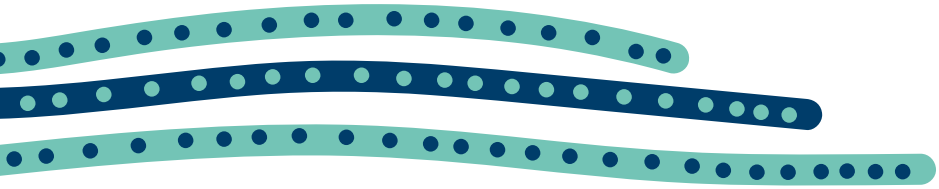
Health access and equity framework

July 2024 – June 2027

A framework to address health inequalities and improve health and wellbeing outcomes for all people in the Brisbane South PHN region through planning and promoting equitable access to healthcare.

phn
BRISBANE SOUTH

An Australian Government Initiative



Acknowledgement of Country

Baugull nyungai – Yugambeh good day (Bundjalung-Yugambeh – Beaudesert, Logan)

Gurumba bigi – Yugarabul good day (Brisbane western suburbs)

Maroomba biggee – Jandai good day (Minjerribah – North Stradbroke Island)

We acknowledge the Traditional Custodians of the land on which we live and work, and of the many different nations across the wider Brisbane south region.

We pay our respects to the Elders, past, present and emerging, as the holders of the memories, the traditions, the culture and the spiritual wellbeing of the Aboriginal and Torres Strait Islander peoples across the nation. We acknowledge any Sorry Business that may be affecting the communities as a whole.

In the spirit of reconciliation, partnership and mutual respect, we will continue to work together with Aboriginal and Torres Strait Islander peoples to shape a health system that responds to the needs and aspirations of the community.

Table of contents

1. Foreword from our Chief Executive Officer

As CEO of Brisbane South PHN, I am proud to present our Health Access and Equity Framework. This framework emerged from the collective efforts of our staff, health sector partners, and community. I extend my heartfelt gratitude to everyone involved in its creation.

At Brisbane South PHN, we recognise and celebrate the strength, resilience, and rich diversity of the people and communities in our region. We understand that when people are welcomed into an inclusive and safe primary healthcare environment, they are more likely to engage with healthcare services early, empowering them to take proactive steps in managing their health with help from local health professionals.

Our Health Access and Equity Framework guides the strategic and operational actions of our PHN, ensuring we continually advance and advocate for equitable access to healthcare for all people in our region. By embracing these principles, we aim to inspire our partners, stakeholders, and commissioned providers to do the same. Together, we can build a healthcare system that addresses community needs and serves everyone with dignity and respect.

Mike Bosel
CEO, Brisbane South PHN

2. About this framework

Brisbane South PHN (the PHN) partners with health service providers, governments and the private sector to build a health and wellbeing system in which every person in our region, especially those with the greatest need, is supported to thrive with healthcare that is connected, high quality and easy to access.

This framework outlines how we will strengthen our efforts to improve equitable access to healthcare for the people and communities in our region. We know we can't do it alone. In the spirit of partnership and collaboration, Brisbane South PHN and Metro South Health have a shared vision and commitment to working together to achieve health equity in our region.

2.1 Aim

We will improve access to healthcare and address health inequities to improve health and wellbeing outcomes for people in the Brisbane South PHN region.

2.2 Objectives

1. Provide a high-level framework to guide Brisbane South PHN in a person-centred approach to supporting equitable access for all.
2. Provide best practice actions to support Brisbane South PHN to deliver locally informed and relevant responses, acknowledging the:
    a. diversity of the region's communities and their intersecting needs
    b. priorities and capacity of Brisbane South PHN.

2.3 How this framework was developed

Development of the framework included the:

- analysis of data and insights collected across Brisbane South PHN's Health Needs Assessments
- desktop review of key national, state and local policy documents and tools (see appendix 1)
- review of international, national and local evidence of best practice
- consultation and engagement with Metro South Health and other government and non-government organisations, including other PHNs (Primary Health Networks)
- consultation with Brisbane South PHN staff, Board, and Clinical and Community Advisory Councils.

2.4 Policy context

Our Health Access and Equity Framework (the Framework) is informed by key national, state and local policy documents, listed in appendix 1. The framework also aligns with key internal frameworks and action plans, which also make important contributions towards achieving the objectives of this framework, listed in appendix 2.

2.5 Acknowledgements

The Framework was developed by the Brisbane South PHN Health Access and Equity Working Group with input and insights from Brisbane South PHN staff, Board, and Community and Clinical Advisory Councils.

We acknowledge our health system partner, Metro South Health, for ongoing support and commitment to working with us to improve health access and equity for the people of the Brisbane south region.

We would also like to acknowledge North Western Melbourne PHN (NWMPHN) for advice, support and guidance in developing the Framework.

Brisbane South PHN values an inclusive culture that embraces the diversity of our people, service providers and community, and models reconciliation. Building a safe and equitable system of healthcare for all is at the core of our business.

3. Understanding health access and equity

By helping to create equitable and accessible healthcare environments within the Brisbane South PHN region, we lead by example and are better positioned to influence our health system partners and regional health service providers to do the same. But what do we mean by these terms?

3.1 Health access

Health access refers to the ease with which people and communities can obtain needed medical and community health services. It encompasses factors like the availability of local healthcare providers, affordability of care, and physical accessibility of healthcare facilities. Health access also refers to the ability to understand and communicate effectively with healthcare providers, and to the availability of safe, culturally responsive and trauma-informed healthcare services.

3.2 Health equity

Equity in healthcare means that everyone has a fair and just opportunity to achieve and maintain optimal health and wellbeing. It involves efforts to address avoidable inequalities and injustices within the health system, ensuring that social, economic and environmental factors—the social determinants of health[1]—do not prevent individuals and communities from experiencing and maintaining optimal health and wellbeing.

3.3 Health equality and health equity: the important distinction between both

It is important to note that equity and equality are not interchangeable terms. Although both terms promote the notion of fairness, equality achieves this by treating everyone the same regardless of need, while equity achieves this by treating people differently, depending on need. Equity is about giving people what they need to help make things fair and potentially achieve equality (Social Change UK, 2021).

This is demonstrated in the picture below.

Figure 1. Demonstrating the difference between health equality and health equity

EQUALITY:
Everyone gets the same—regardless if it's needed or right for them.

EQUITY:
Everyone gets what they need—understanding the barriers, circumstances and conditions.

Reproduced with permission of the Robert Wood Johnson Foundation, Princeton, N.J.

1 The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. (World Health Organization, 2024)

4. Why health access and equity are important to us

Access to healthcare is a basic human right. Addressing social and structural inequities improves health outcomes and reduces the overall burden of disease and ill-health across all of the diverse population groups in our community.

Within the Brisbane South PHN region, several groups experience greater barriers to healthcare and, ultimately, poorer health and wellbeing outcomes.

The PHN has prioritised our ways of working, including allocating internal resources and funding that largely focus on working with the following population groups to reduce health inequities they experience.

- First Nations peoples
- People from multicultural backgrounds
- People who identify as lesbian, gay, bisexual, transgender, intersex, queer/ questioning, asexual (LGBTIQA+)
- People with disability
- People experiencing homelessness
- People living in regional, rural and remote communities
- Older peoples (those aged over 65 years, or over 50 years for First Nations peoples)
- Children and young people
- People transitioning back into the community from correctional facilities

We are Queensland's most culturally diverse PHN region.

- The number of residents who speak a language other than English at home is almost double the state average.
- We have the highest rate of refugee resettlement in Queensland.
- Australia's largest Pasifika and Māori community is in our region.
- We have the largest urban First Nations population compared to all other metropolitan PHNs nationally.

Our geographic priority populations/ diverse groups include:

- Southern Moreton Bay Islands (including Russell (Canaipa), Macleay (Jencoomercha), Karragarra and Lamb (Ngudooroo) Islands)
- North Stradbroke Island (Minjerribah)
- Beaudesert Statistical Area Level 3 (SA3)
- Logan Local Government Area (LGA).

We listen to the voices of our community.

Below are some of the barriers and challenges people face when accessing healthcare in our region, as told by them.

'Unable to find a GP willing to undertake home visits, previous medical visits at the hospital have been traumatising and the environment is overstimulating and transport options are limited.'

Female, 16, Brisbane south

Severe neurological condition, bedbound and unable to travel to access primary care services due to severe pain and fatigue

(Brisbane South PHN, 2024)

'I don't have any family locally, I am unemployed and didn't finish grade 10. I live in a hostel. The Public Trustee helps me make financial decisions and the hostel helps me to remember my medications. I normally go to hospital by ambulance when I am really unwell but it's overwhelming. Going on a bus to see specialists is scary and overwhelming and uses all my spending money.'

Male, 52, Brisbane south

Mental health condition and a cognitive impairment due to an acquired brain injury

(Metro South Health, (n.d))

'I visited a GP in person 2 years ago. It was an extremely traumatic process, and I still haven't recovered from the experience. The GP did express concerns over my ability to access regular medical support but was unsure what advice to provide.'

Female, 31, Wynnum

Chronic illness, permanent disability and non-English speaking background

(Brisbane South PHN, 2024)

'I can't leave my house without a lot of support since my wife passed away. She used to take me to the doctor... I would like to see my GP in person but it's near impossible for me to get to the practice and I'm unsure where I should begin looking.'

Male, 70, Yarrabilba

Multiple complex chronic diseases, elderly with psychosocial isolation

(Brisbane South PHN, 2024)

'Lack of (LGBTIQA+) education for family, friends, colleagues and health professionals.'

LGBTIQA+ community member

A barrier when seeking informal support. MHSPAOD codesign process

(The Australian Centre for Social Innovation, 2018)

'There are limitations of medical mindset: not accommodating spiritual supports and healing.'

Aboriginal and Torres Strait Islander community member

A barrier when accessing and using formal mental health supports. MHSPAOD codesign process

(The Australian Centre for Social Innovation, 2018)

'I was labelled 'disengaged' while trying my best to show up and take part in support. I became too much for my GP.'

Alcohol and other drug community member

Barrier to accessing crisis support. MHSPAOD codesign process

(The Australian Centre for Social Innovation, 2018)

'I used to work at a supermarket but had to stop work when my son finished school so I could care for him. I live off a mixture of Centrelink payments and my son's superannuation. My health has been neglected and I am overweight and have type 2 diabetes. I find it hard to seek support and difficult to understand technical health information for both myself and my son.'

Female, 53, Acacia Ridge

A carer for her 27 year old son who has Down Syndrome. Migrated from the Philippines

(Metro South Health, (n.d))

5. Our sphere of influence

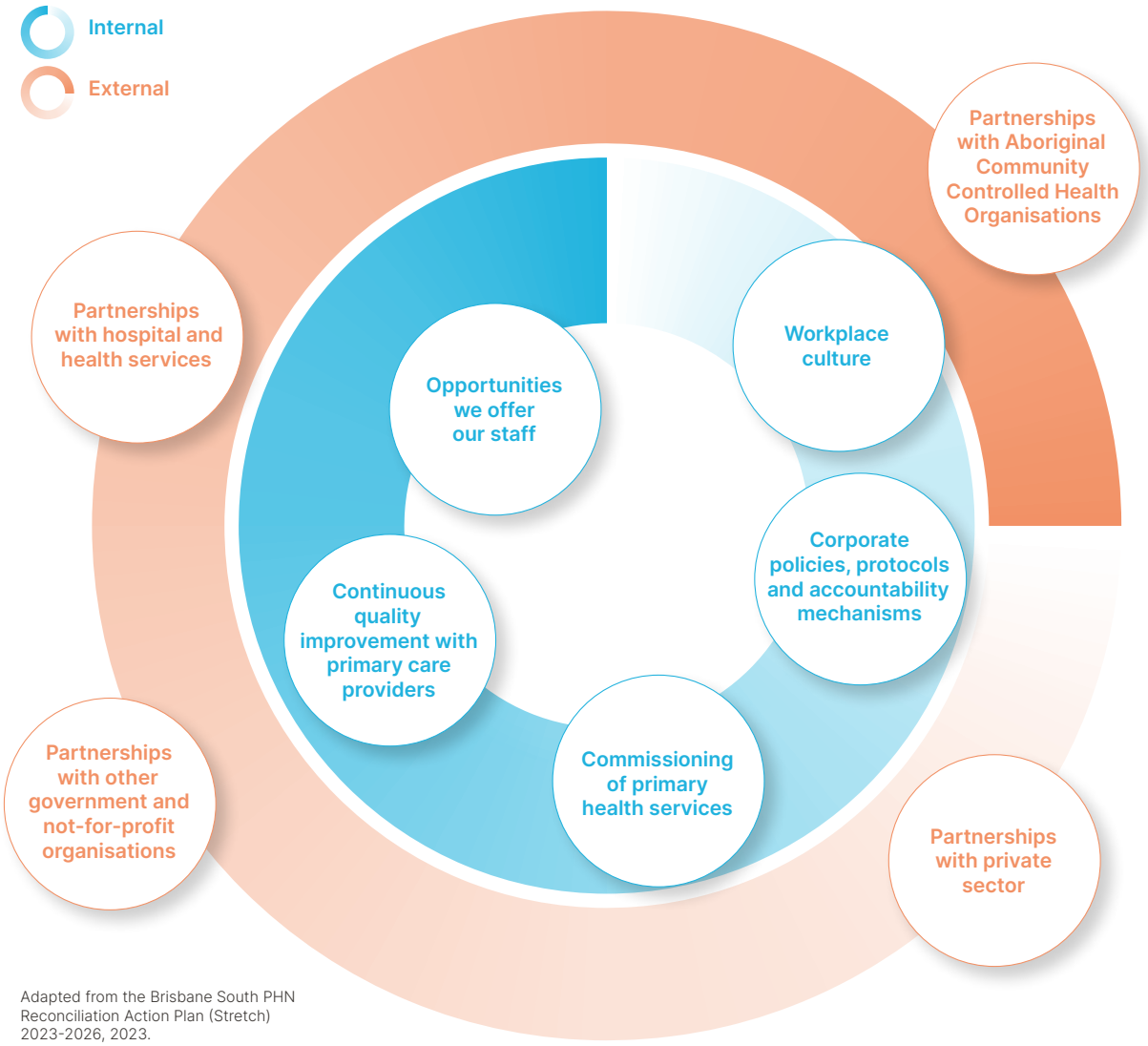
The PHN recognises the importance of working closely with our stakeholders to improve access to healthcare and reduce inequities in our region. We partner to support health systems change.

Internally, our influence lies in the opportunities we offer our staff, our workplace culture, and the corporate policies, protocols and accountability mechanisms that underpin them. This also includes:

- the commissioning of primary health services
- the commissioning of programs that address inequities and focus on social determinants of health, and
- facilitating continuous quality improvement with primary care providers.

Externally, we work with all levels of government, government-funded agencies and not-for-profits, as well as with the private sector, to coordinate resourcing and services that address needs and health gaps in our region. Key stakeholders include:

- Queensland's Hospital and Health System (Metro South Health, Children's Health Queensland and Mater)
- Aboriginal Community Controlled Health Organisations
- other community and not-for-profit organisations.



Adapted from the Brisbane South PHN Reconciliation Action Plan (Stretch) 2023-2026, 2023.

6. Our regional health profile

6.1 Understanding our region to address local health needs and service gaps

The Brisbane South PHN region is one of the most diverse and complex geographical regions in the state of Queensland and nationally.

It is home to 1.23 million people, just under a quarter (23%) of the total state population, and is consequently the largest PHN region in Queensland by population.

Population projections estimate that the Brisbane South PHN region will be home to approximately 1.7 million people by 2046.

Geographically, our region extends from south of the Brisbane River and central business district, is bordered by the Scenic Rim and Tamborine National Park, and extends down to the New South Wales border. Our region is predominantly metropolitan with pockets of regional and remote centres including Beaudesert and the islands of southern Moreton Bay, which are accessible only by boat.

Our region spans 4 local government areas: Logan, Redland, Brisbane and Scenic Rim. Within this extensive catchment, there are 223 suburbs covering approximately 3,770 square kilometres. There are several high-growth communities across the region, including Yarrabilba, Jimboomba, Greenbank and Flagstone areas, with average annual population growth rates almost 7 times higher than the wider region.

See appendix 4 'Health inequities in the Brisbane South PHN region' for Table 1: Community profile comparison of the BSPHN region, subregions and Queensland and Table 2: Health outcome differences between the BSPHN region, subregions and Queensland.

As of April 2024, there are:

331
general practices

3
Aboriginal and Torres Strait Islander Community Controlled health services (operating out of 8 locations)

13
community health centres

18
8 public and 10 private hospitals (see appendix 3)

2
urgent care clinics

6.2 Population diversity in the Brisbane South PHN region

Brisbane South PHN

2.8% identify as First Nations

just over 31% are born overseas

approximately 1 in 5 (20.2%) are from non-English speaking background (NESB) Countries

just over 23% speak a language other than English at home

there are a reported 242 languages spoken across 320 different recorded ancestries

5.6% report a profound or severe disability

38.5 per 10,000 people are experiencing homelessness

~34% of residents live in the most disadvantaged areas (SEIFA IRSAD)[2]

(Queensland Government Statistician's Office, 2024)

Queensland

~11% of Queenslanders are carers who provide care to a person with a disability or an older person

(Australian Bureau of Statistics, 2024)

Australia

~11% of residents are LGBTIQA+ according to national estimates by the Australian Human Rights Commission

(Australian Human Rights Commission, 2014)

With this complexity in demographics and geography, there are immense subregional differences across social determinants and consequently diverse groups and individuals are at greater risk of poor health outcomes.

2. SEIFA IRSAD = This is the Index of Relative Socio-Economic Advantage and Disadvantage. This ranks areas nationally according to their relative socio-economic advantage and disadvantage using Census data.

7. Health access and equity framework – strategic practices

7.1 Our 6 strategic practices

There are 6 key strategic practices that guide our approach to improving health access and equity in our region.

These strategic practices have been adapted from the National PHN Program Performance and Quality Framework (2018).

7.2 How do we practically implement the strategic practices in our ways of working?

To ensure a health equity lens is applied across all our ways of working, the following questions can be asked of our business decisions and actions.

1. Who is affected/impacted?
2. Have those affected helped to shape this?
3. Who is included/excluded?
4. Who benefits and who is harmed?
5. What are the assumptions taking place?
6. What does the data tell us?
7. What data is missing?
8. Who is/is not at the decision-making table?
9. What values underlie the decision-making process?
10. What revisions are needed/what could be done differently?

(Minnesota Department of Health, 2018)

For further practical guidance centred on action for improving health access and equity, please refer to the publications and tools listed in appendix 1.

8. Our framework for health access and equity

Capable organisation

1. Leadership and organisational commitment

Objective: To apply a health access and equity lens across all governance structures, processes and systems and continuously seek opportunities for improvements.

Activities	Actions
1.1 Build an organisational culture and movement of health access and equity.	• Build connections across health sectors, government agencies and community organisations to address health inequity. • Support, acknowledge and celebrate health equity and diversity awareness events. • Ensure strategic documents address health access and equity and are communicated across the organisation. • Ensure all responses and plans consider the needs of diverse populations.
1.2 Advocate for policy and systems change at the national, state and local levels including empowering local communities to address health disparities and promote equity.	• Escalate known health equity gaps and issues to funding bodies and relevant agencies. • Publicly represent health equity issues within external meetings, partnerships, media and strategy. • Stay informed of health equity related policy, funding and research opportunities and share across the organisation.
1.3 Implement an equitable approach to funding and resource allocation and distribution.	• Ensure that equitable funding and resources are identified within planning processes for addressing health inequities and prioritise the distribution of funds to support diverse communities.

2. Workforce capability

Objective: To build the capability and capacity of staff and external stakeholders to improve health access and equity.

Activities	Actions
2.1 Develop and implement equity-focused human resource practices.	• Promote employment opportunities to our diverse community and use accessible and culturally appropriate recruitment processes. • Promote recruitment processes that enable diverse applicants to demonstrate professional experience, lived experience, community connections and formal qualifications. • Strive to support staff in achieving work-life balance through flexible work arrangements by being a flexible employer and considering workplace adjustments so staff can perform at their best to meet personal and organisational needs. • Capture data on internal workforce diversity.
2.2 Provide training opportunities that build and support the workforce.	• Invest in training and provide opportunities for staff and external stakeholders to learn the skills and knowledge they need to work with and support people from diverse backgrounds. • Include diverse voices and equity topics within our training, and learning and development approaches. • Work with our partners to encourage opportunities such as placements, traineeships and secondments, so people can gain experience and join our workforce. • Provide support and professional development opportunities for our workforce to effectively contribute to decision making and support career development.

Address needs

3. Mobilise data and evidence into action

Objective: To understand the region's health inequities and use data, research and evidence to address these local issues.

Activities	Actions
3.1 Strengthen and improve partnerships, systems and evaluation reporting mechanisms.	• Mobilise data sharing agreements with key health system partners that address health access and equity. • Ensure internal data collection systems and evaluation reporting mechanisms address health access and equity.
3.2 Improve collection of data that is meaningful for health access and equity advocacy and strategic planning.	• Provide training and support to people who are collecting health equity data. • Collect data on health outcomes, socioeconomic factors and demographics to track progress and identify disparities. • Use triangulation of data methods including numbers and storytelling to inform projects and planning. • Improve understanding and identification of diverse populations through the process of Health Needs Assessments. • Identify key health inequity data gaps and escalate them internally and externally for strategic planning and action (be transparent with data sharing).
3.3 Close the loop.	• Interpret the health inequity data and feedback to stakeholders and communities to close the loop.

4. Community and stakeholder engagement

Objective: To authentically engage and co-design with our community and stakeholders, adapting our approaches to meet their needs.

Activities	Actions
4.1 Develop inclusive community and stakeholder engagement and co-design processes.	• Conduct ongoing engagement and relationship building with diverse communities and services that specialise in supporting people with health inequities. • Ensure people from diverse backgrounds and with lived experience have input into decisions and are part of governance, working and advisory groups, and co-design processes. Ensure they are adequately prepared, supported and remunerated. • Ensure inclusive co-design is undertaken (from beginning through to evaluation) to identify needs and health inequities and develop solutions with those the program/service is intended for. • Establish a feedback mechanism for diverse groups to report and share their experiences.
4.2 Build flexibility in engagement approaches to meet community needs.	• Develop more inclusive engagement strategies and methodologies to cater for different engagement needs and for groups that are not reached through usual engagement practices.
4.3 Close the loop.	• Analyse information and feedback from participants to sense-check and close the loop.

Quality care

5. Integrated and coordinated care

Objective: Our activities promote integration and coordination across the health system and other sectors to improve access and equity for all people.

Activities	Actions
5.1 Ensure integration and coordination of activities internally and externally.	• Ensure effective internal communication between teams, including about what each team does to better coordinate efforts. • Ensure effective communication and coordination with external stakeholders.
5.2 Strengthen pathways and connections between acute, primary, private, residential and community services.	• Strengthen relationships with health services that specialise in working with populations with health equity barriers. • Raise awareness about healthcare services and their roles for consumers and professionals. • Improve communication and information sharing between health services. • Strengthen future-focused initiatives to enable better communication and information sharing between multiple providers (eHealth, telehealth, virtual care) and account for how these work for people with additional barriers.
5.3 Strengthen health literacy and navigation support services for groups known to have health equity and navigation difficulties.	• Use plain language and consistent messaging across all communications. • Simplify and design programs, services and processes that allow for improved consumer access and easier navigation. • Procure or partner to co-create sustainable health literacy and health service navigation models and activities for consumers. • Develop, adapt or link to a directory of health and social services for professionals and consumers to access.
5.4 Collaborate with health providers, community organisations and social services to support integration and care coordination, including cross-sector collaboration to address the social determinants of health.	• Participate in national, state and local health equity working/advisory groups and networks. • Collaborate with peak body stakeholder organisations.

6. Culturally responsive, accessible and inclusive approaches

Objective: To help create culturally responsive, accessible and inclusive approaches and ways of working.

Activities	Actions
6.1 Embed health access and equity into our models of care and ways of working.	• Ensure we consider health equity across all projects and programs including our commissioning processes. • Build capacity and capability of providers by building a community-controlled service system that responds to their needs and adapt commissioning approaches to enable organisations that specialise in supporting people with health inequities to participate in tendering opportunities. • Support our staff, primary care providers, commissioned services and partners to build the skills, knowledge and attitudes they need to reduce health inequity. • Ensure people with diverse lived experience are involved and feel valued and acknowledged in all of our work.
6.2 Ensure our organisation is welcoming and accessible for all staff and members of our community.	• Create a workplace that is respectful of people's diverse beliefs, values and needs. • Ensure our environment and services feel welcoming and inclusive for staff and all members of our community. • Ensure online platforms and information resources are accessible and welcoming for all people.

9. Governance, implementation and monitoring

9.1 Governance

Brisbane South PHN and Metro South Health are committed to working together to ensure there is a unified approach to reducing health inequities in the Brisbane South PHN region.

The PHN Executive Leadership Team is accountable for the effective leadership, implementation and progress of the framework.

Brisbane South PHN working groups will support the implementation of the Framework and will work with teams to support cross-organisational ways of working.

9.2 Implementation

The Framework and its corresponding implementation plan are intended to apply across all Brisbane South PHN work areas.

The implementation plan will be a stand-alone internal document that will be operational across all teams and included within relevant team planning and reporting processes.

The implementation plan will be reviewed and updated annually, responding to changes and priorities, emerging needs, data and performance measure analysis, and ensuring continuous quality improvement.

9.3 Monitoring and reporting

PHN internal working groups will be responsible for the monitoring of progress against the implementation plan. Progress and performance measures will be reported quarterly to the PHN Executive Leadership Team.

The PHN and Metro South Health Partnership Committee will have oversight of joint health equity activities and actions.

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Appendices

Appendix 1 – List of national, state and local policy equity documents and tools

- A framework for cultural competence: Centre for Culture, Ethnicity and Health
- Bringing Light and Heat: A Health Equity Guide for Healthcare Transformation & Accountability, July 2021
- Children's Health Queensland – Aboriginal and Torres Strait Islander Health Equity Strategy 2022-2025
- Metro South Health Equity and Access Framework diagram (health.qld.gov.au)
- Metro South Health Disability Service Plan 2023-26
- Metro South Health – First Nations Health Equity Strategy 2022-2025
- Multicultural Access and Equity Assessment Tool (homeaffairs.gov.au)
- National PHN Program Performance and Quality Framework
- North Western Melbourne PHN Access and Equity Framework 2021-24
- NSW Health – Sydney Local Health District Equity Framework (nsw.gov.au)
- The Embrace Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery – Mental Health Australia
- WAPHA_Aboriginal-Cultural-Framework.pdf – Western Australian Primary Health Alliance
- WAPHA Cultural Competency and Capability Frameworks – Western Australian Primary Health Alliance
- WAPHA_LGBTIQA_Equity-Inclusion-Framework.pdf – Western Australian Primary Health Alliance

Appendix 2 – List of key internal documents that helped to inform the framework

- Brisbane South PHN Strategic Plan 2024
- Commissioning Framework
- Health Needs Assessment
- Pasifika and Māori Health and Wellbeing: A strategic framework and action plan for Brisbane South 2020-2025
- Performance and Outcomes Framework
- PHN Multicultural Health Framework Feb 2024
- Rainbow Tick (LGBTIQA+) Framework and Implementation Plan
- Reconciliation Action Plan (Stretch) 2023-2026
- Stakeholder Engagement and Partnership Framework

Appendix 3 – Map of hospitals in the Brisbane South PHN region

* includes Mater Private Hospital Brisbane, Mater Children's Private Brisbane and Mater Mothers' Private Brisbane

** includes Mater Hospital Brisbane and Mater Mothers' Brisbane

*** includes Mater Private Hospital Redland and Mater Children's Private Redland

Appendix 4 – Health inequities in the Brisbane South PHN region

Differences in social determinants of health exist in the Brisbane South PHN region, with some populations experiencing poorer health outcomes. Our region's geography and community composition represent a unique and diverse population with varying needs that require specific consideration, particularly at certain sub-geographies.

Table 1. Community profile comparison of the BSPHN region, subregions and Queensland

Population characteristics	Brisbane South PHN region	Subregional range	Queensland
	1,236,517 people (419,159 households)	~23% of State population	5,320,496 people
Born overseas	31.1% (371,160)	Up to 59.4% in Robertson SA2	22.7%
Non-English speaking background countries	20.2% (241,265)	Up to 55.3% in Robertson SA2	10.2%
Speak a language other than English at home	23.1% (275,677)	Up to 61.7% in Robertson SA2	13.5%
First Nations persons	2.8% (33,019)	Up to 16.4% in Wacol SA2[e]	4.6%
LGBTIQA+ persons[a]	~11% (~130,000)	No standardised data collection	~11%
Profound or severe disability	5.6% (66,503)	Up to 13.4% in the Southern Moreton Bay Islands SA2	6%
Experiencing homelessness[b]	~4,244 (35.8 per 10,000)	Estimated up to 205.7 per 10,000 in Logan Central	43.2 per 10,000
SEIFA IRSAD	33.9% in lowest Quintiles (most disadvantaged)	Up to 100% in lowest Quintile in Kingston SA2	40%
Estimation of refugee entrants settled (2022)	~1,200[d]	709 in Brisbane area[d]	1,795[cd]
Remoteness	96.8% in major city	100% remote in North Stradbroke Island	64.8% remote

Comparable or lower than state average

Missing/incomplete data

Higher/denser than state average

a National estimate by Australian Human Rights Commission

b Estimated by ABS operational definition

c Department of Home Affairs Settlement Data including Visa types 200, 201, 202, 203, 204 and 866

d Multicultural Australia – Brisbane area is defined as mostly Brisbane south and the PHN region includes settlements in Brisbane and Logan areas

e Includes incarcerated populations in Wacol SA2

(Queensland Government Statistician's Office, 2024a)

(Australian Human Rights Commission, 2014)

(Department of Home Affairs, 2022)

(Multicultural Australia, 2023)

Table 2. Health outcome differences between the Brisbane South PHN region, subregions and Queensland

In addition to the different health outcomes for certain individuals or groups, adverse health outcomes can occur because of where someone lives, often referred to as place-based disadvantage. Please refer to the notes on the caveats of population data for further context.

Population characteristics	Brisbane South PHN region	Subregional range	Queensland
Life expectancy at birth[a]	~83.2	78.3 (males in Logan and Beaudesert SA4) to 86.2 (females in Brisbane – South SA4)	82.8
Rates of potentially preventable hospitalisations for vaccine-preventable conditions (ASR[b]) (conditions per 100,000 population)	409 per 100,000	698 per 100,000 in Forest Lake – Oxley SA3	366 per 100,00
Prevalence of mental health conditions	9.3%	12% in Beaudesert SA3	9.6%
Prevalence of chronic health conditions (1 or more)	27.1%	37.3% in Eagleby SA2	28.8%
Unemployment rate	3.9%	Up to 20.5% in Logan Central	3.7%
Median rent (3 bedroom house) (2023)[c]	~$525/week	Up to $820 a week in Hawthorne SA2	$500/week
Median sale price (2023)[d]	~$895,000	Up to $1,787,500 in Bulimba	$650,000
Housing vacancy rate (2023)	1.08%	0.6% in Nathan SA3	0.98%
High school level education[e]	69.9%	As low as 43% in Logan Central SA2	63.6%

Comparable or lower than state average

Missing/incomplete data

Higher/denser than state average

a Average for region
b Age Standardised Rate
c Most common bond lodging for dwelling type in the region
d Detached dwellings
e Year 11 and Year 12 (or equivalent)

(Queensland Government Statistician's Office, 2024ab)
(Australian Bureau of Statistics, 2021ab)
(Australian Institute of Health and Welfare, 2019)

A note on the caveats of population data

Various barriers such as historical, legal, medical or cultural factors can impact the collection of demographic information. This highlights the need for sustained advocacy, safety and relationship-building with community, and the systemic refinement of our measurement of populations.

The true magnitude of homeless, houseless or at-risk populations is hard to measure and define. The recorded rates of homelessness can rely on access to internet or specialist services, or the availability of active outreach by organisations to collect data from individuals. Equally, the definition of homelessness and risk of homelessness differ widely across certain peak public bodies. For example, the Australian Bureau of Statistics makes distinction between being 'homeless' and being 'marginally housed' and can differ to how specialist homelessness services classify and count their clients (Australian Bureau of Statistics, 2021b).

Similarly, there is no standardised measurement for the Australian LGBTIQA+ population. This community is not currently included in the Census and estimated population proportions are derived from meta-analyses of literature and research and from the respondent percentages. These various response rates can range from 8–14% of the population identifying as LGBTIQA+ or gender diverse (Rainbow Health Victoria, 2020). These same meta-analyses also show that this proportion increases for young people and can vary due to cultural background with a large influence on attitudes due to the historic colonisation by certain countries. The variance in estimates can, in part, be explained by different ways of asking about gender and sexuality, a local context, and the complex historical trauma of pathologisation and criminalisation of sexual or gender diversity and medical intervention for intersex variations.

phn
BRISBANE SOUTH

An Australian Government Initiative

Contact: accessandequity@bsphn.org.au

Brisbane South PHN

ABN 53 151 707 765
Street address: 1/20 Garden City Office Park, 2404 Logan Road, Eight Mile Plains QLD 4113
Postal address: PO Box 6435, Upper Mount Gravatt QLD 4122
1300 467 265
bsphn.org.au