurosurgery & Psychiatry, 95(6), pp.554-560.
55. Australian Medical Association. AMA Position Statement: Primary Health Care - 2021: AMA; 2021 [updated July 2021]. Available from: https://www.ama.com.au/sites/default/files/2021-09/Primary%20Health%20Care%20-%202021%20-%20Final_0.pdf.
56. Australian Institute of Health and Welfare. Medicare-subsidised GP, allied health and specialist health care across local areas [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 October 29]. Available from: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-specialist.
57. Australian Bureau of Statistics. Patient Experiences. Health service use. Canberra: ABS; 2022-23 [cited 2024 July 24]. Available from: https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release.
58. Australian Government Department of health and Aged care. Supply and demand study general Practitioners in Australia August 2024 [cited 2025 June 24]. Available from: https://hwd.health.gov.au/resources/primary/gp-supply-and-demand-study-compendium-august-2024.pdf.
59. Primary Health Tasmania. Internal analysis. Public hospital admissions 2011-2024, Tasmania. 2025.

60. Primary Health Tasmania. Internal analysis. Emergency department presentations 2011-2024, Tasmania. 2025.
61. Primary Health Tasmania. Internal Analysis. Medicare Urgent Care Clinics dataset. Accessed 30 July 2025. 2025.
62. Palliative Care Australia. What is palliative care? [Internet]. Canberra: Palliative Care Australia; [cited 2025 Jun 25]. Available from: https://palliativecare.org.au/resource/what-is-palliative-care/.
63. Tasmanian Government Department of Health. Tasmanian Palliative Care Policy Framework 2022-27. Tasmanian Palliative and End of Life Care Policy Framework 2022–27 [cited 2025 June 24]. Available from: https://www.health.tas.gov.au/sites/default/files/2022-11/doh8653_palliative_care_policy_framework_web38.pdf.
64. Swerissen H, Duckett S. Dying well. Carlton: Grattan Institute; 2014.
65. Parliament of Tasmania. Inquiry into palliative care. Hobart: House of Assembly Standing Committee on Community Development; 2017.
66. Australian Government Productivity Commission. Report on Government Services 2025: Part F, Section 14 – Aged Care Services [Internet]. Canberra: Productivity Commission; 2025 [cited 2025 June 25]. Available from: https://www.pc.gov.au/ongoing/report-on-government-services/2025/community-services/aged-care-services.
67. Australian Institute of Health and Welfare. Older Australians [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 25]. Available from: https://www.aihw.gov.au/reports/older-people/older-australians.
68. Australian Institute of Health and Welfare. GEN data: People using aged care by region [Internet]. Canberra: AIHW; 2025 Apr 30 [cited 2025 June 25]. Available from: https://www.gen-agedcaredata.gov.au/resources/access-data/2025/april/gen-data-people-using-aged-care-by-region.
69. Australian Institute of Health and Welfare. Aged care service list: 30 June 2024 [Internet]. Canberra: AIHW; 2024 Sep 27 [cited 2025 June 25]. Available from: https://www.gen-agedcaredata.gov.au/resources/access-data/2024/september/aged-care-service-list-30-june-2024.
70. Australian Government Productivity Commission. Report on Government Services 2024. 14 Aged care services data tables. Table 14A.33 Elapsed time between Aged Care Assessment Team (ACAT) approval and entry into residential aged care services, all permanent residents [cited 2025 June 25]. Available from: rogs-2024-partf-section14-aged-care-data-tables.xlsx (live.com)
71. Australian Government Department of Health and Aged Care. Home Care Packages Program – Data Report 2nd Quarter 2024–25 [Internet]. Canberra: Department of Health and Aged Care; 2025 Feb 26 [cited 2025 June 25]. Available from: https://www.gen-agedcaredata.gov.au/getmedia/c2339cbc-3e13-4893-9d03-9ca43ecdc55f/Home-Care-Packages-Program-Data-Report-2nd-Qtr-2024-2025.
72. Australian Institute of Health and Welfare. Medicare-subsidised GP, allied health and specialist health care across local areas: 2022-23 [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 25]. Available from: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23.
73. Australian Institute of Health and Welfare. Residential aged care quality indicators – October to December 2024 [Internet]. Canberra: AIHW; 2025 Mar 18 [cited 2025 June 25]. Available from: https://www.gen-agedcaredata.gov.au/resources/publications/2025/march/residential-aged-care-quality-indicators-%E2%80%93-october-to-december-2024.
74. Sluggett JK, Lalic S, Hosking SM, Ritchie B, McLoughlin J, Shortt T, et al. Root cause analysis to identify medication and non-medication strategies to prevent infection-related hospitalizations from Australian residential aged care services. International Journal of Environmental Research and Public Health. 2020;17(9):3282.
75. Australian Government Department of Health and Aged Care. Managing infectious diseases in aged care [Internet]. Canberra: Department of Health and Aged Care; 2025 Jun 4 [cited 2025 June 25]. Available from: https://www.health.gov.au/topics/aged-care/providing-aged-care-services/training-and-guidance/managing-infectious-diseases.
76. Stuart R, Wilson J, Bellaard‐Smith E, Brown R, Wright L, Vandergraaf S, et al. Antibiotic use and misuse in residential aged care facilities. Internal medicine journal. 2012;42(10):1145-9.
77. Yoshikawa TT, Reyes BJ, Ouslander JG. Sepsis in older adults in long‐term care facilities: challenges in diagnosis and management. Journal of the American Geriatrics Society. 2019;67(11):2234-9.
78. Australian Bureau of Statistics. Tasmania. 2021 Census All persons QuickStats. Canberra: ABS; 2021 [cited 2025 May 28]. Available from: https://www.abs.gov.au/census/find-census-data/quickstats/2021/6.
79. Australian Institute of Health and Welfare. Falls [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 May 28]. Available from: https://www.aihw.gov.au/reports/injury/falls.
80. Council of the aging (COTA) Tasmania. Embracing the Future: Tasmania's Ageing Profile Part II, [cited 2025 June 4]. Available from: Embracing the Future: Part 2 (cotatas.org.au).
81. Australian Bureau of Statistics. Regional population by age and sex. Statistics about the population by age and sex for Australia's capital

cities and regions. Tasmania. Table 3. Estimated resident population by age, Local Government Areas, persons – 30 June 2023. Canberra: ABS; 2023 [cited 2025 June 04]. Available from: https://www.abs.gov.au/statistics/people/population/regional-population-age-and-sex/latest-release.
82. Australian Bureau of Statistics. Census GeoPackages. Geopackage for Tasmania by LGA 2021. Available from: https://www.abs.gov.au/census/find-census-data/geopackages.
83. Australian Institute of Health and Welfare 2024. Aboriginal and Torres Strait Islander Health Performance Framework: summary report August 2024. AIHW: Australian Government. Accessed [2025 July 04]. Available from: https://www.indigenoushpf.gov.au/report-overview/overview/summary-report
84. Australian Institute of Health and Welfare. Determinants of health for First Nations people [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2024 July 03]. Available from: https://www.aihw.gov.au/reports/australias-health/social-determinants-and-indigenous-health
85. Australian Bureau of Statistics. Snapshot of Tasmania. Canberra: ABS; 2022 June 28 [cited 2025 June 04]. Available from: https://www.abs.gov.au/articles/snapshot-tas-2021.
86. Australian Institute of Health and Welfare. Australia's health 2018. 5.3 Culturally and linguistically diverse populations, Chapter 5 Health of population groups. Available from: https://www.aihw.gov.au/getmedia/f3ba8e92-afb3-46d6-b64c-ebfc9c1f945d/aihw-aus-221-chapter-5-3.pdf.aspx.
87. Tasmanian Government Department of Health. The State of Public Health Report 2018. Available from: The_State_of_Public_Health_Tasmania_2018_DoH Tasmania2018.pdf.
88. Australian Bureau of Statistics. Homelessness – Measuring What Matters [Internet]. Canberra: ABS; 2024 [cited 2025 Jun 16]. Available from: https://www.abs.gov.au/statistics/measuring-what-matters/measuring-what-matters-themes-and-indicators/secure/homelessness.
89. Australian Institute of Health and Welfare. Specialist Homelessness Services: monthly data [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 June 16]. Available from: https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-monthly-data.
90. Homes Tasmania. Homes Tasmania Dashboard: September 2025 [Internet]. Homes Tasmania; 2025 [cited 2025 November 5]. Available from: https://www.homestasmania.com.au/__data/assets/pdf_file/0028/287722/Homes-Tasmania-Dashboard-September-2025.pdf.
91. Australian Institute of Health and Welfare. Specialist homelessness services annual report 2023–24 [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 June 16]. Available from: https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report.
92. Centre for Social Impact. Atlas of Homelessness 2021: Australia by LGA Areas [Internet]. Sydney: Centre for Social Impact; 2023 [cited 2025 June 11]. Available from: https://assets.csi.edu.au/assets/Atlas-Census-2021-Australia-by-LGA-Areas-V1.0.pdf.
93. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings [Internet]. Canberra: ABS; 2022 [cited 2025 June 19]. Available from: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release.
94. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings. Disability Tables 4.1, and 4.4 Table 4 All persons, living in households, disability status, by age, sex at birth(a) and geographic location: Estimate, and Proportions. Canberra: ABS; 2022 [cited 2025 June 19]. Available from: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release.
95. National Disability Insurance Scheme (NDIS). Intellectual Disability . Quarterly datasets for Intellectual Disability to 31 March 2025 [cited 2025 June 04]. Available from: https://dataresearch.ndis.gov.au/reports-and-analyses/participant-dashboards/intellectual-disability.
96. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings. Table 25.3 Persons aged 65 years and over, need for assistance, by age and activity type—2018, proportion of all persons [Dataset]. Canberra: ABS; 2020 [updated 05/02/2020; cited 2022 30 Sep]. Disability, Ageing and Carers, Australia: Summary of Findings, 2018. Available from: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release#data-download.
97. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings. Disability Tables Table 19 Persons aged 15 years and over with disability, living in households, whether has experienced discrimination due to disability in the last 12 months(a): Proportion. Canberra: ABS; 2022 [cited 2025 June 23]. Available from: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release.
98. Australia Government Department of Health and Aged care. Health Workforce Locator. Tasmania [cited 2025 June 04]. Available from: https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app?language=en.

99. Parliament of Tasmania. Rural health services in Tasmania report 2022 [cited 2025 June 04]. Available from: final20report20sub-committee20rural20health20services20in20tasmania202520october202022.pdf (parliament.tas.gov.au).
100. Australian Bureau of Statistics. Socio-economic Indexes for Areas (SEIFA). [cited 2025 4 June]. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release#cite-window1.
101. Australian Bureau of Statistics. Patient Experiences [Internet]. Canberra: ABS; 2023-24 [cited 2025 June 16]. Available from: https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release.
102. Australian Institute of Health and Welfare. Social determinants of health [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 16]. Available from: https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health.
103. First steps into healthcare needs assessment: An environmental scan of the health needs, service use and gaps for Tasmanians in their first 2000 days of life report 2024 [cited 2024 6 Sep].
104. Australian Institute of Health and Welfare. Health of young people. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 16]. Available from: https://www.aihw.gov.au/reports/children-youth/health-of-young-people.
105. Australian Institute of Health and Welfare. Australia's children. Canberra: Australian Institute of Health and Welfare, 2022 [cited 2025 June 16]. Available from: https://www.aihw.gov.au/reports/children-youth/australias-children.
106. Australian Bureau of Statistics. National Health Survey [Internet]. Canberra: ABS; 2022 [cited 2025 June 17]. Available from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/latest-release.
107. Australian Bureau of Statistics. Estimates and characteristics of LGBTI+ populations in Australia [Internet]. Canberra: ABS; 2022 [cited 2025 June 11]. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/estimates-and-characteristics-lgbti-populations-australia/2022.
108. Dwyer A, Grant R, Mason R, Barnes A. LGBTIQ+ Tasmanians: Telling Us the Story Final Report December 2021 [Internet]. Available from: LGBTIQ-Tasmanians-Telling-Us-the-Story-Survey-Report-May-2022.pdf.
109. Heredia D, Pankey TL, Gonzalez CA. LGBTQ-Affirmative Behavioural Health Services in Primary Care. Prim Care. 2021;48(2):243-57.
110. Garg P, Ha M, Eastwood J, Harvey S, Woolfenden S, Murphy E, et al. Explaining culturally and linguistically diverse (CALD) parents' access of healthcare services for developmental surveillance and anticipatory guidance: qualitative findings from the 'Watch Me Grow' study. BMC Health Serv Res. 2017;17(1):228.
111. Heredia D, Pankey TL, Gonzalez CA. LGBTQ-affirmative behavioral health services in primary care. Primary Care: Clinics in Office Practice. 2021;48(2):243-57.
112. Department of Health and Aged Care. Current coverage data tables for all children (annual period ending December 2023) [Internet]. Canberra: Department of Health and Aged Care; 2023 [updated 08/04/2024; cited 2024 12 July]. Available from: https://www.health.gov.au/node/38782/childhood-immunisation-coverage/current-coverage-data-tables-for-all-children.
113. Department of Health and Aged Care. Current coverage data tables for Aboriginal and Torres Strait Islander children (annual period ending December 2023) [Dataset]. Canberra: Department of Health and Aged Care; 2023 [cited 2025 June 16]. Available from: https://www.health.gov.au/topics/immunisation/immunisation-data/childhood-immunisation-coverage/current-coverage-data-tables-for-aboriginal-and-torres-strait-islander-children#five-year-olds.
114. National Centre for Immunisation Research and Surveillance (NCIRS). Annual Immunisation Coverage Report 2023 [Internet]. Sydney: NCIRS; 2024 [cited 2025 June 16]. Available from: https://ncirs.org.au/sites/default/files/2024-10/NCIRS%20Annual%20Immunisation%20Coverage%20Report%202023.pdf
115. Australian Institute of Health and Welfare. Health of people experiencing homelessness [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 June 19]. Available from: https://www.aihw.gov.au/reports/australias-health/health-of-people-experiencing-homelessness
116. Mission Australia. Understanding mental health and homelessness [Internet]. Sydney: Mission Australia; [cited 2025 June 17]. Available from: https://www.missionaustralia.com.au/stories/safe-homes/understanding-mental-health-and-homelessness.
117. Australian Institute of Health and Welfare. Rural and remote health [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 19]. Available from: https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health.
118. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings, 2015 [Internet]. Canberra: ABS; 2016 [cited 2025 June 19]. Available from: https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features1022015?OpenDocument.
119. Australian Institute of Health and Welfare. Older Australians [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 19]. Available from:

https://www.aihw.gov.au/reports/older-people/older-australians.
120. Australian Institute of Health and Welfare. Dementia in Australia [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 19]. Available from: https://www.aihw.gov.au/reports/dementia/dementia-in-aus.
121. Australian Institute of Health and Welfare. Dementia in Australia. Table S2.6: Australians living with dementia in 2022: estimated number by sex, and geographic or socioeconomic area [Dataset]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 19]. Available from: https://www.aihw.gov.au/reports/dementia/dementia-in-aus
122. Australian Bureau of Statistics. Causes of Death, Australia. Statistics on the number of deaths, by sex, selected age groups, and cause of death classified to the International Classification of Diseases (ICD). Underlying causes of death (Tasmania). Table 7.1 Underlying cause of death, All causes, Tasmania, 2020. [Dataset]. Canberra: ABS; 2022 [updated 10/10/2024; cited 2025 June 23]. Available from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#data-download.
123. Global Burden of Disease Dementia Forecasting Collaborators. Estimation of the global prevalence of dementia in 2019 and forecasted prevalence in 2050: an analysis for the Global Burden of Disease Study 2019. Lancet Public Health. 2022;7(2):e105-e25.
124. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings. Data downloads: Carers tables. Table 34.3 All persons, living in households, carer status, by geographic location, age and sex at birth(a): Proportion. Canberra: ABS; 2022 [cited 2025 June 19]. Available from: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release.
125. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings. Table 43.3 Primary carers, reasons for taking on caring role(a) and sex at birth(b) of primary carer, by age of main recipient of care: Proportion. Canberra: ABS; 2022 [cited 2025 June 19]. Available from: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release.
126. Cox J, Dyke H, Martino R, Edwards L. Report on the Tasmanian Population Health Survey 2022. Hobart: Department of Health, Tasmania; 2023.
127. Australian Government Productivity Commission. Report on Government Services 2024. 14 Aged care services data tables. Table 14A.23 Representation of older people from Culturally and Linguistically Diverse (CALD) backgrounds in the aged care target population and in aged care recipients [cited 2025 June 19]. Available from: 14 Aged care services - Report on Government Services 2024 - Productivity Commission (pc.gov.au).
128. PHIDU. Social Health Atlas of Older People in Australia. 2023. [Cited: 2025 June 19]. Available from: https://phidu.torrens.edu.au/social-health-atlases/topic-atlas#social-healthatlas-of-older-people-in-australia.
129. Australian Government Productivity Commission. Report on Government Services 2024. Part F, Section 14 Aged care services data tables. Table 14A.25 Representation of older people receiving services from providers located in rural and remote areas in the aged care target population and in aged care recipients [cited 2025 June 19]. Available from: 14 Aged care services - Report on Government Services 2024 - Productivity Commission (pc.gov.au).
130. National Disability Insurance Agency. Quarterly reports [Internet]. Canberra (AU): NDIA; [cited 2025 June 19]. Available from: https://www.ndis.gov.au/publications/quarterly-reports.
131. National Disability Insurance Scheme. NDIS Explore Data] March 2025. [Cited: 2025 June 19]. Available from: https://data.ndis.gov.au/explore-data.
132. Australian Health Ministers' Advisory Council. National Strategic Framework for Chronic Conditions. Canberra: Australia Government; 2017.
133. Australian Government Department of Health. Chronic conditions in Australia [Internet]. Canberra: Department of Health; 2024 [cited 2025 June 23]. Available from: https://www.health.gov.au/health-topics/chronic-conditions/chronic-conditions-in-australia.
134. Australian Institute of Health and Welfare. Australia's health 2024: in brief [Internet]. Canberra (AU): AIHW; 2024 [cited 2025 June 03]. Report No.: AUS 249. Available from: https://www.aihw.gov.au/getmedia/6b19e493-0ebe-420f-a9a3-e48b26aace9f/aihw-aus-249-ib.pdf?v=20240715154739&inline=true.
135. Australian Bureau of Statistics. National Health Survey: First Results, 2022 – Australia. Table 2: Summary health characteristics, 2022- states and territories. Table 2.1 Summary health characteristics — States and territories, Persons [Dataset]. Canberra: ABS; 2022 [cited 2025 June 03]. Available from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/2022.
136. Australian Bureau of Statistics. National Health Survey: First Results, 2022 – Australia. Table 2: Summary health characteristics, 2022 - states and territories. Table 2.3 Summary health characteristics — States and territories, Proportion of persons [Dataset]. Canberra: ABS; 2022 [cited 2025 June 03]. Available from:https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/2022.
137. Australian Institute of Health and Welfare. Cancer screening programs: quarterly data.

Canberra: Australian Institute of Health and Welfare, 2023 [cited 2025 June 03]. Available from: https://www.aihw.gov.au/reports/cancer-screening/national-cancer-screening-programs-participation
138. Australian Institute of Health and Welfare. BreastScreen Australia monitoring report 2024. Canberra: AIHW; 2024.
139. Australian Institute of Health and Welfare. National Cervical Screening Program monitoring report 2024. Canberra: AIHW; 2024. doi:10.25816/1smm-mp67.
140. Australian Institute of Health and Welfare. National Bowel Cancer Screening Program monitoring report 2024. Canberra: AIHW; 2024.
141. Cancer Council Australia. How sexual assault survivors can feel in control during cervical screenings [Internet]. Sydney: Cancer Council Australia; 2020 Nov 1 [cited 2025 June 03]. Available from: https://www.cancer.org.au/blog/how-sexual-assault-survivors-can-feel-in-control-during-cervical-screenings.
142. Australian Institute of Health and Welfare. Behaviours & risk factors [Internet]. Canberra: AIHW; 2024 Mar 25 [cited 2025 June 03]. Available from: https://www.aihw.gov.au/reports-data/behaviours-risk-factors.
143. Australian Bureau of Statistics. Smoking and vaping. Canberra: ABS; 2022 [cited 2025 June 03]. Available from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/smoking-and-vaping/latest-release.
144. Joshy G, Soga K, Thurber KA, Egger S, Weber MF, Sarich P, Welsh J, Korda RJ, Yazidjoglou A, Nguyen MTH, Paige E, Gourley M, Canfell K, Banks E. Relationship of tobacco smoking to cause-specific mortality: contemporary estimates from Australia. BMC Med. 2025 Feb 25;23(1):115. doi: 10.1186/s12916-025-03883-9. PMID: 39994694; PMCID: PMC11854379.
145. Australian Bureau of Statistics. Insights into Australian smokers, 2021-22 [Internet]. Canberra: ABS; 2022 December 5 [cited 2025 June 04]. Available from: https://www.abs.gov.au/articles/insights-australian-smokers-2021-22.
146. Kalitsis, L, Greenhalgh, EM and Winnall, W. 3.30 Burden of death and disease attributable to tobacco use in Australia. In Greenhalgh, EM, Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. Melbourne : Cancer Council Victoria; 2025. Available from https://www.tobaccoinaustralia.org.au/chapter-3-health-effects/3-30-total-burden-of-death-and-disease-attributable-to-tobacco-by-disease-category.
147. Greenhalgh, EM, Bayly, M, Kalitsis, L and Scollo, M. 1.13 Smoking by Australian states and territories. In Greenhalgh, EM, Bayly, M and Scollo, MM [editors]. Tobacco in Australia: Facts and issues. Melbourne : Cancer Council Victoria; 2025. Available from https://www.tobaccoinaustralia.org.au/chapter-1-prevalence/1-13-smoking-states-territories.
148. Greenhalgh, EM , Jenkins, S , EM, Bain and Scollo, MM. 18.3 Prevalence of e-cigarette use. In Greenhalgh, EM , Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. Melbourne : Cancer Council Victoria; 2025. Available from https://www.tobaccoinaustralia.org.au/chapter-18-e-cigarettes/18-3-prevalence-of-e-cigarette-use.
149. Australian Institute of Health and Welfare. Measuring risky drinking according to the Australian alcohol guidelines [Internet]. Canberra: Australian Institute of Health and Welfare, 2021 [cited 2025 June 05]. Available from: https://www.aihw.gov.au/reports/alcohol/measuring-risky-drinking-aus-alcohol-guidelines.
150. Australian Institute of Health and Welfare. Alcohol-related injury: hospitalisations and deaths, 2019–20 [Internet]. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2025 June 05]. Available from: https://www.aihw.gov.au/reports/injury/alcohol-related-injuries-2019-20.
151. Australian Government Department of Health and Aged Care. What are the effects of alcohol? [Internet]. Canberra: Australian Government; [cited 2025 June 05]. Available from: https://www.health.gov.au/topics/alcohol/about-alcohol/what-are-the-effects-of-alcohol.
152. Australian Institute of Family Studies. Alcohol use: Snapshot 3 [Internet]. Canberra: AIFS; 2024 Jun [cited 2025 June 05]. Available from: https://aifs.gov.au/sites/default/files/2024-06/2024_TTM_Snapshot_3_Alcohol%20use.pdf.
153. Australian Bureau of Statistics. National Health Survey [Internet]. Canberra: ABS; 2022 [cited 2025 June 04]. Available from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/2022.
154. Gabb GM, Mangoni AA, Anderson CS, Cowley D, Dowden JS, Golledge J, Hankey GJ, Howes FS, Leckie L, Perkovic V, Schlaich M, Zwar NA, Medley TL, Arnolda L. Guideline for the diagnosis and management of hypertension in adults - 2016. Med J Aust. 2016 Jul 18;205(2):85-9. doi: 10.5694/mja16.00526. PMID: 27456450.
155. The Tasmanian Council for Social Service. Preventing hospitalisations in Tasmania, 2020/2021: TasCOSS Budget Priorities Statement. Hobart: TasCOSS; 2020.
156. Australian Institute of Health and Welfare. Physical health of people with mental illness [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 05]. Available from: https://www.aihw.gov.au/reports/mental-health/physical-health-of-people-with-mental-illness.
157. Australian Government, Department of Health. General Practice Workforce providing Primary Care services in Australia Canberra: Department of Health; 2023 [cited 2025 June 05]. Available from:

https://hwd.health.gov.au/resources/data/gp-primarycare.html.
158. The Royal Australian College of General Practitioners. General Practice: Health of the Nation 2023. East Melbourne, Vic: RACGP, 2023 Health-of-the-Nation-2023.pdf.aspx (racgp.org.au).
159. Primary Health Tasmania. Internal analysis. General practice dataset from July 2019 to June 2025. Accessed 09 July 2025. 2025.
160. Australian Government. Medicare Item Reports. Canberra: Services Australia; 2025 [cited 2025 June 05]. Available from: https://medicarestatistics.humanservices.gov.au/statistics/mbs_item.html.
161. Australian Government, Department of Health and Aged Care. Medicare statistics – per patient bulk billing dashboard 2023-24 [cited 2025 June 05]. Available from: https://www.health.gov.au/resources/publications/medicare-statistics-per-patient-bulk-billing-dashboard-2023-24?language=en.
162. Australian Bureau of Statistics. Patient Experiences in Australia by small geographic areas in 2019-20. Tab 16, Percentage of adults who did not see or delayed seeing a GP due to cost in the preceding 12 months, by Primary Health Network (PHN) area [Internet]. Canberra: ABS; 2021 [updated 03/09/2021; cited 2023 26 Sep]. Available from: https://www.aihw.gov.au/reports/primary-health-care/patient-experiences-small-geographic-areas-2018-19/data.
163. Australian Bureau of Statistics. Patient Experiences [Internet]. Canberra: ABS; 2023-24 [cited 2025 June 05]. Available from: https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release.
164. Australian Government. Chronic disease management patient information. Canberra: Department of Health; 2014 [updated 14/03/2014; cited 2021 13 Jun]. Available from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdisease-pdf-infosheet.
165. Australian Institute of Health and Welfare. Use of chronic disease management and allied health Medicare services [Internet]. Canberra: Australian Institute of Health and Welfare, 2022 [cited 2024 15 Jul]. Available from: https://www.aihw.gov.au/reports/chronic-disease/medicare-chronic-disease-allied-health-items
166. Australian Institute of Health and Welfare. Australia's hospitals at a glance. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 04]. Available from: https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance.
167. Primary Health Tasmania. Internal analysis. Emergency department presentations 2010-2024, Tasmania. 2025.
168. Purdey S, Huntley A. Predicting and preventing avoidable hospital admissions: a review. The journal of the Royal College of Physicians of Edinburgh. 2013;43(4):340-4.
169. Steering Committee for the Review of Government Service Provision. Report on Government Services 2025: Part E, Section 10 – Primary and community health, data tables [Internet]. Canberra: Productivity Commission; 2025 Feb 6 [cited 2025 June 06]. Available from: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.pc.gov.au%2Fongoing%2Freport-on-government-services%2F2025%2Fhealth%2Fprimary-and-community-health%2Frogs-2025-parte-section10-primary-and-community-health-data-tables.xlsx.
170. Australian Institute of Health and Welfare. Coordination of health care: patient and primary care factors associated with potentially preventable hospitalisations for chronic conditions. Canberra: AIHW; 2022. doi:10.25816/yb6m-ck29.
171. Australian Institute of Health and Welfare. Endometriosis. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2025 June 06]. Available from: https://www.aihw.gov.au/reports/chronic-disease/endometriosis-in-australia.
172. Australians Together. Who are indigenous Australians? [Internet]. Fullarton, SA: Australians Together; 2021 [cited 2025 June 06]. Available from: https://australianstogether.org.au/discover/the-wound/who-are-indigenous-australians/.
173. Tasmanian Government. Department of Premier and Cabinet. Diversity & inclusion info sheet: respectful language Aboriginal and Torres strait islander respectful language guidelines [cited in 2025 June 06]. Available from: https://www.dpac.tas.gov.au/__data/assets/pdf_file/0026/186812/Aboriginal_-_Respectful_Language_Fact_Sheet_FINAL.pdf.
174. Australian Government. Style Manual. Accessible and inclusive content. Inclusive language: Aboriginal and Torres Strait Islander peoples [cited 2025 June 06]. Available from: https://www.stylemanual.gov.au/accessible-and-inclusive-content/inclusive-language/aboriginal-and-torres-strait-islander-peoples.
175. Australian Bureau of Statistics. Census of Population and Housing - Counts of Aboriginal and Torres Strait Islander Australians [Internet]. Canberra: ABS; 2021 [cited 2025 June 06]. Available from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/census-population-and-housing-counts-aboriginal-and-torres-strait-islander-australians/latest-release.
176. Australian Bureau of Statistics. Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016', Aboriginal and Torres Strait Islander Population – Tasmania Canberra: ABS; 2019 [Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20-%20Tasmania~10006.

177. Australian Institute of Health and Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework [Internet]. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2025 June 06]. Available from: https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework.
178. Australian Government, Australian Institute of Health and Welfare, National Indigenous Australians Agency. Aboriginal and Torres Strait Islander Health Performance Framework. 4. Tier 1 – Health status and outcomes Leading causes of disease burden and mortality [cited 2025 June 06]. Available from: https://www.indigenoushpf.gov.au/report-overview/overview/summary-report/4-tier-1-%E2%80%93-health-status-and-outcomes/leading-causes-of-disease-burden-and-mortality.
179. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey [Internet]. Canberra: ABS; 2022-23 [cited 2025 June 06]. Available from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release.
180. Australian Institute of Health and Welfare. Health and wellbeing of First Nations people [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 June 06]. Available from: https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing.
181. Australian Institute of Health and Welfare. First Nations people – Suicide & self-harm monitoring [Internet]. Canberra: AIHW; [cited 2025 June 06]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/first-nations-people.
182. Australian Commission on Safety and Quality in Health Care. Action 1.21: Improving cultural competency [Internet]. Sydney: ACSQHC; [cited 2025 June 06]. Available from: https://www.safetyandquality.gov.au/standards/national-safety-and-quality-health-service-nsqhs-standards/resources-nsqhs-standards/user-guide-aboriginal-and-torres-strait-islander-health/action-121-improving-cultural-competency**[1](https://www.safetyandquality.gov.au/standards/national-safety-and-quality-health-service-nsqhs-standards/resources-nsqhs-standards/user-guide-aboriginal-and-torres-strait-islander-health/action-121-improving-cultural-competency).
183. National Centre for Aboriginal and Torres Strait Islander Wellbeing Research. Mental health and wellbeing in the lead up to the Voice to Parliament Referendum: Factsheet for organisations Canberra: ANU; 2023 [Available from: https://nceph.anu.edu.au/files/Factsheet%20for%20Organisations_0.pdf.
184. Wilkes, B., Hasan, M., Thandrayen, J., Colonna, E., Evans, O., McKay, C., Nguyen, M. T. H., Sedgwick, M., Thurber, K. A., Lovett, R. (2024). Research summary: Aboriginal and Torres Strait Islander mental health and wellbeing in the lead up to the Voice to Parliament Referendum. National Centre for Aboriginal and Torres Strait Islander Wellbeing Research, Australian National University. Research Summary_Referendum mental health project_March2024.pdf
185. Wilkes B, Hasan M, Thandrayen J, Colonna E, Evans O, McKay C, et al. Report 1: Focus groups – Aboriginal and Torres Strait Islander mental health and wellbeing in the lead up to the Voice to Parliament Referendum [Internet]. Canberra: National Centre for Epidemiology and Population Health, Australian National University; 2024 [cited 2025 June 06]. Available from: https://nceph.anu.edu.au/files/Referendum%20Mental%20Health_Report%201_Focus%20Groups.pdf.
186. Australian Institute of Health and Welfare. Admitted patient. Admitted patient care 2023–24 3: Who used these services. Table S3.7: Separations, by Indigenous status, public and private hospitals, states and territories, 2023–24 [cited 2025 June 06]. Available from: https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients.
187. Australian Government Productivity Commission. Report on Government Services 2024. Part E, Section 10 Primary and community health 2024. Table 10A.66 Separations for selected potentially preventable hospitalisations by Indigenous status (per 1,000 people) [cited 2025 June 06]. Available from: https://www.pc.gov.au/ongoing/report-on-government-services/2024/health/primary-and-community-health.
188. Australian Institute of Health and Welfare & National Indigenous Australians Agency. Measure 3.07 Selected potentially preventable hospital admissions, Aboriginal and Torres Strait Islander Health Performance Framework website [Internet]. Canberra: Australian Institute of Health and Welfare & National Indigenous Australians Agency, 2024 [cited 2025 June 06]. Available from: https://www.indigenoushpf.gov.au/measures/3-07-potentially-preventable-hospital-admissions.
189. Australian Institute of Health and Welfare. 1.02 Top reasons for hospitalisation [Internet]. Canberra: AIHW; 2023 Jan [cited 2025 June 06]. Available from: https://www.indigenoushpf.gov.au/getmedia/7eed510c-1fd0-4373-bdfb-c7a92e58fffa/102-top-reasons-hospitalisation-jan-23.xlsx.
190. Australian Institute of Health and Welfare & National Indigenous Australians Agency. Measure 3.17 Regular general practitioner or health service, Aboriginal and Torres Strait Islander Health Performance Framework website [Internet]. Canberra: Australian Institute of Health and Welfare & National Indigenous Australians Agency, 2020 [cited 2025 June 06]. Available from: https://www.indigenoushpf.gov.au/measures/3-17-regular-gp-health-service.
191. Productivity Commission. Aboriginal and Torres Strait Islander people enjoy long and healthy

lives – Dashboard. Closing the Gap Information Repository. Canberra: Productivity Commission; 2025 [cited 2025 June 06]. Available from: https://www.pc.gov.au/closing-the-gap-data/dashboard/se/outcome-area1/access-use-of-health-services.
192. Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 June 06]. Available from: https://www.aihw.gov.au/reports/indigenous-australians/indigenous-primary-health-care-results-osr-nkpi.
193. Hull B, Hendry A, Macartney K, Beard F. Annual Immunisation Coverage Report 2023. Sydney: National Centre for Immunisation Research and Surveillance; 2024. Available from: https://ncirs.org.au/sites/default/files/2024-10/NCIRS%20Annual%20Immunisation%20Coverage%20Report%202023.pdf.
194. Australian Institute of Health and Welfare & National Indigenous Australians Agency. Measure 3.08 Cultural competency, Aboriginal and Torres Strait Islander Health Performance Framework website [Internet]. Canberra: Australian Institute of Health and Welfare & National Indigenous Australians Agency, 2020 [cited 2025 June 06]. Available from: https://www.indigenoushpf.gov.au/measures/3-08-cultural-competency.
195. Griew R, Tilton E, Cox W, Thomas D. The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. A report for the Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing. Waverly, NSW: Department of Health and Ageing; 2008.
196. Australian Institute of Health and Welfare. Barriers to accessing health services. Aboriginal and Torres Strait Islander Health Performance Framework [Internet]. Canberra: AIHW; 2025 [cited 2025 June 06]. Available from: https://www.indigenoushpf.gov.au/report-overview/overview/summary-report/6-tier-3-%E2%80%93-health-system-performance/barriers-to-accessing-health-services
197. Australian Institute of Health and Welfare. Australian Burden of Disease Study 2024 [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2025 July 01]. Available from: https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024.
198. Primary Health Tasmania. Rethink 2020: A state plan for mental health in Tasmania 2020–2025. Hobart: Primary Health Tasmania; 2020.
199. Australian Bureau of Statistics. National Study of Mental Health and Wellbeing [Internet]. Canberra: ABS; 2020-2022 [cited 2025 July 01]. Available from: https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release.
200. Howes F, Ahmed S, Lin L, Kitsos A, Shaw K. General Practice in Tasmania 2019. Hobart: Primary Health Tasmania; 2020.
201. Australian Institute of Health and Welfare. Physical health of people with mental illness [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 July 01]. Available from: https://www.aihw.gov.au/reports/physical-health-of-people-with-mental-illness.
202. Morgan VA, Waterreus A, Jablensky A, Mackinnon A, McGrath JJ, Carr V, et al. People living with psychotic illness in 2010: the second Australian national survey of psychosis. Australian & New Zealand Journal of Psychiatry. 2012;46(8):735-52.
203. Morgan VA, McGrath JJ, Jablensky A, Badcock JC, Waterreus A, Bush R, Carr V, Castle D, Cohen M, Galletly C, Harvey C, Hocking B, McGorry P, Neil AL, Saw S, Shah S, Stain HJ, Mackinnon A. Psychosis prevalence and physical, metabolic and cognitive co-morbidity: data from the second Australian national survey of psychosis. Psychol Med. 2014 Jul;44(10):2163-76. doi: 10.1017/S0033291713002973. Epub 2013 Dec 23. PMID: 24365456; PMCID: PMC4045165
204. DE Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, Detraux J, Gautam S, Möller HJ, Ndetei DM, Newcomer JW, Uwakwe R, Leucht S. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry. 2011 Feb;10(1):52-77. doi: 10.1002/j.2051-5545.2011.tb00014.x. PMID: 21379357; PMCID: PMC3048500. .
205. Australian Government. The fifth national mental health and suicide prevention plan. Canberra: Department of Health; 2017.
206. National Mental Health Commission. Monitoring mental health and suicide prevention reform: Fifth National Mental Health and Suicide Prevention Plan, 2021: Progress Report 4 – Final report and review [Internet]. Sydney: NMHC; 2023 [cited 2025 July 01]. Available from: https://www.mentalhealthcommission.gov.au/sites/default/files/2024-04/fifth-national-mental-health-and-suicide-prevention-plan-2021-progress-report-4.pdf.
207. Garrett A, Stojcevski V. Report to the Tasmania Government on Suicide in Tasmania. 1 January 2012 – 31 December 2018 Hobart: Department of Health; 2021.
208. Van Hoeken D, Hoek H. Review of the burden of eating disorders: mortality, disability, costs, quality of life, and family burden. Curr Opin Psychiatry. 2020;33(6):521-7.
209. de Mooij LD, Kikkert M, Theunissen J, Beekman ATF, de Haan L, Duurkoop PWRA, Van HL, Dekker JJM. Dying Too Soon: Excess Mortality in Severe Mental Illness. Front Psychiatry. 2019 Dec 6;10:855. doi: 10.3389/fpsyt.2019.00855. PMID: 31920734; PMCID: PMC6918821.

210. Morgan VA, Waterreus A, Carr V, Castle D, Cohen M, Harvey C, Galletly C, Mackinnon A, McGorry P, McGrath JJ, Neil AL, Saw S, Badcock JC, Foley DL, Waghorn G, Coker S, Jablensky A. Responding to challenges for people with psychotic illness: Updated evidence from the Survey of High Impact Psychosis. Aust N Z J Psychiatry. 2017 Feb;51(2):124-140. doi: 10.1177/0004867416679738. Epub 2016 Dec 5. PMID: 27913580.
211. Australian Institute of Health and Welfare. Suicide & self-harm monitoring: Overview [Internet]. Canberra: AIHW; 2025 [cited 2025 July 02]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/overview/summary.
212. Australian Institute of Health and Welfare. Annual deaths over time – Suicide & self-harm monitoring [Internet]. Canberra: AIHW; 2025 [cited 2025 July 02]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/geography/states-territories/annual-deaths-over-time.
213. Australian Institute of Health and Welfare. Risk factors – Suicide & self-harm monitoring [Internet]. Canberra: AIHW; 2025 [cited 2025 July 02]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/risk-factors.
214. Tasmanian Department of Health. Report to the Tasmanian Government on Suicide in Tasmania 2012–2020 [Internet]. Hobart: Tasmanian Department of Health; 2025 Apr 14 [cited 2025 July 02]. Available from: https://www.health.tas.gov.au/sites/default/files/2025-04/Report%20to%20the%20Tasmanian%20Government%20on%20Suicide%202012-2020.PDF.
215. Mental Health Alcohol and Drug Directorate. Compassion and Connection: Tasmanian Suicide Prevention Strategy 2023-2027 Hobart: State of Tasmania; 2022 [cited 2025 July 02]. Available from: https://www.health.tas.gov.au/sites/default/files/2022-11/tasmanian_suicide_prevention_strategy_2023-2027_final.pdf.
216. Australian Bureau of Statistics. National Study of Mental Health and Wellbeing [Internet]. Canberra: ABS; 2020-2022 [cited 2025 July 02]. Available from: https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release.
217. Whiteford HA, Buckingham WJ, Harris MG, Burgess PM, Pirkis JE, Barendregt JJ, et al. Estimating treatment rates for mental disorders in Australia. Aust Health Rev. 2014 Feb;38(1):80-5. doi: . Australian Health Review. 2013;38(1):80-5.
218. Australian Institute of Health and Welfare. Medicare mental health services – Mental health [Internet]. Canberra: AIHW; 2024 [cited 2025 July 02]. Available from: https://www.aihw.gov.au/mental-health/topic-areas/medicare-subsidised-services.
219. Australian Institute of Health and Welfare. Mental health: Medicare-subsidised mental health-specific services Canberra: AIHW; 2023 [updated April 2023.] Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia/overview-of-mental-health-services-in-australia.
220. Australian Institute of Health and Welfare. Mental health prescriptions – Mental health [Internet]. Canberra: AIHW; 2025 [cited 2025 July 03]. Available from: https://www.aihw.gov.au/mental-health/topic-areas/mental-health-prescriptions.
221. Primary Health Tasmania. Internal analysis. MDS dataset from 2020-21 to 2024-25. Accessed 27 August 2025. 2025.
222. Primary Health Tasmania. Internal analysis. Performance report 2025. Accessed 27 August 2025. 2025.
223. Australian Government, National Suicide Prevention Office. The National Suicide Prevention Strategy. Canberra: Mental Health Commission; 2025. Available from: https://www.mentalhealthcommission.gov.au/sites/default/files/2025-02/the-national-suicide-prevention-strategy.pdf.
224. Australian Institute of Health and Welfare. Alcohol, tobacco & other drugs in Australia [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 July 02]. Available from: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia.
225. Chikritzhs T, Livingston M. Alcohol and the Risk of Injury. Nutrients. 2021 Aug 13;13(8):2777. doi: 10.3390/nu13082777. PMID: 34444939; PMCID: PMC8401155.
226. Australian Government. National Drug Strategy 2017–2026. Canberra: Department of Health; 2017.
227. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2022–2023 [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 July 02]. Available from: https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey
228. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2022–2023: States and Territories [Internet]. Canberra: AIHW; 2024 [cited 2025 July 07]. Available from: https://www.aihw.gov.au/getmedia/db6d1df6-ddb3-454c-9a51-d00eced3b017/National-Drug-Strategy-Household-Survey-2022-2023-9b-States-and-Territories.xlsx.
229. Foundation for Alcohol Research and Education. Alcohol-induced deaths in Australia [Internet]. Canberra: FARE; 2023 Nov [cited 2025 July 03]. Available from: https://fare.org.au/wp-content/uploads/Alcohol-induced-deaths-in-Australia-November-2023.pdf.
230. Australian Institute of Health and Welfare. Alcohol-related injury: hospitalisations and deaths, 2019–20 [Internet]. Canberra: AIHW; 2023 Mar 21 [cited 2025 July 04]. Available from: https://www.aihw.gov.au/getmedia/a227a579-d1e7-

41d3-b849-877acb451084/alcohol-related-injury-hospitalisations-and-deaths-2019-20.pdf
231. Australian Institute of Health and Welfare. Alcohol: fact sheet PHE 221 [Internet]. Canberra: AIHW; 2024 Dec [cited 2025 July 15]. Available from: https://www.aihw.gov.au/getmedia/2e3fa2c7-177e-4163-9d21-c97b5f0e665c/aihw-phe-221-alcohol_december-2024.pdf
232. Australian Institute of Health and Welfare. Illicit drug use [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 July 07]. Available from: https://www.aihw.gov.au/reports/illicit-use-of-drugs/illicit-drug-use.
233. Australian Institute of Health and Welfare. Alcohol, tobacco & other drugs in Australia [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 July 07]. Available from: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia
234. Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia annual report [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2025 July 07]. Available from: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia.
235. Tasmanian Government. Reform agenda for the alcohol and other drugs sector in Tasmania. Hobart: Department of Health; 2024 [cited 2025 July 08]. Available from: https://www.health.tas.gov.au/sites/default/files/2021-11/AOD_Reform_Agenda_DoHTasmania2020.pdf.
236. Youth Network of Tasmania (YNOT). Response to the Review of Alcohol and Other Drug Services in Tasmania [Internet]. Hobart (AU): YNOT; 2017 [cited 2025 September 26]. Available from: https://www.ynot.org.au/sites/default/files/documents/2019-09/YNOT-Response-to-Review-of-AOD-Services-in-Tasmania-2017.pdf.