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Mallacoota Health Check

The path for a remote community towards adequate health care for all.
The development of an aged care village model for a remote community.
Demography

Mallacoota (1063) a remote community in Far East Gippsland with its neighbours Gipsy Point (15) Genoa (68) Cann River (198) are in Victoria more distant from the primary health services usually associated with rural communities than any other group of communities. Mallacoota is 2 hours distant from the nearest emergency hospital in NSW or 3 hours in Victoria. Until recently, 1 GP, no after hours care, reliant on Ambulance Victoria for emergencies with a Paramedic Trainer and a variable number of Ambulance Community Officers.

Lack of after hours and pressure on the sole GP saw Mallacoota using Ambulances 3.5 times more than the Bairnsdale.

The population of Mallacoota is aged, over 50% of the population is over 55 with 251 of the population over 70 and 142 in the age group 65-69. This raises a key issue for EGSC and other service providers, is Mallacoota with its services an age friendly precinct?

In the last 18 months the community has seen 48 people leave the town for better aged care places elsewhere. Around 165 have left in the last 8 years

Attachment 1 identifies the population is unlikely to increase significantly to 2036. The Age profile is however likely to change as is the town demographic as more houses are sold into to holiday accommodation. 469 Occupied Private Dwellings and 310 Unoccupied Private dwellings.

Mallacoota is effectively an aged care village without the services or support that would normally accrue to such an integrated facility.

This document explores the needs and processes to achieve adequate support for all in our community.

Remoteness Effect on Health – Academic Analysis – Setting the Scene

CHIRF's Grants Manager is an Australian expert in rural health worker retention. Dr Cath Cosgrave has recently completed a Churchill Fellowship. The key observations made following that research tour to remote Canada set the scene for the work for CHIRF for the next period.

- Community engagement in delivering outcomes for its own health future.
- Identification of our health issues to better control the health resources needed for this remote community

- Hubbing the key medical and related allied health services to better co-ordinate the health outcomes for the community
- Identification ofr the special social and health needs of the workforce
- Creating a medical precinct that provide intellectual challenges and satisfaction as well satisfaction in the day to day work.
- Identification of the special health needs of a community with over 50% over 60
    - Creation of a new model of aged care for remote communities
- Special interest in a model of mental health care for the community
- Development of a fly in fly out model of allied health for key specialities for which the population size does not justify full time support
    - Development of a model that relates to other communities such as Eden, Bombala and Cann River

Dr Cath Cosgraves Conclusions:

The majority of health professionals live and work in cities, resulting in a global phenomenon of rural health workforce shortages. **Compared to Australians living in urban areas, people living rurally have reduced access to health services, which negatively affects health-care equity and health outcomes.**

A major contributing factor to this inequity and health disparity is rural health workforce shortages and high turnover.

The literature identifies the decision of an individual to take-up, stay, or leave a rural health position as a complex interaction between workplace conditions, career building opportunities, and psychosocial and personal factors.

Most of the rural health workforce retention studies undertaken have focused on the influence of workplace and career building factors, and have, in the main, ignored the psychosocial determinants.

Recently published studies, including my own, have identified the need for a community engagement approach for successfully attracting, recruiting and retaining a rural health workforce. For newcomer health workers, social isolation is a major issue and community engaged solutions are urgently needed, but there are few examples to draw on in Australia.

My Churchill Fellowship visit to Canada and the interviews I conducted strongly confirmed the need for a community engaged approach to support the development of effective rural health workforce strategies. It also highlighted that this is relatively new thinking and there are still few examples of successful approaches to draw on (the notable exception being the recruiter and community connector model being used in Marathon, Ontario). However, over the last decade, rural and remote northern countries have been working in partnership to develop the Recruit & Retain Framework and this is being used to trial community engaged approaches in the development of recruitment and retention strategies. My Fellowship provided many opportunities to build understanding with stakeholders involved in addressing rural health workforce issues, both in Canada and from other northern countries. It also provided opportunities to discuss the similar challenges we face in Australia and to promote the whole-of-person rural retention improvement project and the community engaged approaches being trialled.

Internationally, there is an urgent need to strengthen the evidence base on effective community engaged approaches for recruitment and retention of rural health workforces. **I believe this can be best achieved**

through greater collaboration among rural and remote communities in far northern countries and Australia.

In Australia, there is need for strengthened understanding of the importance of community engagement in addressing rural health workforce issues.

Government and rural community support to undertake a longitudinal trial and evaluation of Marathon's recruiter and community connector model is critical.

My key recommendations are:

- stronger collaboration with northern periphery and arctic countries on recruitment and retention research and strategy development; and
- a national Australian trial and evaluation of the *Recruiter - Community Connector model* from northern Ontario.

Why do we need to act?

The Australian Medical Association in its 2017 report Australia Medical Association. (2017) AMA Position Statement on Rural Workforce Initiatives. Available at: https://ama.com.au/position-statement/rural-workforce-initiatives-2017

Identified:

Death rates in regional, rural, and remote areas (referred to as 'rural' in this document unless otherwise specified) are higher than in major cities, and the rates increase in line with degrees of remoteness.

People living in rural areas are more likely to defer access to general practitioners (GPs) due to cost. Rural patients often have to travel significant distances for care, or endure a long wait to see a GP close to where they live.

They have higher rates of potentially preventable hospitalisations, and are less likely to gain access to aged care.

The closure and downgrading of rural hospitals is seriously affecting the future delivery of health care in rural areas. For example, more than 50 per cent of small rural maternity units have been closed in the past two decades in Australia.

It's worth drawing on the primary source as well especially when drafting grant applications. https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/health-status-and-outcomes

Especially salient is this passage on..

"Potentially preventable hospitalisations
Potentially preventable hospitalisations (PPH) are conditions where hospitalisation could have potentially been prevented through the provision of appropriate individualised preventative health

interventions and early disease management, usually delivered in primary care and community-based settings."

"In 2017–18, the PPH rate increased with increasing remoteness. When compared with *Major cities,* the rate for those in *Very remote* areas was 2.5 times as high and in *Remote* areas was 1.7 times as high. For regional areas the PPH rates were slightly higher than for *Major cities* (Figure 4) (AIHW 2019a)."

This echoes and generalises on our findings about the anomalous use of ambulance services under potential savings and the like available with more support for remote medical centres.

Mallacoota Priorities

Community connectedness, a GPHN perspective

The Gippsland population has a low acceptance of diverse cultures, a high proportion report high or very high psychological distress and a low proportion believe there are good facilities and services.

Stakeholder and consumer input identified a lack of community connectedness as an issue underlying many health conditions.

Community input confirms that social isolation is a real concern, especially for people with a disability, for older people and for Indigenous people.
• The proportion of the community who think multiculturalism makes life better is low in Gippsland (40%), compared to Victoria (55%); especially in Wellington (31%), Latrobe (32%) and East Gippsland (37%). [73]

• There is a high proportion of people who volunteer in Gippsland (29%), compared to Victoria (23%); especially in South Gippsland (35%), Wellington and Baw Baw (33%), Bass Coast (32%) and East Gippsland (30%). [73]
•
• The proportion of persons experiencing high or very high psychological distress was high in Gippsland (14.3%), compared to 12.6% in Victoria in 2014; especially in South Gippsland (20.5%), Latrobe (17.0%) and Bass Coast (15.4%). [73]
• Transport was identified as an issue across Gippsland impacting on isolation, both due to lack of public transport options and due to the sheer distance to access many services even if they exist within Gippsland.[77, 78, 79]
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• The Gippsland PHN Clinical Council identified community connectedness as a priority factor affecting health.
• Feeling part of the community was rated as the 7th most important health issue by community survey respondents, with older people and Indigenous people rating it higher. [79]"Feeling that you are part of the community, many people these days feel isolated."
• Social isolation was the 8th most common health issue theme in community interviews and was specifically mentioned in relation to people with a disability.[79] Social support groups were mentioned as important
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• 10% of survey respondents expressed concerns about mental health stigma and acceptance. [35]
• A theme identified among comments provided in the 'Have your say' web survey was the importance of community activities.[79]

Dr Search History

To provide a greater degree of security for the future the Community in April 2016 banded together to fund a program, Dr Search which has successfully found an additional 2 Doctors to service the community with the possibility of a 4th Dr, being the wife of one of the Doctors.

The Community has also created a tax deductible charity CHIRF to source funds for and organise Dr Search and to improve the Practices access to a more extensive range of equipment that allows the Drs to treat patients instead of sending them 2 – 3 hours away. In that process the Practice was made proof against frequent power outages and a new medical centre is being built to modernize the system.

The Community achieved this without financial or support from any federal or state government body. CHIRF organized the funding and provided the highly experienced and committed workforce.

Aged Care History

For 52 years there has been an enduring and relentless drive to achieve residential aged care facilities in Mallacoota. Currently there are no facilities. Five units built for aged care in the precinct of the Mallacoota District Health and Support Service with community money have been converted to commercial uses. See History of Aged Care fund raising…….Linda Bruce……..https://chirf.org.au/miva-miva-history/

As part of the commitment to this goal, the current iteration, Mallacoota Inlet Aged Care Inc purchased the property upon which the current Medical Practice resides. CHIRF working with MIAC has obtained a federal grant to build the new medical centre on that property with MIAC cash reserves and a loan from

the Bendigo Bank completing the funding. The property is expected to be occupied and towards the end of 2018.

CHIRF as part of its extended program has applied to the Commonwealth Government for $5.5million to build a residential aged care facility and a high care room. A decision on funding is currently awaited. In the course of this application and recognizing the needs for the future CHIRF is in the process of becoming an aged care and home care provider. Other aged care support plans are in process.

Previous Reviews

In 2017, the Gippsland Primary Health Network GPHN and the Department of Health and Human Services co funded a report (DHHS contribution is reported as $35,000) and survey by the firm Community Owned Primary Health Enterprises entitled "Optimal Approach to Stabilise Primary Health Care and GP Services in Far East Gippsland" The work was supported by a organization that conducted community engagement in Mallacoota, "The Primary Agency". 199 Questionnaires were received and 80 people attended the open day. A number of organisations were contacted. The Report has not been publicly released as of the date of writing this report.

Key Findings

A key finding of the Community consultation were the following issues

- *Current difficulty in accessing GP services
- Lack of after hours services
- *Lack of choice of GP
- *Danger of sudden loss of current GP services
- *The need to take the pressure off the current GP
- *Need to cope with demand from large temporary population in holiday season
- The lack of bulk billing.

Strong concern was expressed about emergency and urgent care.

The Community Dr Search and CHIRF activity has resolved * 5 of the 7 concerns. Bulk Billing is not an issue that is within the control of the medical practice, if it is to survive financially in the current climate of freeze on Medicare Rebates. After Hours has been a goal of the Practice and CHIRF and a section of this report is devoted to resolution of that issue.

It should be noted that in securing the additional Doctors the clinical capacity of the Practice has been extended considerably with the extended skill base provided and the support of a team of highly skilled emergency Doctors. CHIRF and the medical staff are reviewing how to supplement the skill set to extend the services the practice can offer to patients and obviate their need to travel distantly.

In the survey 26% of the survey population rated the quality of health services good or excellent, 51% as poor or very poor and 24% on average in the middle.

A key statement in the report is that "The majority of people(73%) did not agree that the services are what you must expect in a country area and 93% considered the Government needed to act to improve the situation. There were multiple requests for:-

- Improved mental health services and particularly for young people
- More maternal and infant support particularly outside hours
- More aged care support in home and out of home again with a focus on outside hours support.

Existing Services - MDHSS

The Report identifies the services provided by the Mallacoota District Health and Support Service(MDHSS) which advised following a Client Survey undertaken in 2017 there were no identified gaps in the services provided by MDHSS and that there were an adequate range of services to meet the needs of the Mallacoota community. The COPHE Report adds Feedback from the community engagement process indicated some service gaps such as access to after-hours nursing extent of the level of dental services poor access to mental health and allied health appointments hard to obtain.

The services identified in the Report are:-

- Home Support and Care
- Community Nursing
- Post Acute Care
- Respite Care
- Allied Health
- Volunteer Transport
- Dental
- Other Community Based Services

The following table shows the use of these programs for 2015/16

Service Program	Unit	Amount
Commonwealth Home Support Program	Hours	1,433
Home Care Packages	Packages Individuals	10 6
Post-Acute Care	Hours Individuals	436 71
Community Nursing	Hours Individuals	1030 195
Flexible and centre based respite care	Hours Individuals	1,300 6
Volunteer Transport	Individuals Trips	20 66
Physiotherapy	Hours Individuals	485 171
Podiatry	Hours Individuals	313 124
Continence	Individuals	19
Speech	Individuals	5
Dietician	Hours Individuals	25 14
Counselling	Hours Individuals	473 34
Maternal and Child Health Nursing	Consults Individuals	187 66
Dental	Consults Individuals	285 189
Optometrist	Individuals	199
Planned Activity Groups	Hours	13,058
Emergency Housing	Individuals	41
Neighbourhood House	Individuals	298
Telecentre	Attendances Hours	466 561

MDHSS reported that there is an adequate level and range of services to meet the needs of the Mallacoota and District community. MDHSS supported the increased provision of GP services and recruitment of more GPs. Feedback from the community engagement process indicated some service gaps such as access to after-hours nursing, extent of the level of dental services, poor access to mental health and allied health appointments hard to obtain.

Victorian State Government

DEPT. OF HEALTH AND HUMAN SERVICES

Home and Community Care Program for Younger People

Services:

- Community Nursing
- Domestic Assistance
- Property Maintenance
- Physiotherapy
- Podiatry
- Volunteer Transport
- Service System Resourcing
- Assessment and Care

— *Health Services*

- Planned Activity Group

— *Social Services*

- ***Palliative Care***
- ***Post-acute Care***

— *Health Services*

- ***Homelessness Support Program***
- ***Housing Establishment Fund***
- ***Community Housing (Vic) Limited***
- ***Flexible Support Packages***

— *Social Services*

- ***Neighbourhood House***

— *Community Services*

DEPT. OF EDUCATION & EARLY CHILDHOOD DEVELOPMENT

Learn Local

Australian Government

DEPT. OF HEALTH

Rural Primary Health Services Program

Services:

- Physiotherapy*
- Podiatry*
- Counselling
- Skin Cancer Awareness
- Occupational Therapy
- PapScreen
- Oral Health
- Project Coordination

— *Health Services*

- ***Commonwealth Home Support Program***
- ***Home Care Packages***
- ***Flexible Respite and Centre-based Respite***

DEPT. OF VETERANS' AFFAIRS

Community Nursing*

DEPT. OF HUMAN SERVICES

Centrelink

EAST GIPPSLAND SHIRE COUNCIL

Home and Community Care*

ORBOST REGIONAL HEALTH SERVICE

Maternal and Child Health Nurse

VICTORIAN CANCER COUNCIL

BreastScreen (Bus)

KIDS UNDER COVER INCORPORATED

Kids Under Cover Accommodation

MDHSS SELF-FUNDED PROGRAMS

Dental Clinic, Telecentre, The Shed, MDHSS Units

**Also funded by the Victorian Department of Health and Human Services*

The above table identifies the funding sources entering the community through the services of MDHSS. The actual revenue for the past two financial years is:-

NOTE 2: REVENUE

Government Grants - Operating		
- Department of Health and Human Services	355,390	756,193
- Department of Health	782,122	411,226
- Department of Education – Learn Local	3,075	3,973
- East Gippsland Shire	16,148	12,000
Rent Received	40,385	43,472
Lease Premium – Flats	1,500	6,000
Interest and Investment Income	41,572	44,784
Recoveries		
- Home Care Services	8,871	25,904
- Other Recoveries	13,629	13,717
Service Fees		
- Post Acute Care	20,661	33,694
- Department of Veterans Affairs	3,830	8,597
- Dental Service	64,164	61,586
- Planned Activity Group	32,938	31,238
- Neighbourhood House	6,863	1,943
- Home Care Packages	16,112	19,069
- Other Services	43,187	40,353
Loss on Sale of Non-Current Assets – refer Note 4	14,051	18,718
Other Income	4,206	10,750
Total Operating Revenue	**1,468,704**	**1,543,816**
Government Grants - Capital		
- Department of Health and Human Services	7,500	29,912
- Department of Education – Learn Local	5,000	5,000
Total Capital Purpose Income	**12,500**	**34,912**
Total Revenue	**1,481,204**	**1,578,728**

NOTE 3: EXPENDITURE

Employee Expenses:		
- Salaries & Wages	809,415	888,886
- Superannuation	73,667	79,097
- WorkCover	8,889	8,959
	891,971	976,942
Program Expenses:		
- Services Purchased	84,718	94,130
- Day Care Expenses	31,365	29,518
- Medical Supplies	7,699	7,509
- RAFS	18,518	17,597
- Consulting Fees - Dental	35,382	33,758
- Consulting Fees - Other	119,117	53,941
- Other Program Expenses	41,636	65,260
	338,435	301,713
Property Expenses:		
- Electricity and Gas	10,917	10,022
- Rates & Property Charges	8,750	8,614
- Repairs & Maintenance	23,111	27,445
- Minor Equipment Purchases	18,694	3,540
	61,472	49,621
Administrative Expenses:		
- Accountancy	18,527	12,259
- Auditors' Remuneration *(other services $nil)*	7,275	9,200
- Legal Costs	-	400
- Motor Vehicle Expenses	30,431	32,213
- Travel	11,067	9,130
- Telephone & Postage	13,320	16,835
- Other Administrative Expenses	43,842	37,955
	124,462	117,992
Depreciation:		
- Buildings	64,169	64,617
- Plant & Equipment	10,342	8,294
- Furniture & Fittings	5,217	4,121
- Computers & Equipment	17,051	10,336
- Motor Vehicles	20,961	14,992
	117,740	102,360

NOTE 4: PROFIT ON SALE OF NON-CURRENT ASSETS		
Proceeds in Sale of Non-Current Assets	14,051	31,528
Less: Written Down Value of Assets Sold	-	(12,810)
	14,051	18,718
NOTE 5: CASH AND CASH EQUIVALENTS		
Cheque and Cash Management Account	405,847	509,538
NOTE 6: TRADE AND OTHER RECEIVABLES		
Trade Debtors	48,035	23,760
Accrued Interest	23,680	18,603
	71,715	42,363
NOTE 7: TERM DEPOSITS		
Term Deposit – Bendigo & Adelaide Bank	834,155	683,208
Term Deposit – Westpac Bank	500,000	500,000
	1,334,155	1,183,208

Mallacoota Medical Centre

The Mallacoota Medical Centre has been in existence for 30 years ranging from a sole GP at start up through to 3 GPs for much of the 2000 to 2 GP's in 2014/5 1 GP in 2016/2017 and now 3 GP's. One RACGP, One on a RVTS Scholarship and one on a AGTP Program both working towards RACGP fellowship. This represents a Practice GP presents of 2.6 FTE

The Practice has been working on the servicing about 8000 patients per annum before the advent of the third Doctor. .

Based on national presentation statistics the demand that Mallacoota generates is between 15 – 18,000 patients. This estimate included the transient population load that occurs mostly in the Christmas easter period

Remote benchmarking indicates that Mallacoota District generates a patient load equivalent to 2.8 FTE.

A back of the envelope estimate based on national statistics is that the Pracitce generated in 2015/2016 $400,000 health care costs from the Commonwealth

Mallacoota Pharmacy

Estimate only made based on Medical Centre estimate.

Ambulance Victoria

Ambulance Victoria has some 315 call outs a year from Mallacoota. The COPHE Report identifies 220 of these are to hospitals in Bega or Orbost, 67% to Bega.

https://www.aihw.gov.au/getmedia/3a34cf2c-c715-43a8-be44-0cf53349fd9d/20592.pdf.aspx?inline=true

Health Delivery Cost Comparison

The Annual Expenditure on Health by Governments per person in Australia in 2015/16 was $7096. The above revenue going into MDHSS represents $1393 per person in Mallacoota. The Medical Centre and the Pharmacy are estimated to draw on about $750 in payments from the Commonwealth. Ambulance Victoria approximently $20

Total Commonwealth and State health care funding to Mallacoota is estimated to be of the order $2163. There will be leakage to the nearby communities and the major metropolitans for specialist health care etc. The gap however $4933 even if out by half is a substantial shortfall in services to the community.

The gap occurs because there are no aged care or nursing facilities. Almost all the ambulance work no matter how minor it exported and people are forced to travel to Merimbula Bega and Bairnsdale for minor services.

COPHE Report – Health Deliverables for Rural Communities

The COPHE Report uses a research study undertaken by Susan L Thomas, John Wakerman and John S Humphreys on What core PHC servicds should be available in rural and remote communities incuding equity of access:-

[6] Susan L Thomas, John Wakerman and John S Humphreys: Ensuring equity of access to primary health care in rural and remote Australia – what core services should be locally available? International Journal for Equity in Health 2015, 14:111

The Key core groups are

- Care of the sick and injured
- Mental Health/Social and emotional well being
- Allied Health
- Sexual and Reproductive Health
- Rehabilitation
- Oral/Dental Health
- Public Health/Illness Prevention.

The extensive table based on population identifies the following

Core PHC Services	Population Thresholds		
	101-500 Nowa Nowa Cann River	1,001-3,000 Mallacoota	3.001-5,000 Orbost
Care of the sick and injured			
24 hour care including evacuation	√	√	√
Treatment of injury & poisoning	√	√	√
Pathology	√	√	√
Radiology		√	√
Provision of essential drugs	√	√	√
Patient advocacy	√	√	√

Core PHC Services	Population Thresholds		
	101-500 Nowa Nowa Cann River	1,001-3,000 Mallacoota	3.001-5,000 Orbost
Mental Health and Social and Emotional Wellbeing			
Counselling		√	√
Drug and alcohol treatment		√	√
Maternal and Child Health			
Ante/post-natal care		√	√
Child development checks		√	√
Immunisations		√	√
Sexual and Reproductive Health			
Sexually transmitted infections and blood borne viruses		√	√
Family planning		√	√
Public Health/Illness Prevention			
Advocacy		√	√
Immunisation		√	√
Communicable disease control		√	√
Targeted population/health promotional programs		√	√
Screening programs		√	√
Well men's and women's service		√	√
Youth program		√	√
Rehabilitation			
Alcohol and drug rehabilitation		√	√
After trauma		√	√
Post-cerebrovascular accident (stroke)		√	√
Oral/Dental Health		√	√
Allied Health Services			
Audiology		√	√
Dietetics		√	√
Occupational therapy		√	√
Optometry			
Physiotherapy		√	√
Podiatry		√	√
Psychology			√
Counselling/social work/family violence		√	√
Speech pathology		√	√
Aged care and disability services	√	√	√
Palliative care		√	√

√ Core Services that **should** be available to all Australians based on population thresholds

CHIRF Key List of immediate priorities

Through the Course of its work with the Mallacoota Medical Centre in the search for Doctors and building a locum pool sympathetic to the needs of a remote rural practice, the CHIRF group have identified the following key Gaps to focus on in support for the community

Doctor Succession	After Hours Medical Services
Face to Face Psychology Service	Youth Psychology Services
Aged Care Facilities, Short Term	Aged Care Facilities Medium Term
Aged Care – Residential Aged Care and high care beds	Trauma and High Care Facilities
Transport Home from distant medical	Palliative Care 24/7/365
Doctor Accommodation	Fitness Centre
Rehab Services including Hydrotherapy	X Ray Equipment

In recognition of the AMA assessment of the needs for remote rural areas, the reduction in mean death aged faced by what is identified as the most aged community in Victoria, CHIRF identifies the above needs as part of the process in working with the community and for the community.

It is recognized that there needs to be some assessment of the actual need and whether the services can be provided with Mallacoota and Cann River, or patients must be resigned to travel.

CHIRF Identification of Need

The following is our assessment of the key issues confronting the community of 1063, the numbers involved and based on the statistics available through MDHSS table above the shortfall. Not all calculations are based on Australian medical averages. The demand figures are likely to understate the need
The majority of the data is sourced from the GPHN-Needs-Assessment-Report-July-2019-June-2022

Mental Health

https://www.aihw.gov.au/getmedia/5ef33083-6a64-4456-8c7d-5bd16f3b25eb/Medicare-subsidised-mental-health-related-services-2011-12.pdf.aspx

Over 7.9 million Medicare-subsidised mental health-related services were provided by psychiatrists, GPs, psychologists and other allied health professionals to over 1.6 million patients in 2011–12.
• GPs provided more services to more patients than the other provider types.
• There has been an average annual increase of 11.2% in the total number of services recorded for the 5-year period 2007–08 to 2011–12.

• Victoria had the highest number of patients and services per 1,000 population in 2011–12.
• Females accessed more services from all provider types than males.

Medicare-subsidised mental health-related services for states and territories There were 7,934,277 Medicare-subsidised mental health-related services reported in 2011–12 for an estimated 1,603,263 patients, an average of 4.9 services per patient. Victoria had the highest number of patients and services per 1,000 population (80.7 and 432.0 respectively), compared to the national average of 71.3 patients and 352.9 services per 1,000 population. The Northern Territory had the lowest rate for both patients (31.3) and services (104.7 per 1,000 population) (Figure MBS.1).

Mallacoota assessment of demand – Mental Health

Mallacoota is on this basis in 2011 was likely to have at least 80 people within the community needing to use mental health services. Based on an annual increase of 11% that number is likely to be closer to 140

The sole provider of mental health services is as identified in the Report as VSPC.

The following drawn from the Australian Psychological Societies Report contains many very relevant observations and recommendaations about the pathway for delivery.

The Future of Psychology in Australia June 2019 White Paper..

A blueprint for better mental health outcomes for all Australians through Medicare

Recommendation Fifteen:

Enhance access to psychological services for people in regional, rural and remote Australia

Introduce financial incentives, such as rural loadings, to improve the financial viability of providing psychological services to people who live in regional, rural and remote areas of Australia.

The current structure of psychological services is no longer fit for purpose.

The one-size-fits-all approach of 10 sessions per annum is incompatible and insufficient to meet the mental health needs of the Australian community.

Approximately 62% of government spending is for acute and specialised mental health services.[1] Additionally, statistics show that Australians aged 15-64 represent the largest proportion of mental health related presentations to emergency departments.[8] In 2017-18, almost 300,000 Australians presented to an emergency department due to mental health problems.[9] Of these, almost 93% were classed as
an emergency, urgent or semi-urgent requiring immediate care within 10-60 minutes of presenting, however the average length of stay was approximately 3.5 hours.

Increase access to mental health services for those in need: through increased services and mediums of psychological support. While access to psychological services has increased over the last decade, regional and remote populations, and those in deprived regions, continue to be under-serviced. For example, mental health disorders are more common among children and adolescents who experience socio- economic disadvantage[19] and these young people, along with those living in more remote areas, are less likely to use psychological services compared with their metropolitan counterparts.[20]

Generate health sector savings: resulting from a reduction in health service utilisation including fewer emergency department visits and inpatient hospital stays. Individuals experiencing mental illness can incur a range of avoidable health-related expenses, including emergency department presentations and hospitalisations. In 2017-18, there were 286,985 mental health-related visits to public hospital emergency departments, with almost a third resulting in hospital admissions.[9]
With the average cost of an admitted emergency department presentation
of $977 (and the average cost of a non-admitted presentation of $517),[25] the costs of emergency department presentations and hospitalisation relating to mental illness are estimated to be over $190 million each year. Investing in mental health and

wellbeing provides an opportunity to reduce avoidable costs associated with emergency department presentations and hospitalisations. An early evaluation of the Better Access initiative found
that improved access to psychological services within the community helped deliver better outcomes for patients in the long term and prevented unnecessary hospitalisations.[20]

The APS suggests clients are stepped through levels of psychological care according to the:
• nature of the mental health disorder • expertise of the psychologist
• needs of the client (number of sessions required to achieve effective clinical outcomes; up to 20 sessions for low intensity treatment needs and up to 40 for clients with a specific diagnoses and high intensity treatment needs).

The APS suggests the following amendments to medical practitioner referrals:
• Increase the maximum number of
allowable sessions per referral from
6 to 10 sessions.
• Broaden eligible referrers to include
all medical practitioners registered with the Australian Health Practitioner Regulation Agency to enhance collaboration, reduce administrative burden on the client and reduce the cost to government.
The APS suggests the following amendments and new criteria for medical practitioner reviews:
• Require reviews after each block of
sessions (maximum of 10 sessions)
• Introduce pre- and post- outcome
measures for each block of sessions
• Require a psychological report to be
provided to the referring practitioner
prior to each review
• Introduce review criteria after each
course of treatment (up to 10 sessions).

Review Criteria

The criteria to access more than the initial 10 sessions is based on the combination of measured outcomes, the nature of the presenting problem and how they match with the qualifications of the treating psychologist.
This requires amendments to the current triage and referral processes, the embedding of outcome measures and communication (reporting) between health professionals and simplifying the initial triage process.
Our ageing population means a concomitant increase in the risk of neurocognitive impairment and associated mental health concerns.[63-66] Improving diagnosis and care can reduce the socioemotional and economic burden of this fast-growing area of need in
the community.[67-69]
Differentiating mental health conditions from neurocognitive impairments such as dementia, as well as early/timely diagnosis of dementia by a clinical neuropsychologist, can facilitate the provision of more appropriately targeted treatment and care, at the same time reducing the impact or risk of further mental health concerns. In particular, certain mental health disorder (e.g., depression, anxiety, psychosis) and dementia frequently co-occur or can masquerade as one another, increasing diagnostic complexity.[70,71] Early onset dementias, as well as rare, atypical and comorbid neurological presentations
in this domain are also vulnerable to misdiagnosis.[70] Thorough, objective neuropsychological assessment and expert knowledge is critical to the provision of appropriate care for this client group.

Case conferencing
with other health professionals enhances clinical care; aligns with the evidence-base, and supports multidisciplinary collaboration for the benefit of the client.

The current structure of care pathways to psychological treatment include
a brief assessment by the referring medical practitioner.[80] This assessment typically involves identifying and treating medical issues that may be causing or contributing to mental health symptoms and preparing a mental health care plan and referral for psychological treatment services.
There is a need to strengthen the collaboration and communication between medical practitioners and psychologists for the benefit of the client.[81] This includes collaboratively assessing the client's mental health needs by respecting the differentiation between the professions and supporting team-based care where the client benefits from a multidisciplinary approach to their treatment.

Background and context

A third of Australians live in regional, rural and remote areas of Australia and the APS recognises there are significant challenges involved with delivering mental health services to these Australians. The nature of the mental health workforce is determined by various factors including health services models, and recruitment and retention strategies.
Efforts to improve the engagement

and participation with mental health services is a priority across Australia[89] and this relies on the availability of psychologists in regional, rural and remote areas. The distribution of psychologists declines with remoteness.[1]
Psychology practices in regional,
rural and remote areas face greater financial challenges due to a decreased client base, larger distances between psychologists and clients; and the increased demand for bulk billing.
These challenges negatively impact
on the financial viability of providing psychological services and the availability of psychologists in these areas. While this disproportionate spread of health practitioners is recognised within Medicare for rural GPs, there remains no financial incentive to improve the sustainability of regional, rural and remote psychological practices.

Mallacoota Mental Health servicing req

After Hours Care Medical Care

CHIRF ASSESSMENT OF AFTER HOURS NEED

Access to services – After-hours. GPHN ASSESSMENT

Community engagement reveal **after-hours service access as a community concern in many parts of Gippsland, especially in more remote locations with no access to an emergency departmen**t.
GPs are responsible for around half of all after-hours medical activity in Gippsland, either through a general practice or urgent care centre.
Cost is a barrier to people accessing GP practices after-hours due to lack of bulk billing. At the same time, providers find it challenging to attract staff after hours due to lack of financial incentives.
Awareness of after-hours options is generally low.
• The after-hours period is defined as:
○ Before 8.00am and after 6.00pm weekdays ○ Before 8.00am and after 12.00pm Saturdays ○ All day Sundays and public holidays
• The after-hours period is further categorised into the following periods:
○ The sociable after-hours period, between 6.00pm and 11.00pm, and 7.00 am until 8.00 am ○ The unsociable after-hours period, between 11.00pm and 7.00am
• An after-hours practice incentive payment (PIP) is available and **PHNs are funded by the Department of Health to increase the efficiency and effectiveness of after-hours primary care in their catchments**.
• ***Emergency Departments funded by DHHS are available in five locations across Gippsland; Bairnsdale, Sale, Traralgon, Warragul and Wonthaggi.***
• ***GP operated urgent care centres in six locations; Omeo, Orbost, Leongatha, Korumburra, Foster and Yarram.***
• ***Support by Gippsland PHN for GP practices to operate in the after-hours period is provided in Cowes, Leongatha, Moe, Omeo and Orbost***.
• 40 GP practices in Gippsland received the level 5 after-hours incentive payment for the November quarter 2017.[42]
• Additional GP practices operate in the after-hours period through use of PIP and/or MBS funding support.
• **After-hours service options in remote communities include an urgent care type service in Mallacoota, supported by the Ambulance service, and bush nursing services in Cann Valley, Ensay, Gelantipy, Buchan, Swifts Creek and Dargo.**
• The average number of after-hours GP attendances is low across Gippsland with 0.18 visits per year per person compared to 0.49 for Australia. [26]
• Workforce issues are an important consideration influencing after-hours medical service provision. **GPs willing to accept the responsibility of 24 hours coverage can be hard to find, leading to recruitment issues in rural areas.**[100]
• Approximately half of after-hours activity in Gippsland is provided by GPs (at a general practice or via urgent care centers) with the other half accounted for by emergency departments.[100] Variation by LGA highlight South Gippsland as very GP reliant due to lack of funded ED.
• After-hours ED presentations are high in Gippsland compared to the rest of Victoria (except in South

Gippsland where there is no ED).[100]
• ED presentations for category 4-5 (semi-urgent and non-urgent) account for 54% of after-hours activity.[100]
• MBS items are available for urgent and non-urgent after-hours attendances. Data for 2015-16 shows the distribution of the type of claims; [100]
○ 9.6% were a consultation in an aged care facility
○ 1.6% were home visits (or a consultation at an institution other than hospital) ○ 14.4% were urgent after-hours attendances

• Based on regional de-identified GP practice data, after-hours activity provided in 2016, 50.3% occurred in the 6 pm to 8 pm period on week-days, when there is no after-hours MBS item available. [100]
• Access to after-hours emergency care on Philip Island has been an on-going community concern. A project to identify a suitable model to address this gap has been undertaken, including literature review, data analysis of current activity and community focus groups. Findings include:[101]
○ The community is not aware of all existing options
○ Any model needs to cater for the strong fluctuation in demand due to tourism
○ The needs of people with mental illness, drug and alcohol and domestic violence issues need to be considered
○ Transport needs are an important service consideration
• Gippsland PHN Clinical Councils have expressed some concerns about the sustainability of GPs providing after-hours care due to the impact on work / life balance for rural and regional GPs. Poor remuneration is an additional concern.
• The Gippsland PHN Clinical Councils have identified that access to after-hours medical care for residents of aged care facilities is an issue contributing to deteriorating conditions for residents who are then more likely to present to the emergency department.
• Access to medical services after-hours was identified as a need in community interviews across Gippsland; a need is access to ED in South Gippsland.[79]
• Survey results show that respondents are most likely to access the ED after hours if they had a health problem (86%). The proportion reporting they were likely to seek help from other services; [79]
○ Ambulance 76%
○ Family / friends 69%
○ Nurse on call / GP help line 59% ○ Their doctor / GP 31%
• After-hours access of own doctor / GP was reported as not likely by 53% and 17% did not know how to

contact. South Gippsland and Baw Baw residents were more likely to seek help from own doctor / GP after-hours (around 40%), while East Gippsland residents were less likely (22%).[79]
• After-hours access of Nurse on call / GP help line was reported as not likely by 33% and 8% did not know how to contact. Parents, Carers and people with a disability were more likely to contact help lines (around 70%), while males were less likely (47%).[79]
• Barriers and enablers to access after-hours services were identified; [79]
○ GPs are often not available ○ GPs are too expensive
"It's too expensive to go to the GP on any normal visit time, let alone an after-hours fee. Forget it. I'd go the emergency dept instead"
○ GP would refer to ED
"I end up at emergency with doctor's letter"
○ Nurse on call had mixed reviews
○ ED was seen as a good options but wait times were a barrier
○ Ambulance is the only option in some areas; concern about response time was noted ○ A lack of knowledge about after-hours options
"More info should be provided to people about what to do when mental health problems occur after hours"
• Service providers have identified some specific challenges; [127]
○ Making it financially attractive for GPs to provide an after-hours service without increasing the cost for consumers. Potential use of a nurse practitioner model.
○ Increased demand for mental health services.
○ Increased demand for chronic disease management.
○ High proportion of patients with low socio-economic status leading to high demand for bulk billing.
○ Workforce challenges in outer regional areas could be addressed by additional incentives for international graduates and funding for locum cover.
○ Tourism activities can lo added injuries which add to after-hours service pressure.
○ After-hours medical issues include heart related issues, injuries, mental health issues, family violence issues and exacerbation of asthma.

Mallacoota proposed Model for After Hours Care

Digital health

Stakeholder feedback indicated that there is awareness and some optimism that digital health initiatives such as telehealth and e-

Emergency management

Emergency management was identified as a theme by stakeholders but not a priority. Community input revealed specific concern around fires.

• Comments related to fires, floods, extreme heat and other emergencies was a theme in stakeholder feedback. This included preparedness for climate change and its impact on coastal communities in Gippsland. [78, 79]

• Fires were mentioned as a health issue in community interviews and communication and information was called for. [79]

"Far more honest discussion about the fires as it affects us and our children..."

• Concerns about health effects of fires were also mentioned in community surveys. [79]

Alcohol and Other Drugs

Alcohol-related family violence rates in four of six Gippsland Local Government Areas (LGAs) is well above the Victorian rate; Bass Coast, East Gippsland, Latrobe and Wellington.[1] The highest rate was seen in the 25-39 year age group and the rate for women was twice as high as for men.

• The rate of alcohol-related ambulance attendances for four Gippsland LGAs are among top 25% for Victoria; Bass Coast, East Gippsland, Latrobe and Wellington. [1]

For males, the alcohol related hospital admission rate was among the top 25% in Victoria for three Gippsland LGAs; Bass Coast, East Gippsland and Wellington. [1]

• For females, the alcohol related hospital admission rate was among the top 25% of rates for four Gippsland LGAs; Bass Coast, East Gippsland, Latrobe and South Gippsland. [1]

The rate of ambulance attendances for illicit drug use were higher than the State rate for East Gippsland and Latrobe. [1]

• The rate of hospital admissions for illicit drug use were high in East Gippsland, Latrobe and Wellington. [1]

• Alcohol-consumption at levels likely to cause long term harm (>2 standard drinks per day) among adults is higher than Victoria (59%) in Bass Coast (63%), East Gippsland (61%), Latrobe (61%) and Wellington (76%).[2]

The rate of clients receiving alcohol and drug treatment service are higher than the Victorian rate in Bass Coast, East Gippsland, Latrobe and Wellington.[2] The episodes of care rate were more than double the State rate in East Gippsland and Latrobe. [1]

10% of Gippsland GP patients (aged 15 years or older) have a high alcohol consumption recorded (>14 standard drinks per week), (77% of patients did not have alcohol consumption recorded). [61]

Mallacoota statistical assessment for drug alcohol and family violence

Mallacoota needs for drug alcohol and family violence

qqqq

Cancer

Cancer

Cancer is a leading cause of death with lung cancer, colorectal cancer, prostate cancer and breast cancer in the top ten causes of death for males and/or females in Gippsland. Cancer is also the third cause of disability (based on DALY) in Gippsland. The rates of cancer deaths are high in Gippsland, especially due to lung cancer.

Community input demonstrates strong support for cancer screening and services as a priority, while clinician input does not suggest it is a priority. Cancer screening rates

• Bowel cancer screening rates across Gippsland continue to be higher than the rates for Victoria at 48.6% (compared to 41.9%). Coverage rates are lower for males, younger age groups (50-55 years) and there is variation by LGA.[24]

• The proportion of positive bowel cancer screening results for Gippsland were a little higher than for Victoria with 8.1% of males (Vic 7.7%) and 6.8% of females (6.2%) returning a positive result in 2014-15.[25]

• Cervical cancer screening rates in Gippsland were 56.9%, very similar to Victoria (56.6%) in 2015-16, with regional variation; Baw Baw (60.7%), East Gippsland and Bass Coast / South Gippsland (58.3%), Latrobe (54.4%) and Wellington (55.1%). Variation by age group is noted with screening rates generally lower for younger age groups.[24]

• Cervical cancer screening was significantly more likely to detect a high-grade abnormality among women in Latrobe (16.6 per 10,000 screened women) and South Gippsland (15.2); Victoria (12.5). [25]

• Cervical cancer screening was more likely to detect a low grade abnormality among women in South

are generally good in Gippsland, but improvements in some LGAs, for males and for certain age groups is an opportunity for improved outcomes.

Gippsland (51.4 per 10,000 screened women) and Latrobe (49.5); Victoria (44.2).[25]

• Breast cancer screening rates for 2015 – 2016 show that 56.3% of Gippsland women aged 50-74 were screened, compared to 53.8% of Victorian women. Variation by age group is noted with screening rates lowest for the 70-74-year age group. [24]

• Breast cancer screening was not more likely to detect breast cancer among women in Gippsland (range of 29 to 44 cancers detected per 10,000 screened women – age-standardised); Victoria (35.3). [25]

• Age-standardised cancer incidence rates for all cancers are similar to national rates (499 new cancers per 100,000 people compared to 498 for Australia).[26]

• Cancer incidence rates for colorectal cancer are high in Gippsland (69 per 100,000 people) compared to Australia (63).[26]

• Cancer incidence rates for lung cancer are high in Gippsland (50 per 100,000 people) compared to Australia (44).[26]

• Nationally, cancer is the leading cause for burden of disease (as DALY), accounting for 19%.[27]

• A high proportion of the disease burden from cancer is fatal and overtakes mental and substance use disorders as the major cause from age 40 years.[27]

• Malignant cancer is the third cause of disability (based on Disability Adjusted Life Years [DALY]) in Bass Coast, East Gippsland, Latrobe and South Gippsland, while it is the fifth cause of disability in Baw Baw and Wellington.[28]

• Lung cancer deaths have become relatively more common (2012-16) and was the 2nd cause of death among males in five of six Gippsland LGAs (3rd in East Gippsland); (Australia 2nd).[29]

• For females, lung cancer was the 4th cause of death in Bass Coast, Baw Baw, East Gippsland and South Gippsland while it was the 5th in Latrobe and Wellington (Australia 4th).[29]

• Prostate cancer was the 2nd cause of death for males in East Gippsland, 3rd in Baw Baw and Wellington, 5th in South Gippsland and Latrobe and 6th in Bass Coast (Australia 6th).[29]

• Breast cancer has become relatively less common (2012-16) and was the 5th cause of death for females in Bass Coast, Baw Baw and South Gippsland, 6th in East Gippsland and Wellington and 9th in Latrobe (Australia 6th). [29]
• Colorectal cancer has become relatively less common (2012-16) and was the 7th cause of death for males in East Gippsland 8th in Wellington and Latrobe and 9th in Bass Coast (Australia 8th); for females colorectal cancer was 8th in Wellington, 9th in East Gippsland and less common in other LGAs (Australia 9th).[29]
• Cancer mortality rates due to all cancers are high in Latrobe (193 age-standardised rate per 100,000 people), East Gippsland (194) and Wellington (202) compared to Australia (167).[30]

• Lung cancer mortality rates are high across Gippsland (age-standardised rate of 32 per 100,000 people), compared to Australia (27), except in Baw Baw.[30]
• Colorectal cancer mortality rates are high in East Gippsland (age-standardised rate of 19 per 100,000 people), compared to Australia (16). [30]
• Breast cancer mortality rates are high in Gippsland (age-standardised rate of 23 per 100,000 women), compared to Australia (21), especially in Wellington, Bass Coast and South Gippsland. [30]
• Prostate cancer mortality rates are high in Gippsland (age-standardised rate of 32 per 100,000 men), compared to Australia (27), especially in East Gippsland, Wellington and Latrobe. [30]
• Melanoma mortality rates are high in Baw Baw and Latrobe (age-standardised rates of 9 per 100,000 people), compared to Australia (6). [30]
• Colonoscopy rates vary across Gippsland, being high in Baw Baw and low in Latrobe and Wellington.[31]
• Prostate biopsy rates are low for men aged 40 or above in Gippsland.[31]
• Stakeholder input identified cancer as a minor theme.[78]
• Cancer screening (pap smear / mammogram) was the 3rd most commonly identified service gap identified by a Gippsland Women's Health survey.[32]
• Cancer screening / services was rated 4th most important health issue in the community survey and older people ranked it 3rd most important.[79] Five people made a comment related to cancer, illustrating barriers to early diagnosis and management;
"Follow up on my breast cancer, breast reconstruction. The surgeon is in Melbourne. The problem is with my lymphedema arm. There is so much else in my life that I don't have the time to look at my own health."
"I am also skeptical of tests like mammograms, I have heard they can start cancers. I would take a blood test for breast cancer but not a mammogram."
"Skin cancer was ignored."
"Family history of breast cancer in middle age. Requested earlier scanning/testing ... was told age limit (50) still applies ... it was up to me to examine and report any changes to the breast (which I am not confident in doing)."
"I need to have an endoscopy done to look at things and I cannot afford it"
• A few people mentioned cancer in community interviews; two were concerned about incidence of cancer in the community, two saw chemotherapy as a service gap and another two made mention of accessing specialists;[79]
"Reasonably good cancer specialists. There are only visiting specialists - not ever enough but they are visiting."

"Travel to Melbourne and Traralgon for specialist treatment. Understand why this is so but it's a hassle ..."
• A detailed analysis of cancer screening rates in Latrobe showed great variation in screening rates between age groups, genders and smaller geographical areas.[33]
• Focus groups and community engagement via vox pops and social media to identify barriers and enablers to screening has occurred in Latrobe.[33] Findings include;
o Main reasons for not screening were; lack of awareness, fear of results, worry about costs and lack of time.
"Price worst thing ... too high income for health care card but still scrape from week to week "
o Men expressed a fear of bowel screening results being bad. They were more likely to be reactive rather than proactive and many don't see the benefit of screening, are worried about privacy and focused on looking after others.
"Don't want to know – rather die quickly"
o Women were worried about not knowing the process of breast screening and any follow up care, had issues with appointments and recall and were concerned about transport, cost and the impact on others.
"I'm due to have a screen but am very scared"
o It was not that "disadvantaged groups are difficult to reach and there is a large proportion of disadvantaged people here."
o Enablers were identified;
- Reliance on personal reminders from GPs with written reminders to screen seen as useful

- Awareness raising through media campaigns and at locations including shopping centers, community health centers and newsagents

"Trust is a big part of testing, and there's such a high turnover of GPs locally, it's too hard to build a relationship, so there's no trust."

- 60% of young women (aged 18-25 years) surveyed in a University setting were unaware of new recommended cervical screening practices

A high proportion of the disease burden from cancer is fatal, and overtakes mental and substance use disorders as the major cause from age 40 years. [57]

- Lung cancer is the 2nd cause of death for males in each of Gippsland LGAs, while it is the 4th cause of death among females in Bass Coast, East Gippsland, and Latrobe; for females in other LGAs Baw Baw (5th), Wellington (6th) and South Gippsland (7th).[45]

- Breast cancer is the 4th cause of death for females in Baw Baw, South Gippsland and Wellington, 5th in Bass Coast and 6th in East Gippsland and Latrobe. [45]

- Prostate cancer is the 3rd cause of death for males in East Gippsland and Wellington, 4th in South Gippsland and 5th in Bass Coast, Baw Baw and Latrobe. [45]

Colorectal cancer is the 5th cause of death for males in East Gippsland 7th in South Gippsland and 8th for females in East Gippsland and Wellington; less common in other LGAs. [45]

- Cancer (unknown and ill defined) was the 7th cause of death for males in East Gippsland, 8th in Bass Coast and Wellington and 8th for females in East Gippsland and Wellington; less common in other LGAs. [45]

- Malignant cancers is the third cause of disability (based on Disability Adjusted Life Years [DALY]) in Bass Coast, East Gippsland, Latrobe and South Gippsland, while it is the fifth cause of disability in Baw Baw and Wellington.[5]

Cervical cancer screening was significantly more likely to detect a low grade abnormality among women in East Gippsland (48.5 per 10,000 screened women) and Latrobe (47.5); Victoria (43.0). [6]

Diagnosis rates of malignant cancers are high in Gippsland, especially in Bass Coast and East Gippsland.[2]

Premature death rates due to lung cancer are high in East Gippsland and Latrobe. [6]

Cancer screening (pap smear / mammogram) was the 3rd most commonly identified service gap identified by a Gippsland Women's Health survey. [42]

- Cancer screening / services was rated 4th most important health issue in the community survey and older people ranked it 3rd most important. [32] Five people made a comment related to cancer, illustrating barriers to early diagnosis and management;

Cardiovascular Diseases

Cardiovascular diseases

The rate of cardiovascular disease in Gippsland is high and this is reflected by a high rate of death, disability and service use. Variation between LGAs is evident.

• Coronary heart disease is the leading cause of death for both males and females in Gippsland (and for both males and females in Australia).[29]

• Cerebrovascular diseases (includes stroke) is the third cause of death for females and 4th for males in Gippsland (Australia 3rd for males and females). [29]

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Stakeholder consultation confirmed cardiovascular diseases as an important health issue.

Community input also confirms heart health as an important health issue for people in Gippsland.

Recent data from GP practices show that high blood pressure remains a concern for many people in Gippsland.

• Cardiovascular disease is the fifth cause of disability (based on Disability Adjusted Life Years) in Bass Coast, East Gippsland, Latrobe and South Gippsland.[28]

• Nationally, cardiovascular disease is the second cause for burden of disease (as DALY), accounting for 15%.[27]

• Much of the disease burden from cardiovascular disease is fatal but with a notable non-fatal component. It becomes prominent from age 50 as a major cause of disability. [27]

• Hypertension and congestive heart failure are both among the top five conditions leading to potentially preventable hospitalisations (PPH) in Gippsland, relevant for 15% and 8% of PPH respectively.[31]

• It is estimated that 29.7% of adults in Gippsland have high blood pressure, compared to 25.9% across Victoria; LGAs with the highest estimates were Latrobe (37.1%), Wellington (29.1%) and Baw Baw (28.4%).[73]

• 27% of Gippsland GP patients (15 years or older) have a high blood pressure recorded (>140 systolic), (19% of patients did not have a blood pressure recorded).[3]

• High blood pressure was the most common diagnosis for patients visiting their GP in Gippsland in 2017-18, and among the top 5 for patients over the age of 40 years. [3]

• Survey data shows that 80.1% of the adult population had a blood pressure check in past two years, compared to 79.9% for Victoria; highest rate was in Latrobe at 86.6%.[73]

• Survey data shows that 57.0% of the adult population had a cholesterol check in the past two years, compared to 59.5% for Victoria; highest rate was in Latrobe (62.2%) and lowest in Bass Coast (51.5%).[73]

• The proportion of people reporting heart disease is highest in South Gippsland (8.7%) and Latrobe (8.5%), compared to 7.2% for Victoria. [73]

• Admission rates to hospital due to heart failure are high for Latrobe residents.[31]

• The rate of potentially preventable hospitalisations due to congestive heart failure are similar in Gippsland (206 per 100,000 age-standardised) compared to Australia (211) with some variation across the region (180 to 235).[26]

• The rate of potentially preventable hospitalisations due to angina are high in East Gippsland (208 per 100,000) compared to Australia (130). The Gippsland rate was 144 with some variation for LGAs from a low of 94 in Baw Baw. [26]

• Cardiovascular diseases was a key theme in stakeholder consultation.[79]

• Cardiovascular diseases was a top priority identified by Gippsland PHN's Clinical Council members (2016).

• Heart health was identified as one of the most important health issues by survey respondents,

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especially by older people. [79] Six people mentioned heart disease as an issue that has not been managed well;

"I attended ED last week after the chemist told me my blood pressure was dangerously high and that I could have a stroke or heart attack. They brought it down ... I was told to attend my GP in the morning but was refused due to there being no appointments available."

"After having chest pains my doctor inferred that I had IHD and that my cholesterol was too high and wanted me to take aspro and statins, I said that I didn't want to take those and suggested that I would like to try and reduce my cholesterol with diet, he said no and said if I had a heart attack that it would be fatal which I took to be rather threatening and intimidating, seeing how I have never had a heart attack! I went and had the prescribed tests for IHD which came back all clear, changed my diet ... and have never felt better."

• Cardio-vascular disease was mentioned as a health issue in interviews and cardiologists were mentioned as a service gap. [79]

"Timely and local access to "basic specialist" (mental health, heart, ortho)..."

"Some charge some bulk bill and you have no choice - you go where you are sent. 6-8 weeks wait to see heart specialist..."

"Visit monthly or fortnightly and then they are too busy to get in so you have to go to Melbourne"

• A study of heart disease in Australian electorates identified Gippsland (including the LGAs of East Gippsland, most of Latrobe and Wellington) as having a high rate of coronary artery disease among people aged 35 or older.[34]

• 39% of Gippsland GP patients (15 years or older) have high cholesterol recorded (>5.5 mmol/l), (47% of patients did not have a cholesterol level recorded). [3]

• High cholesterol was among the top 5 diagnoses for patients aged 50 years or over with GP activity in 2017-18.[3]

• 13% of South Gippsland Dairy Expo attendees reported that they or someone in their household had experienced heart disease in the past 12 months. Of these, 23% expressed some dissatisfaction with the services they received either wanting more and/or different support.[35]

Chronic respiratory diseases

Chronic respiratory disease is a top health issue in Gippsland leading to disability, death and high service use and prescribing across age groups. Some variation between LGAs is evident.

• Chronic obstructive pulmonary disease (COPD) was the third cause of death for males in Gippsland and the fifth for females.[29]

- For males COPD is the 3rd cause of death in Latrobe, 4th in Bass Coast and South Gippsland, 5th in Baw Baw, East Gippsland and Wellington (Australia 5th).
- For females, COPD was the 4th cause of death in Baw Baw, Latrobe and Wellington (not in

Stakeholder consultation confirmed chronic respiratory conditions as a health priority and identified a lack of respiratory specialists, both medical and nursing, as a service gap across the region.
Community input confirm lung health as an issue of note, especially for Indigenous people and older people. Local concern is evident in Latrobe and linked to air pollution and coal mines.

top 5 elsewhere), (Australia 5th).

• COPD is the fourth highest condition contributing to 8% of potentially preventable hospitalisations in Gippsland.[31]
• The proportion of persons reporting asthma is high in Bass Coast (14%) and Wellington (14%). [8]
• Avoidable death rates due to COPD are high in Latrobe (15 per 100,000 age-standardised) compared to Victoria (8).[25]
• Admission rates to hospital due to asthma and related respiratory conditions for 3-19-year olds is high in Baw Baw and Latrobe.[31]
• Admission rates to hospital due to asthma for 20-44-year olds is high in East Gippsland and Latrobe. [31]
• Admission rates to hospital due to asthma and COPD for people aged 45 years and over is high in Wellington. [31]
• Prescribing rates for asthma medications for 3-19-year olds is high in Baw Baw, Latrobe and Wellington. [31]
• Prescribing rates for asthma medications for 20-44-year olds is high in Baw Baw, East Gippsland, Latrobe and Wellington. [31]
• Prescribing rates for asthma and COPD medications for people aged 45 years and older is high in Latrobe. [31]
• The rate of potentially preventable hospitalisations due to COPD are high in Latrobe (369 per 100,000) and East Gippsland (313), but low in Baw Baw (138), compared to Australia (260). [26]
• Chronic disease was identified as key issue in stakeholder interviews, with COPD a common sub-theme.[79]
• The Gippsland PHN Clinical Council identified chronic respiratory disease as an important health condition (2016).
• Service gaps related to chronic respiratory disease were identified and include the need for respiratory specialists (medical and nursing) across the catchment.[77,78]
• Reports produced by the Hazelwood mine fire inquiry were reviewed and include recommendations to address respiratory health in the Latrobe Valley through the creation of the Latrobe Health Innovation Zone.[36]
• Lung health was rated as the 6th most important health issue by community survey respondents, with older people and Indigenous people rating it as a top health issue. [79] Three people mentioned asthma as an issue that has not been managed well by their GP.
• Respiratory issues were reported as a health issue in community interviews, including mentions from the Latrobe area relating to air pollution and coal mines, including the mine fire. [79]

"Respiratory – it's part of being around here [Latrobe] - not just about the fires – it's always been like it - if you live around here you just expect it - asthma and lung disorders are a huge issue"

• 12% of patients seeing a GP in Gippsland in 2017-18 had a current diagnosis of (any) asthma.[3]
• Asthma was among the top 5 diagnoses for patients aged 5-54 years seeing a GP in 2017-18. [3]

Coronary heart disease is the leading cause of death for both males and females in Gippsland.[45]

- Cerebrovascular diseases (includes stroke) is the third cause of death for both males and females in Gippsland.[45]

- Cardiovascular disease is the fifth cause of disability (based on Disability Adjusted Life Years) in Bass Coast, East Gippsland, Latrobe and South Gippsland.[5]

Cardiovascular disease is the fifth cause of disability (based on Disability Adjusted Life Years) in Bass Coast, East Gippsland, Latrobe and South Gippsland.[5]

- Nationally, cardiovascular disease is the second cause for burden of disease (as DALY), accounting for 15%.[57]

- Much of the disease burden from cardiovascular disease is fatal but with a notable non-fatal component. It becomes prominent from age 50 as a major cause of disability. [57]

- Hypertension and congestive heart failure are both among the top five conditions leading to potentially preventable hospitalisations (PPH) in Gippsland, relevant for 15% and 8% of PPH respectively.[8]

- The proportion of people reporting high blood pressure in Gippsland is high (28%), especially in East Gippsland, Latrobe and Wellington. [2] More recent data from 2014 estimate that 29.7% of adults in Gippsland have high blood pressure, compared to 25.9% across Victoria; LGAs with the highest estimates were Latrobe (37.1%), Wellington (29.1%) and Baw Baw (28.4%).[42]

- 26% of Gippsland GP patients (15 years or older) have a high blood pressure recorded (>140 systolic), (23% of patients did not have a blood pressure recorded). [61]

- High blood pressure was the most common diagnosis for patients visiting their GP in Gippsland in 2016-17, and among the top 5 for patients over the age of 40 years. [61]

The rate of potentially preventable hospitalisations due to angina are high in East Gippsland (208 per 100,000); compared to Australia (130). [77]

A study of heart disease in Australian electorates identified Gippsland (including the LGAs of East Gippsland, most of Latrobe and Wellington) as having a high rate of coronary artery disease among people aged 35 or older.[58]

- 38% of Gippsland GP patients (15 years or older) have high cholesterol recorded (>5.5 mmol/l), (54% of patients did not have a cholesterol level recorded). [61]

Children 0-14 Years

Population group:
Children 0-14 years
A high proportion of children in Gippsland are developmentally vulnerable on two or more domains and up to 21% of children grow up in jobless families. At school entry, many children have speech and language problems and/or emotional or behavioral problems.
Family incidents with children present are more common in Gippsland and the rate of substantiated child abuse is high. The rate of children in out of home care is high. In addition, prescribing rates for medications related to mental conditions are high.

Variation between Gippsland LGAs is evident, in many cases related to socio-economic status. Consumer and other stakeholder feedback identified service gaps related to children, especially in more remote areas. Community input notes cost and long waiting times as key barriers to accessing services for children, including GPs, specialists and mental health. It was noted that early assessment and intervention is key to improved outcomes.

- *The number of Child FIRST assessments were high in Gippsland (17.1 per 1,000 eligible population), compared to Victoria (10.1); Bass Coast (24.6) and East Gippsland (19.6) has even higher rates.*
- *There is a high proportion of children with speech and language problems at school entry in Gippsland (17.4%); compared to Victoria (14.2%), especially in East Gippsland (19.8%).[8]*
- *The proportion of children with emotional or behavioral problems at school entry is high across Gippsland (7.4%), compared to 4.6% in Victoria, especially in Latrobe (8.5%).[8]*

The rate of child protection substantiations is high in Gippsland (20 per 1,000 eligible population), especially in Latrobe (26), East Gippsland (23), Bass Coast (21) and Wellington (18), compared to Victoria (11) Gippsland has the highest rate of Victorian regions.[8]

- *The rate of children in out of home care is high in Latrobe, Wellington, Bass Coast and East Gippsland.[8]*
- *• Prescribing rates for anti-depressants, antipsychotics and ADHD medicines in Gippsland are high for those aged 17 or less, with some variation between LGAs.[31]*
- *• Prescribing of asthma medicines for 3-19-year olds is high in most Gippsland LGAs. [31]*
- *• Consumer input highlighted some service gaps relevant for children, including parenting support, autism spectrum disorder support, pediatric speech services and access to a pediatrician.[77]*
- *• Stakeholder (professionals) identified service gaps including access to pediatrician, pediatric allied health, public speech therapy and support for children with a disability. Access to services is especially challenging in more remote areas.[78]*
- *• The Gippsland PHN Clinical Council identified children as an important population group (2016).*
- *• The health issues rated as most important by parents of children aged 0-14 years were mental health, healthy living and immunisation as identified in a community survey.[79]*
- *• 77% of parents reported knowing how to find mental health support; 44% felt they would be able to afford the support they would need for themselves or their children, and 55% felt that they would be able to take time away from work or study to care for themselves or their children if they were experiencing a mental health issue.[35]*
- *A state funded partnership identified key issues for keeping children safe and secure with their family: including family violence often co-occurring with AOD and mental health issues; entry into child protection is most prominent in the early years; generational poverty, unemployment and trauma require multiple lens interventions; and increasing complexity of issues facing families.[9]*

Population group:
People with a disability

The proportion of working age people on a disability support pension in Gippsland is high. While disability was not directly mentioned by many stakeholders, themes related to access and mobility issues were common. In addition, service gaps related to pediatric care and mental health were reported by many stakeholders.
The introduction of the NDIS is a key factor to consider in terms of the impact on the service system and consumers broadly, and specifically for pediatric services, the private allied health provider system and mental health.
Community input revealed that people with a disability are heavy users of health services, but they experience significant barriers for accessing required services. Cost and waiting times were top barriers (as for other groups), but transport was more often an issue for people with a disability.

- *The proportion of 16-64 year olds on a disability support pension is high in Gippsland (8.9% compared to 4.9% in Victoria), especially in Bass Coast (9.0%), East Gippsland (10.4%) and Latrobe (9.8%).[25]*
- *• The rate of eligible people on the disability support pension in Gippsland is high (86.6 per 1,000), compared to Victoria (51.3); especially in East Gippsland (106.3), Latrobe (100.0) and Bass Coast (91.9).[8]*
- *• The number of Home and Community Care (HACC) clients aged 0-64 years per 1,000 target population is high in Gippsland (479), compared to Victoria (305), especially in South Gippsland (877), East Gippsland (881), Bass Coast (497) and Wellington (508). In contrast, rates in Latrobe are low (260). [8]*
- *The prevalence of disability among people with a chronic disease is high (51%), especially among people aged 65 years or older.[13]*
- *Disability was not ranked highly in qualitative reports, but consumer and other stakeholder analyses identified strong themes around the need to have built infrastructure that enables access to services, mobility, social participation and community connectedness. [77, 78, 79]*
- *• Service gaps were identified in relation to children with autism, especially in the more remote parts of the catchment., [79]*
- *• Workforce shortages related to disability were reported in pediatric speech therapy, pediatric care, and in child and adult mental health. [78]*
- *Depression and heart disease were more common among people with an intellectual disability, while arthritis was less common in the 60 years or over age group.[14]*
- *• More people with an intellectual disability had sought professional help for a mental health problem compared to the general population. [14]*
- *The SEIFA (Socio-Economic Indexes for Areas) is lower than the national index of 1,000 for each Gippsland LGA, indicating more disadvantage; especially in East Gippsland (937) and Latrobe (916). [10] Analysis by smaller geographical areas highlight pockets of disadvantage within each LGA.*
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- *The number of people (and proportion of the total population) with highest disadvantage (among the 10% most disadvantaged in Australia) for Gippsland's LGAs in 2016 were;[10]*
  - *Bass Coast 3,784 (11.5%)*

- ○ *Baw Baw 3,766 (7.8%)*
- ○ *East Gippsland 6,363 (14.2%)*
- ○ *Latrobe 20,526 (28.0%)*
- ○ *South Gippsland 338 (1.2%)*
- ○ *Wellington 5,696 (13.3%)*
-

This is an extra 3,000 people in Gippsland since 2011.

- *10.4% of 0-64-year olds in Gippsland held a Healthcare card in 2016 compared to 8.3% of people in Victoria. The proportion varies between 8.7% in South Gippsland to 12.0% in East Gippsland*

- *Gippsland rates poorly on several other social indicators;* ○ *Median weekly income in Gippsland ($540); especially Bass Coast ($507) and East Gippsland ($506), compared to Victoria ($644).*[10]
- ○ *Children in low income / welfare dependent families; 30.2% compared to 21.5% in Victoria; especially high in Latrobe (37.5%) and Bass Coast (33.3%).*[25]
- ○ *Population with food insecurity; 6.8% compared to 4.6%*[8]
- ○ *Rental stress (low income households spending 30% or more on rent); 39.2% compared to 27.2%.*[25]
- ○ *School leavers participating in higher education; 20.7% compared to Victoria (39.3%); especially East Gippsland (12.0%) and Bass Coast (17.4%).*[25]
- ○ *People 16-64 year receiving an un-employment benefit; 8.2 % compared to 4.9%; especially high in Latrobe (10.2%), East Gippsland (9.6% and Bass Coast 8.5%).*[25]
-

- *Transport was the 3rd most commonly reported health issue in community interviews; in many cases directly mentioned as a barrier to accessing health care, especially for people with low SES.* [79]

"Public transport - we get 2 buses a day …"
"Transport is enormous …. too hard …"
"There are transport programs … but how you get on to that I have no idea …

- *Community interviews identified service gaps, often specifically relating to affordable health services. This included GPs, medical specialists and allied health services.*

- The following things to improve health were identified. [79]

"More GPs" (3)
"More jobs "(3)

- • *The Victorian Population Health Survey (VPHS) found that across Gippsland, 18.7% of adults report being socially isolated compared to 17.3% for Victoria; highest rates are reported for East Gippsland (24.4%), South Gippsland (22.5%) and Latrobe (20.6%).*[37] ○ *Latrobe has a high proportion of people with fewer than five social contacts per day (27%), compared to 20% in Victoria.* [37]
- ○ *People lacking in perceived social support and/or social and civic trust, and being socially isolated, are more strongly associated with mental ill-health than the lifestyle risk factors of smoking and obesity.*[37]
- ○ *Similarly, the VPHS found that lacking in perceived social support and/or social and civic trust, and being socially isolated, are more strongly associated with physical ill-health than lifestyle risk factor such as smoking.* [37]
-

The fertility rate is higher across Gippsland compared to Victoria, especially in Bass Coast, East Gippsland and South Gippsland (2014). [2]

• The teenage birth rate in Gippsland is twice that for Victoria and even higher in Bass Coast, East Gippsland and Latrobe. [2]

• The proportion of low birth weight babies is high in Latrobe (8.2%), Wellington (8.0%) and East Gippsland (7.8%), compared to Victoria (6.6%).[2]

There is a high proportion of children with speech and language problems at school entry in Gippsland (17%); compared to Victoria (14%), especially in East Gippsland (20%). [2]

Gippsland has a high proportion of children living in a low income or welfare dependent family (30.2%), compared to 21.5% for all Victorian children; especially in Latrobe (37.3%), Bass

Coast (33.3%), East Gippsland (31.1%) and Wellington (27.4%).[6]

- The proportion of children aged less than 15 living in jobless families is high in Gippsland (16.6%); especially in Latrobe (21.8%), East Gippsland (17.3%) and Wellington (16.2%), compared to 12.7% in Victoria.[6]

- The proportion of children who are developmentally vulnerable on two or more domains is high in Latrobe (18%), East Gippsland (10%), and Baw Baw (10%), compared to Victoria (9%).[6]

- There is a high rate of family incidents with children present in Latrobe (3.376 per 100,000), East Gippsland (2,057), and Wellington (1,917), compared to Victoria (1,242). Latrobe had the highest rate of any Victorian LGA.[22]

- The rate of child protection substantiations is high in Gippsland (20 per 1,000 eligible population), especially in Latrobe (26), East Gippsland (23), Bass Coast (21) and Wellington (18), compared to Victoria (11) Gippsland has the highest rate of Victorian regions.[2]

The rate of children in out of home care is high in Latrobe, Wellington, Bass Coast and East Gippsland.[2]

Prescribing rates for anti-depressants, antipsychotics and ADHD medicines in Gippsland are high for those aged 17 or less, with some variation between LGAs.[8]

- Prescribing of asthma medicines for 3-19 year olds is high in most Gippsland LGAs.[8]

- Consumer input highlighted some service gaps relevant for children, including parenting support, autism spectrum disorder support, pediatric speech services and access to a pediatrician.[3]

The health issues rated as most important by parents of children aged 0-14 years were mental health, healthy living and immunisation as identified in the community survey.[31]

57% of parents reported problems accessing a GP within business hours in a community survey.[32] The main reason for this was un-availability of an appointment or a long wait for an appointment. Wanting to see a preferred GP was also a common concern.

9% of the activity at Gippsland GP practices was provided for children aged 0- 14 years, with an average of 3.5 activities per patient.[61]

- A state funded partnership identified key issues for keeping children safe and secure with their family: including family violence often co-occurring with AOD and mental health issues; entry into child protection is most prominent in the early years; generational poverty, unemployment and trauma require multiple lens interventions; and increasing complexity of issues facing families.[76]

Chronic Respiratory Diseases

Chronic respiratory disease is the third cause of death in two of Gippsland's six LGAs; Bass Coast and East Gippsland, and the fourth in remaining LGAs. [5]

- Chronic obstructive pulmonary disease is the fifth cause of death for males in Gippsland.[45]

- Chronic obstructive pulmonary disease is the 3rd cause of death for males in Baw Baw and Latrobe, 4th in Bass Coast, 5th in South Gippsland and Wellington and 6th in East Gippsland. For females, it was the 5th cause of death in East Gippsland, Latrobe, South Gippsland and Wellington and 7th/8th in Bass Coast/Baw Baw.[45]

Chronic obstructive pulmonary disease (COPD) is the fourth highest condition contributing to 8% of potentially preventable hospitalisations in Gippsland.[8]

Avoidable death rates due to chronic obstructive pulmonary disease are high in Latrobe (13 per 100,000), Baw Baw (10), East Gippsland, Wellington and Bass Coast (9), compared to Victoria (7). [6]

Admission rates to hospital due to asthma for 20-44 year olds is high in East Gippsland and Latrobe. [8]

Prescribing rates for asthma medications for 20-44 year olds is high in Baw Baw, East Gippsland, Latrobe and Wellington. [8]

The rate of potentially preventable hospitalisations due to COPD are high in Latrobe (369 per 100,000) and East Gippsland (313), but low in Baw Baw (138), compared to Australia (260). [77]

The Gippsland PHN Clinical Council identified chronic respiratory disease as an important health condition.[10]

11.0% of patients seeing a GP in Gippsland in 2016-17 had a current diagnosis of (any) asthma.[61]

- Asthma was among the top 5 diagnoses for patients aged 5-54 years seeing a GP in 2016-17. [61]

Diabetes

Diabetes

Diabetes is a priority health issue in Gippsland with a high proportion of the population reporting diabetes in Latrobe and Wellington. Potentially preventable hospitalisations are high across Gippsland, especially in Latrobe and Baw Baw. Deaths due to diabetes are also high, especially in Latrobe.
Stakeholder consultation identified diabetes as a top priority, especially in the Aboriginal population. Community perception of diabetes as an important health issue is not as strong as from clinicians, possibly due to lack of awareness.

• Avoidable deaths due to diabetes are high in Gippsland as a whole (7 per 100,000 people), especially in Latrobe (12) and Bass Coast (7), compared to 5 for Victoria. [25]
• Diabetes is the 7th cause of death for males in Gippsland and the 8th for females;[29]
○ For males, diabetes is the 5th cause of death in Bass Coast, Baw Baw, 6th in South Gippsland, 7th in Latrobe, 9th in Baw Baw, 10th in East Gippsland and 12th in Wellington (Australia 7th); ○ For females, diabetes is the 6th cause of death in Latrobe, 8th in South Gippsland, 9th in Bass Coast, 10th in Wellington, 11th East Gippsland and 12th in Baw Baw (Australia 7th).
• Diabetes mellitus is the fourth cause of disability (based on Disability Adjusted Life Years) in Baw Baw and Wellington LGAs. [28]
• The proportion of persons reporting type 2 diabetes is high in Bass Coast (6.8%), Latrobe (6.4%) and Wellington (5.9%), compared to 5.3% for Victoria.[73]
• Diabetes prevalence is 17.4% for people 65 years or over compared to 3.1% of people under 65.[38]
• Diabetes prevalence is increasing and was 8.5% for people aged 65 years or older in 1995 compared to 17.4% in 2015.[38]
• The rate of potentially preventable hospitalisations due to diabetes complications are high in Gippsland as a whole (241 per 100,000); especially in Baw Baw (381) and Latrobe (274), compared to Australia

(183). Gippsland has the third highest rate of any PHN in Australia. [26]
• The prevalence of certain conditions is much higher among people with diabetes, including heart disease, stroke, depression, vision loss and kidney disease.[39]
• In a national analysis, self-reported type 2 diabetes was significantly higher among those living in the most disadvantaged areas when compared to those living in the least disadvantaged areas (5.6% and 2.5%, respectively).[40] The same report highlights many indicators for diabetes by priority population groups.
• According to a national analysis of MBS data, 7.9% of the Gippsland population made a diabetes related MBS claim in 2014-15 (this is the highest proportion for any PHN); with the highest proportion in Latrobe (8.6%). 4.6% of the Gippsland population made a diabetes related PBS claim in the same year.[41]
• Survey data shows that 50.2% of the adult population had a blood sugar or diabetes check in past two years, compared to 53.1% for Victoria; highest rate was in Latrobe (60.2%) and lowest in East Gippsland (38.6%).[73]
• The rate of hospital admissions for Aboriginal people due to diabetes is almost six times that of non- Aboriginal people.[28]
• Diabetes was the most frequently identified health issue in stakeholder interviews.[78]
• Service gaps related to diabetes include diabetes education, care coordination and lack of endocrinologist.[78,79]
• The Gippsland PHN Clinical Council ranked diabetes as the top health condition (2016).
• Diabetes was rated as a health issue by community survey respondents, no sub-group rated it as a top issue.[79] Five people mentioned diabetes as a condition that was not well managed, but there was also mention of diabetes educators and good experiences;.
“Having a chronic illness, Type1 diabetes, I will often put off seeking medical treatment that is not urgent just because it's too hard to access.”
“I have diabetes that is being managed properly.”
• Diabetes was mentioned as a health issue in community interviews, but there was also mention of diabetes nurses and having well managed diabetes. [79]
• A survey of allied health stakeholders in Gippsland identified diabetes as a key issue among clients.[35]
• 6.5% of South Gippsland Dairy Expo attendees reported that they or someone in their household had experienced diabetes in the past 12 months. [35]
• 9.0% of patients with GP activity in 2017-18 had (any) diagnosis of diabetes; 18.6% of these patients had completed a diabetes cycle of care.[3]

• Diabetes was among the top 5 diagnoses for patients aged 70-84 years with GP activity in 2017-18. [3]
• 5% of people in Gippsland with a GP activity recorded a diabetes related diagnosis in 2017-18. [3]
• Nine practices in Gippsland received the diabetes incentive outcomes payment for the November 2017 quarter.[42]

Diabetes is the 6th cause of death for males in South Gippsland and females in Bass Coast, the 7th cause of death for males in Bass Coast, Baw Baw, Latrobe and Wellington and for females in Latrobe and Wellington; 8th for males in East Gippsland and females in South Gippsland; lower for females in Baw Baw and East Gippsland.[45]

Diabetes complications is the top condition involved in ambulatory care sensitive

conditions in Gippsland, relevant for 22% of admissions.[8]

Avoidable deaths due to diabetes are high in Gippsland as a whole, especially in Latrobe (11 per 100,000), compared to 5 for Victoria. [6]

The rate of potentially preventable hospitalisations due to diabetes complications are high in Gippsland as a whole (241 per 100,000); especially in Baw Baw (381) and Latrobe (274), compared to Australia (183). Gippsland has the third highest rate of any PHN in Australia. [77]

Survey data shows that 50.2% of the adult population had a blood sugar or diabetes check in past two years, compared to 53.1% for Victoria; highest rate was in Latrobe (60.2%) and lowest in East Gippsland (38.6%).[42]

The rate of hospital admissions for Aboriginal people due to diabetes is almost six times that of non-Aboriginal people.[12]

7.0% of patients with GP activity in 2016-17 had (any) diagnosis of diabetes; 18.3% of these patients had completed a diabetes cycle of care.[61]

- Diabetes was among the top 5 diagnoses for patients aged 65-74 years with GP activity in 2016-17.[61]

- Nine practices in Gippsland received the diabetes incentive outcomes payment for the August 2017 quarter.[81]

Dementia

Dementia, including Alzheimer's disease, has become the top cause of death for females in parts of Gippsland and the prevalence is projected to increase. An increasing need for appropriate health services has been noted in the past years due to higher numbers of affected people.

- Neurological and sense disorders is the leading cause of disability (based on Disability Adjusted Life Years) in Bass Coast and East Gippsland, while it is the second leading cause in Baw Baw, Latrobe, South Gippsland and Wellington.[28]
- Dementia is the 2nd cause of death for females in Gippsland and the 6th for males. [29]
  - For males, dementia was the 3rd cause of death in Bass Coast, 6th in Baw Baw, East Gippsland, Latrobe and Wellington and 7th in South Gippsland (Australia 4th);
  - For females, dementia was the top cause of death in East Gippsland and Wellington, 2nd in Bass Coast and Latrobe, and 3rd in Baw Baw and South Gippsland (Australia 2nd).
- Projections show that 2.0% of the Gippsland population are expected to have dementia by 2020, compared to 1.6% in Victoria; with even higher rates in Bass Coast (2.3%), East Gippsland (2.4%) and South Gippsland (2.1%).[43]
- 40.3% of people using permanent residential aged care in Gippsland had a dementia diagnosis. [19]
- GP data for Gippsland indicate that 1.2% of people 65 years and over had an active dementia related diagnosis in 2017-18; rising to 5% for people 85 years and over.[3]
- Dementia was identified as a theme in stakeholder feedback. [78]
- Dementia was mentioned as an issue in the community survey.[79]
- Gippsland PHN's Clinical Councils have noted an increased demand for services suitable for dementia patients, both in residential aged care and support in the community setting (2018).
- Stakeholders identified a lack of understanding of dementia, both in the community and among professionals:[20]

"There is a stigma [associated with dementia]. People are worried about being judged for it. They also think "oh well, there's no cure no tablet to fix it". There's a lack of awareness. GPs and nurses are not particularly good at identifying it or taking action if they even get a diagnosis. There are people that never receive a diagnosis. Doctors and nurses aren't dementia-literate; they need help with early identifying."

Disability

People with a disability

The proportion of working age people on a disability support pension in Gippsland is high. While disability was not directly mentioned by many stakeholders, themes related to access and mobility issues were common. In addition, service gaps related to pediatric care and mental health were reported by many stakeholders.
The introduction of the NDIS is a key factor to consider in terms of the impact on the service system and consumers broadly, and specifically for pediatric services, the private allied health provider system and mental health.
Community input revealed that people with a disability are heavy users of health services, but they experience significant barriers for accessing required services. Cost and waiting times were top barriers (as for other groups), but transport was more often an issue for people with a disability.

- *The proportion of 16-64 year olds on a disability support pension is high in Gippsland (8.9% compared to 4.9% in Victoria), especially in Bass Coast (9.0%), East Gippsland (10.4%) and Latrobe (9.8%).[25]*
- *• The rate of eligible people on the disability support pension in Gippsland is high (86.6 per 1,000), compared to Victoria (51.3); especially in East Gippsland (106.3), Latrobe (100.0) and Bass Coast (91.9).[8]*
- *• The number of Home and Community Care (HACC) clients aged 0-64 years per 1,000 target population is high in Gippsland (479), compared to Victoria (305), especially in South Gippsland (877), East Gippsland (881), Bass Coast (497) and Wellington (508). In contrast, rates in Latrobe are low (260).[8]*

- *The prevalence of disability among people with a chronic disease is high (51%), especially among people aged 65 years or older.[13]*

- *Disability was not ranked highly in qualitative reports, but consumer and other stakeholder analyses identified strong themes around the need to have built infrastructure that enables access to services, mobility, social participation and community connectedness.[77, 78, 79]*
- *• Service gaps were identified in relation to children with autism, especially in the more remote parts of the catchment.[, 79]*
- *• Workforce shortages related to disability were reported in pediatric speech therapy, pediatric care, and in child and adult mental health.[78]*

- *Depression and heart disease were more common among people with an intellectual disability, while arthritis was less common in the 60 years or over age group.[14]*
- *• More people with an intellectual disability had sought professional help for a mental health problem compared to the general population.[14]*

- *The SEIFA (Socio-Economic Indexes for Areas) is lower than the national index of 1,000 for each Gippsland LGA, indicating more disadvantage; especially in East Gippsland (937) and Latrobe (916).[10] Analysis by smaller geographical areas highlight pockets of disadvantage within each LGA.*
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- *The number of people (and proportion of the total population) with highest disadvantage (among the 10% most disadvantaged in Australia) for Gippsland's LGAs in 2016 were;[10]○ Bass Coast 3,784 (11.5%)*
- *○ Baw Baw 3,766 (7.8%)*
- *○ East Gippsland 6,363 (14.2%)*
- *○ Latrobe 20,526 (28.0%)*
- *○ South Gippsland 338 (1.2%)*
- *○ Wellington 5,696 (13.3%)*
-

This is an extra 3,000 people in Gippsland since 2011.

- *10.4% of 0-64-year olds in Gippsland held a Healthcare card in 2016 compared to 8.3% of people in Victoria. The proportion varies between 8.7% in South Gippsland to 12.0% in East Gippsland*

- *Gippsland rates poorly on several other social indicators; ○ Median weekly income in Gippsland ($540); especially Bass Coast ($507) and East Gippsland ($506), compared to Victoria ($644).[10]*
- *○ Children in low income / welfare dependent families; 30.2% compared to 21.5% in Victoria; especially high in Latrobe (37.5%) and Bass Coast (33.3%).[25]*
- *○ Population with food insecurity; 6.8% compared to 4.6%[8]*
- *○ Rental stress (low income households spending 30% or more on rent); 39.2% compared to 27.2%.[25]*
- *○ School leavers participating in higher education; 20.7% compared to Victoria (39.3%); especially East Gippsland (12.0%) and Bass Coast (17.4%).[25]*
- *○ People 16-64 year receiving an un-employment benefit; 8.2 % compared to 4.9%; especially high in Latrobe (10.2%), East Gippsland (9.6% and Bass Coast 8.5%).[25]*
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- *Transport was the 3rd most commonly reported health issue in community interviews; in many cases directly mentioned as a barrier to accessing health care, especially for people with low SES.[79]*

"Public transport - we get 2 buses a day …"
"Transport is enormous …. too hard …"
"There are transport programs … but how you get on to that I have no idea …

- *Community interviews identified service gaps, often specifically relating to affordable health services. This included GPs, medical specialists and allied health services.*

- The following things to improve health were identified. [79]

"More GPs" (3)
"More jobs "(3)

- *• The Victorian Population Health Survey (VPHS) found that across Gippsland, 18.7% of adults report being socially isolated compared to 17.3% for Victoria; highest rates are reported for East Gippsland (24.4%), South Gippsland (22.5%) and Latrobe (20.6%).[37]* ○ *Latrobe has a high proportion of people with fewer than five social contacts per day (27%), compared to 20% in Victoria. [37]*
- ○ *People lacking in perceived social support and/or social and civic trust, and being socially isolated, are more strongly associated with mental ill-health than the lifestyle risk factors of smoking and obesity.[37]*
- ○ *Similarly, the VPHS found that lacking in perceived social support and/or social and civic trust, and being socially isolated, are more strongly associated with physical ill-health than lifestyle risk factor such as smoking. [37]*
-

The proportion of 16-64 year olds on a disability support pension is high in Gippsland (8.8% compared to 5.3% in Victoria), especially in Bass Coast (9.0%), East Gippsland (11%) and Latrobe (10%).[6]

The rate of eligible people on the disability support pension in Gippsland is high (86.6 per 1,000), compared to Victoria (51.3); especially in East Gippsland (106.3), Latrobe (100.0) and Bass Coast (91.9).[2]

- The number of Home and Community Care (HACC) clients aged 0-64 years per 1,000 target population is high in Gippsland (479), compared to Victoria (305), especially in South Gippsland (877), East Gippsland (881), Bass Coast (497) and Wellington (508). In contrast, rates in Latrobe are low (260).[2]

Workforce shortages related to disability were reported in pediatric speech therapy, pediatric care, and in child and adult mental health.[4]

Dental Health

Dental health

Poor dental health was identified as an issue in some parts of Gippsland and is known to be associated with health conditions such as cardiovascular disease. However,
• The rate of potentially preventable hospitalisations due to dental issues are high in Gippsland as a whole (301 per 100,000 people); especially in Wellington (461), compared to Australia (284). [26]
• A high proportion of people reported poor dental health in East Gippsland (8.3%) and South Gippsland (7.6%), compared to Victoria (5.6%), while Latrobe residents were less likely to report poor dental

stakeholders did not identify it as a priority. Community survey and interviews revealed that affordable dental services are a top service gap in the Gippsland community.
health (4.4%).[73]
• Dental health was identified a minor theme by stakeholders and was mentioned as a service gap. [78, 79]
• Dental care was the 8th most commonly reported health issue and dental as a service gap rated 3rd in community interviews. [79] In most cases, the affordability of dental services (including denture services) was the key concern, but things appear to have improved in some areas;
"Up to 2 years wait for public affordable dental"
"There is now affordable dental in town and its reasonably good"
• 30% of community survey respondents had not seen a dentist in the past 12 months.[79] The main barrier to accessing services was cost and dental services was the most commonly reported service for which cost was a barrier.
"I've needed a filling for 2-3 years and have to cope with pain every day because it's not available on Medicare benefits."

• Dental issues were reported as not well managed by a few respondents in the community survey.[79] "...poor dental work - all the fillings have fallen out and teeth chipped and broken off after thousands of dollars of pain and agony for nothin

Community survey and interviews revealed that affordable dental services is a top rated service gap in the Gippsland community.

There is a high rate of poor dental health in East Gippsland (8.3%) and South Gippsland (7.6%), compared to Victoria (5.6%), while Latrobe had a low rate (4.4%).[2]

Family Violence

Family violence

Gippsland has a high rate of family incidents and of family incidents with children present. Alcohol related family violence is also high as is the rate of substantiated child abuse.
It has been shown that the health costs of violence are very high and stakeholder input in Gippsland identified family violence as a key health issue. The Gippsland PHN Clinical Council also identified family violence as an important factor affecting health.
Service
• There is a high rate of family incidents in Latrobe (3,482 per 100,000 people), Baw Baw (2,705), and Wellington (1,867), compared to Victoria (1,177). Latrobe had the highest rate of any Victorian LGA.[74]
• The rate of child protection substantiations is high in Gippsland (20 per 1,000 eligible population), especially in Latrobe (26), East Gippsland (23), Bass Coast (21) and Wellington (18), compared to Victoria (11) Gippsland has the highest rate of Victorian regions.[8]
• The rate of family violence incidents where alcohol was involved is very high in much of Gippsland with 835 incidents per 100,000 people in Latrobe, 768 in East Gippsland, 56.5 in Wellington and 45.0 in Bass Coast, compared to Victoria (313).[74]
• A national report on family violence notes that;[44]
○ 1 in 6 Australian women has experienced physical or sexual violence by a partner since age
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gaps were identified related to family violence.
Community input noted service gaps for family violence, including sexual assault.
15 years (1 in 16 men)
○ 1 in 4 women have experienced emotional abuse by a partner since age 15 (1 in 6 men)
○ Intimate partner violence contributed to more burden of disease than any other risk factor for women aged 25–44, primarily due to mental health conditions including anxiety and depression
○ A leading cause of homelessness for women with children
○ The cost of violence has been estimated to at least $22 billion (2015-16) ○ Indigenous women and children are more likely to be affected
○ There are still data gaps and many victims do not contact police
• Family violence was identified as a key theme across consumer and other stakeholder input. [78, 79]
• The Gippsland PHN Clinical Councils and the Community Advisory Committee continue to identify family violence as a priority issue to improve health (2018).
• 'Services for victims of domestic violence' was the 2nd most commonly identified service gap in a Gippsland Women's Health survey. [32]
• Service gaps related to family violence were identified by stakeholders and include; support for women and children who have suffered trauma, increased awareness and knowledge in the primary care setting and education for men.[78]
• Family violence was mentioned as a health issue in community interviews and service gaps were noted.[79]
"...it's not easy to get a termination [of pregnancy] around here [remote] and that impacts on Family Violence etc."
"[Service for] Family violence including elder abuse"
"I wanted a supportive environment when escaping 'family violence' in middle of the night (police station can exacerbate the trauma) - but multidisciplinary sexual assault service is only open business hours?!"

There is a high rate of family incidents with children present in Latrobe (3,376 per 100,000), East Gippsland (2,057), and Wellington (1,917), compared to Victoria (1,242). Latrobe

had the highest rate of any Victorian LGA.[22]

- The rate of child protection substantiations is high in Gippsland (20 per 1,000 eligible population), especially in Latrobe (26), East Gippsland (23), Bass Coast (21) and Wellington (18), compared to Victoria (11) Gippsland has the highest rate of Victorian regions.[2]

- The rate of alcohol related family violence is more than twice the Victorian rate in Latrobe, East Gippsland, Wellington and Bass Coast. [1]

Immunisation

Immunisation

While childhood immunisation rates in Gippsland are relatively high, improvement is needed to reach the target of 95% of children being fully immunised for all age-groups and for sub-groups of the population, which may have lower coverage rates. Community input supports immunisation as important and already working well for many.

- Influenza and pneumonia was the 16th cause of death among males in Gippsland and 15th among females (Australia 13th and 11th).[29]
- The rate of potentially preventable hospitalisations due to acute and vaccine-preventable conditions are high in Wellington (1,762 per 100,000); compared to Australia (1,456). [26]
- Immunisation rates for Gippsland children continue to be higher than the national average (fully immunised children), 2016-17;[26]
  - 94.9% of 1-year-olds compared to 93.8% across Australia
  - 93.6% of 2-year-olds (92.2%)

  - 95.7% of 5-year-olds (93.5%)
- There is variation in the proportion of children fully immunised across Gippsland's LGAs; lowest rates are found in Bass Coast / South Gippsland for 2-year olds. [26]
- In 2016-17, 87.4% of Indigenous 1-year olds in Gippsland were fully immunised, compared to 87.0 % of 2-year-olds and 96.4% of 5 –year-olds.[26] More recent quarterly data indicate that these rates have improved.
- Notification rates for pertussis were high in South Gippsland and Wellington compared to Victoria in 2018.[56]
- Notification rates for influenza are high in Wellington compared to Victoria in 2018. [56]
- Immunisation rates were identified as an issue by a number of early childhood workers. [78]
- Coverage rates of HPV immunisation in Gippsland are above the Victorian rate (75.8% for boys and 80.9% for girls); Gippsland boys (81.2%) and girls (81.6%). [26] Coverage rates for boys in Wellington were low at 68.1%.
- Immunisation was rated as 5th most important health issue in the community survey, especially by parents. [79] It was noted that immunisation is working well by some in the community interviews, while others still have concerns;

"Access to immunisation is really easy and great"
"Better research into immunisation (enforced) even when Drs don't even realize that there is mercury in them"

Immunisation rates for Gippsland children are higher than the national average (fully immunised children), 2015-16; [7]

- 94.3% of 1-year-olds compared to 93.0% across Australia
- 92.5% of 2-year-olds (90.7%)
- 94.9% of 5-year-olds (92.9%)

Indigenous Health

The Aboriginal and Torres Strait Islander population in Gippsland is high compared to Victoria with East Gippsland, Latrobe, Wellington and Baw Baw having the highest population.[13]

Hospital admissions are almost twice as common for Aboriginal people compared to non-Aboriginal people.[12]

- Presentations to the emergency department are more than twice as common for Aboriginal people compared to non-Aboriginal people (difference increasing).[12]

- Conditions where hospitalisations for Aboriginal people are much more common than for non-Aboriginal people;

○ Renal dialysis – 26 times ○ Diabetes – 7 times ○ Mental and behavioral disorders – 6 times ○ Cardiovascular diseases – 4.5 times

○ Hospitalisations attributable to alcohol or tobacco – 3.4 times

○ Hospitalisations attributable to tobacco – 2.7 times [12]

The top Ambulatory Care Sensitive Conditions leading to a hospital admission in Gippsland are:

Diabetes (28%) ○ Dental conditions (17%) ○ COPD (12%) ○ Convulsions / epilepsy (9%) ○ Asthma (9%) ○ Angina (8%) [12]

Immunisation rates for Aboriginal children aged 1 and 2 years were generally lower than the rates for all children; for 1 year olds, 91.7% of Aboriginal children were fully immunised compared to 94.3% of all children in 2015-16, for 2 year olds 86.8% of Aboriginal children compared to 92.5% of all children. Immunisation rates for 5 year old children; 93.8% of Aboriginal children were fully immunised compared to 94.9% of all children.[7]

- Hospitalisations rates for Aboriginal people were high in East Gippsland- Wellington (57,310 hospital admissions per 100,000 population, age

standardised rate) and Latrobe (49,133) compared to Victoria (35,861),

especially for digestive, respiratory and circulatory system diseases.[48]

- The health issue rated as most important for Indigenous people was work and study opportunities, mental health and heart and lung health as identified in the community survey. [32]

18% of Indigenous survey respondents reported that they did not think they could get the help they needed if they had a health problem (compared to 10% of respondents overall). [32]

A national study found that Indigenous Australians experience a burden of disease that is 2.3 times the rate of non-Indigenous Australians.[57]

- Chronic diseases as a group accounted for almost two-thirds (64%) of the total disease burden for Indigenous Australians. Disease groups causing the most burden was mental & substance use disorders (19% of the total), followed by injuries (including suicide) (15%),

cardiovascular diseases (12%), cancer (9%), respiratory diseases (8%) and musculoskeletal conditions (7%).[57]

• The biggest difference to non-Indigenous was for cardiovascular diseases (19% of the gap), mental & substance use disorders (14%) and cancer (9%).[57]

Inflammation of the Kidney

Inflammation of the kidney

Inflammation of the kidney is a common reason for potentially preventable hospitalisations in Gippsland but was not identified as a priority.

• Kidney failure was the 17th cause of death among males and females in Gippsland (Australia 17th and 16th).[29]

• The rate of potentially preventable hospitalisations due to kidney and urinary tract infections are similar to national rates across most of Gippsland (260 per 100,000); compared to Australia (288). [26]

• Kidney issues were mentioned in the community survey and a renal specialist was mentioned as a service gap. [79] One respondent noted a kidney issue that was not well managed;

"Last year I had ... a kidney infection. I was very sick and should have been in hospital. Instead, I was put on one antibiotic after another and sent home... it was mismanaged and misdiagnosed from start to finish."

• Kidney health was the only health issue Gippsland Dairy Expo attendees indicated was missing from the list of health priorities mentioned by 1% of attendees.[35]

The rate of potentially preventable hospitalisations due to kidney and urinary tract infections are similar to national rates across most of Gippsland (260 per 100,000); compared to Australia (288). [77]

Injuries

Injuries

While the rate of unintentional injuries is high in Gippsland, stakeholder input did not identify this as a priority area.

• Accidental falls is the 12th cause of death for male and the 10th for females in Gippsland (Australia 16th and 15th). [29]

• Land transport accidents were the 15th cause of death for males in Gippsland (Australia 20th) and not in

Note that intentional injuries are included under mental health.

top 20 among females. [29]

• Avoidable deaths due to external causes (not including suicide) are high in Gippsland (20 deaths per 100,000 people age-standarided), especially in South Gippsland and Latrobe.[25]

• Avoidable deaths due to transport accidents are also high in Gippsland (13 PER 100,000)), especially in South Gippsland and Baw Baw. [25]

• Unintentional injuries treated in hospital are high in Bass Coast (113 per 1,000 people), Wellington (112), Baw Baw (102), East Gippsland (101) and Latrobe (98), compared to Victoria (61). [8]

• The proportion of unintentional injuries due to falls is low in Bass Coast (35%), Baw Baw (33%) and Wellington (31%), compared to Victoria (39%).[8]

• Stakeholder input did not rate injuries highly as a health issue.[78]

• Injuries were mentioned in the community survey in relation to issues that have not been well managed. [79]

"I feel the process of my injury that I have may have been a different outcome had the specialists / doctors been available sooner, to make decisions and treat the disability sooner rather than years apart ..."

Avoidable deaths due to suicide and self-inflicted injuries is high in Gippsland, with Bass Coast, East Gippsland, Baw Baw, Wellington and Latrobe all recording a higher rate than Victoria.[6]

• Unintentional injuries treated in hospital are high in Bass Coast (113 per 1,000 people), Wellington (112), Baw Baw (102), East Gippsland (101) and Latrobe (98), compared to Victoria (61). [2]

Intentional injuries treated in hospital are more common in Gippsland with 4.4 admissions per 1,000 people compared to 3.0 in Victoria. Highest rates are seen in Wellington, Latrobe and East Gippsland.[2]

Iron deficiency anaemia

The rate of potentially preventable hospitalisations (PPH) due to iron deficiency anaemia are high in Gippsland as a whole (397 per 100,000); especially in Latrobe (706), East Gippsland (361), and Wellington (276) compared to Australia (206). Latrobe has the highest rate of iron deficiency anaemia PPH of any SA3 in Australia. [77]

Same Sex Attracted and Gender Diverse People (SSAGD)

In Victoria, 21% of headspace clients identified as LGBTI. [34] Gippsland data indicate that an even higher proportion (29%) of clients identify as LGBTI (2016 unpublished data).

LGBT people are between 3.5 and 14 times more likely to attempt suicide compared to the national average. [34]

SSAGD people under utilise health services and delay seeking treatment due to actual or anticipated bias from service providers. [34]

Iron deficiency anaemia

Gippsland has a high rate of potentially preventable hospitalisations due to iron deficiency anaemia.

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The rate of potentially preventable hospitalisations (PPH) due to iron deficiency anaemia are high in Gippsland as a whole (397 per 100,000); especially in Latrobe (706), East Gippsland (361), and Wellington (276) compared to Australia (206). Latrobe had the highest rate of iron deficiency anaemia PPH of any SA3 in Australia in 2015-16. [26]

Lifestyle Factors

Lifestyle factors

Smoking rates in Gippsland are among the highest in Victoria. Alcohol consumption at levels likely to cause short and long-term harm are high in many parts of Gippsland. Obesity rates and soft drink consumption are high across the region.
Lifestyle factors was a key theme identified by consumers and other stakeholders. The Gippsland PHN Clinical Council also identified lifestyle factors as a priority in addressing poor health outcomes in Gippsland.
Community focus group highlight the
• It is estimated that 20.0% of the Gippsland population are current smokers (2014 VPHS) which is high significantly higher than Victoria (13.1%); LGAs with significantly higher rates were Baw Baw (29.7%) and Latrobe (24.4%).[73]
• It is estimated that 16.8% of the Gippsland population are daily smokers (2014 VPHS) which is significantly higher than Victoria (9.8%); LGAs with significantly higher rates were Baw Baw (19.7%) and Latrobe (22.4%).[73]

• 23.3% of males and 16.4% of females were current smokers in Gippsland; both significantly higher than Victoria (14.7% and 11.6% respectively).[73]
• 20% of Gippsland GP patients (15 years or older) with smoking status recorded are current smokers (19% of patients did not have smoking status recorded).
• Obesity rates are high in all Gippsland LGAs, except Baw Baw, according to the 2014 VPHS (estimates range from 14.8% in Baw Baw to 22.8% in South Gippsland, compared to 18.8% in Victoria). [73]
• 46.7% of adults met the dietary guidelines for fruit consumption, similar to Victoria 47.8%.[73]
• 6.8% of adults met the dietary guidelines for vegetable consumption, similar to Victoria 6.4%.[73]

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challenges in reducing smoking rates among people with social and financial worries.

• 41.8% of adults met the physical activity guidelines (sufficient time and sessions) was similar to Victoria 41.4%.[73]
• Social isolation (extreme) has been found to be more strongly associated with physical ill-health than obesity. [37]
• 41% of Gippsland GP patients with BMI information recorded in POLAR Explorer were obese (30+ BMI score), while 34% were overweight (25-30 BMI score) (49% of patients did not have a BMI specified). [3]
• In 2014, all Gippsland LGAs had a higher consumption of sugar sweetened drinks (range 12.8% to 20.6% in Wellington) compared to Victoria (11.2%).[73]
• 41.8% of adults in Gippsland are sufficiently physically active; compared to 41.4% across Victoria. Variation across Gippsland show the lowest levels in Latrobe (35.4%) and the highest in East Gippsland (54.1%).[73]
• Lifestyle factors were identified as a major theme by both stakeholder and consumers in the analysis of existing reports, and by interviewed stakeholders.[77, 78]
• Consumer and other stakeholder analyses identified strong themes around the need to have built infrastructure that enables access to services, mobility, social participation and community connectedness. [77, 78]
• The Gippsland PHN Clinical Councils identified lifestyle factors as a priority (2016).
• Obesity was a major theme identified by stakeholders[78] and the Clinical Council suggested it be included among lifestyle factors (2016).
• Healthy living (quit smoking, eating well, exercise) was rated as the most important health issue by community survey respondents.[79] A few respondents pointed out the importance of exercise to manage symptoms;
"Prevention of ... problems through diet! Focus more on prevention rather than dealing with problems once they arise."
"... cheaper fitness programs like at a gym or regular dance class for mature age (not old!) folk like me, as I find these help me to maintain flexibility and help with the pains."
• Community interviews identified issues relating to recreation as the 8th most commonly reported health issue, noting barriers as affordability of activities, especially for youth. A healthy diet was also noted as important. Recreation opportunities such as hydrotherapy pool and physical infrastructure such as footpaths were mentioned as gaps. [79]
• Community interviews provided information about suggestions for improving health. There were many suggestions involving prevention; both by improved access to exercise and a healthy diet, and about education in these areas. [79]

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• Community interviews identified obesity among the top 15 most commonly reported health issues, with children a specific concern. [79] Survey respondents also mentioned obesity as an issue that has not been well managed.
• There is community support for prevention activities and support for individuals to lead a healthy lifestyle including access to healthy food and a community that makes it easy and cheap to be physically active. Local governments' Municipal Public Health and Wellbeing Plans are the foundation for work in this area. [45, 46, 47, 48, 49, 50]
• Significant barriers to addressing smoking rates have been documented among vulnerable groups. Qualitative research undertaken in Latrobe highlights poverty, hopelessness and a generally challenging life where many struggle to see past their immediate future. Long term risks become insignificant.[33] The research included smokers who were young (some were mothers), Indigenous, un- employed and blue-collar workers.
"I don't know, I just smoke, like I've watched my parents smoke, and they're fine, um and so it's just sort of like, it's part of life to me I guess, like when you watch somebody, like, especially your parents, smoke all the time, and like you grow up and then you're like, 'oh, well we're supposed to do this then' like you know." (F, 18-21)
"I'd like to stop, I just don't know when. Probably if I had something that made me stop, like a job or something, just something that prevented me from smoking." (M, 18-21)
"I am a person who struggles with mental illness ...because it is so easy to pick up a smoke and that is the quick fix ..." (F, 21-29)
"In relation to smoking in pregnancy "Yeah, I've cut down to like five a day, I didn't quit completely, there was never a day that I went without one, probably would have died if I did." (F, 18-21)

High smoking rates by males are evident in Bass Coast (26%), East Gippsland (27%) and Wellington (24%), compared to Victoria (18%) in 2011.[2]

21% of Gippsland GP patients (15 years or older) with smoking status recorded are current

smokers (24% of patients did not have smoking status recorded). [61]

- A national survey identified Gippsland as the PHN with the fourth highest smoking rate in the country at 17.8% compared to 12.2% nationally.[62]

Alcohol-consumption at levels likely to cause long term harm (>2 standard drinks per day) among adults is higher than Victoria (59%) in Bass Coast (63%), East Gippsland (61%), Latrobe (61%) and Wellington (76%).[2]

Obesity rates are high in all Gippsland LGAs, except Baw Baw, according to the 2014 VPHS (estimates range from 14.8% in Baw Baw to 22.8% in South Gippsland, compared to 18.8% in Victoria).[42]

- 40% of Gippsland GP patients with BMI information recorded in POLAR Explorer were obese, while 33% were overweight (49% of patients did not have a BMI specified). [61]

In 2014, all Gippsland LGAs had a higher consumption of sugar sweetened drinks (range 12.8% to 20.6% in Wellington) compared to Victoria (11.2%).[42]

- 41.8% of adults in Gippsland are sufficiently physically active; compared to 41.4% across Victoria. Variation across Gippsland show the lowest levels in Latrobe (35.4%) and the highest in East Gippsland (54.1%).[42]

Low Sociioeconomic Factors

The number of people (and proportion) with highest disadvantage (among the 10% most disadvantaged in Australia) for Gippsland's LGAs were;[64]

- Bass Coast 3,516 (12%)
- Baw Baw 3,359 (8%)

East Gippsland 5,441 (13%)
- Latrobe 19,122 (26%)
- South Gippsland 549 (2%)
- Wellington 5,371 (13%)

- The proportion of 0-64 year olds who are Healthcare card holders varies between 8.7% in South Gippsland to 12.0% in East Gippsland, compared to 7.3% for Australia.[6]

- The proportion of the population who believe there are good facilities and services is 76% in Gippsland compared to 85% for Victoria; Bass Coast and South Gippsland rate even lower. [2]

- Gippsland rates poorly on a number of other social indicators; [2, 6]

- Median equivalised income is lower in all LGAs; especially Bass

Coast ($855) and East Gippsland ($798), compared to Victoria

($1,216)

- Low income / welfare dependent families with children; 11% compared to 9% in Victoria

○ Population with food insecurity; 7% compared to 5% ○ Rental stress; 28% compared to 25% ○ Higher education qualification; 27% compared to 46% ○ School leaver participation in higher education; 19% compared to

36% ○ People 16-64 year receiving an un-employment benefit; 7.2%

compared to 4.9%

○ Gaming machine losses per head of adult (18+) population are high in Latrobe ($769), Wellington ($657) and East Gippsland ($638), compared to Victoria ($553).

Community interviews identified service gaps, often specifically relating to affordable health services. This included GPs, medical specialists and allied health services.[31]

Wellington and East Gippsland. [6]

- Prostate biopsy rates are low for men aged 40 or above in Gippsland. [8]

Mens Health

Males in parts of Gippsland have a high smoking rate; Bass Coast (26%), East Gippsland (27%) and Wellington (24%). [2]

- Male life expectancy is low in Gippsland, 78.1 years compared to 80.3 for Victoria with Latrobe (76.9) and Wellington (78.0) even lower. [2]

- The rate of premature deaths for males is high in Gippsland, especially in Latrobe,

60% of males reported that nothing stopped them from getting health care they needed in the past 12 months. Main barriers were: [32]

○ Cost 23%

○ Long wait for appointments 14% ○ Couldn't get there 7% ○ Didn't feel comfortable accessing the service 6% ○ Didn't understand how to access the service 3%

Mental Health

Mental health is the leading cause of disability (based on Disability Adjusted Life Years) in Baw Baw, Latrobe, South Gippsland and Wellington LGAs and the second cause in Bass Coast and East Gippsland. [5]

The registered workforce of psychologists shows that Gippsland has only about half the expected number compared to Victoria.[26]

The rate of completed mental health treatment plans by GPs is high in Bass Coast / South Gippsland and low in East Gippsland, with Latrobe and Wellington similar to the Victorian rate. [8]

Mental health was rated as the top health issue identified by consumers and health professionals in feedback provided via the Gippsland PHN web site. There was specific mention of services for young people and psychiatry. [40]

According to national data for 2015–16 (BEACH), 12.4% of all GP encounters were mental health related.[60]

- Depression was the most commonly managed problem at mental health related encounters (32%).[60]
- Management of mental health problems were most commonly managed by medication (62%).[60]

• In Gippsland, data extracted from GP practices show that for patients with GP activity in 2016-17; [61]

- 9.3% of patients had an active diagnosis of depression
- 6.9% had an anxiety diagnosis
- 4.7% had a mental health treatment plan

PBS data for mental health service provision shows that East Gippsland has by far the lowest proportion of its population claiming a mental health item (7.3%), while Baw Baw has the highest proportion claiming (11.1%).[69]

• MBS data for mental health service provision shows that East Gippsland and Wellington residents have a low usage of psychiatrists and clinical psychologists compared to other LGAs.[69]

MBS data shows that East Gippsland has a low usage of GPs for mental health items.[69]

Service gaps were identified for mental health generally and specific gaps were identified for;

- Psychiatry (affordable)
- Psychology
- Treatment services for moderate mental health issues
- Specialised youth mental health
- On-going mental health services (care coordination)
- Treatment services for mild mental health
- Remote access to mental health services
- Mental health nurse

Suicide prevention services
- Counselling service for children
- Public psychiatry for clients not in crisis
- Services addressing co-morbidity with Alcohol and Other Drugs
- Psycho-social services[4]

• For the nation as a whole, mental and substance use disorders was the third highest cause of burden of disease (as DALY) at 12%.[57]

• Mental and substance use disorders is the leading cause of non-fatal burden for both

males and females.[57]

- Mental and substance use disorders and injuries were the largest disease groups in terms of DALY in the younger age groups (from childhood through to age 49 years). [57]

In Gippsland, 22% of adolescents report being bullied, compared to 18% for Victoria; the rates are even higher in East Gippsland (30%) and Latrobe (23%).[2]

- The proportion of children with emotional or behavioral problems at school entry is high in Gippsland (7.4%), compared to 4.6% in Victoria. The highest proportions are in Latrobe (8.5%), South Gippsland (7.8%) and East Gippsland (7.7%). [2]

- The proportion of persons experiencing high or very high psychological distress was high in Gippsland (14.3%), compared to 12.6% in Victoria in 2014; especially in South Gippsland (20.5%), Latrobe (17.0%) and Bass Coast (15.4%). [42]

- The proportion of children exposed to trauma in the form of child abuse, and attending family violence incidents is high (see under the priority children).

- Avoidable deaths due to suicide and self-inflicted injuries is high in Gippsland, with Bass Coast, East Gippsland, Baw Baw, Wellington and Latrobe all recording a higher rate than Victoria.[6]

- Intentional self-harm is the leading cause of death in the 15-34 year age bracket, and remains in the top three until age 54 years.[76]

- The rate of registered mental health clients in Gippsland are high (15.1 clients per 1.000 population) compared to Victoria (11.9). The highest rates were in Latrobe, Bass Coast and East Gippsland. [2]

- The rate of completed mental health treatment plans by GPs is high in Bass Coast / South Gippsland and low in East Gippsland, with Latrobe and Wellington similar to the Victorian rate. [8]

- Prescribing rates for anti-depressant medications are high for people 17 years and under in Baw Baw, East Gippsland and Wellington. [8]

- Prescribing rates for anti-depressant medications are high for 18-64 year olds in East Gippsland and Latrobe. [8]

- Prescribing rates for anti-depressant medications are high for 65 year olds or older in Latrobe. [8]

- Prescribing rates for anxiolytic medications are high for 18-64 year olds in Latrobe. [8]

- Prescribing rates for anxiolytic medications are low for 65 year olds or older in Bass Coast / South Gippsland and East Gippsland. [8]

The proportion of children exposed to trauma in the form of child abuse, and attending

family violence incidents is high (see under the priority children).

- Avoidable deaths due to suicide and self-inflicted injuries is high in Gippsland, with Bass Coast, East Gippsland, Baw Baw, Wellington and Latrobe all recording a higher rate than Victoria.[6]

- Intentional self-harm is the leading cause of death in the 15-34 year age bracket, and remains in the top three until age 54 years.[76]

- The rate of registered mental health clients in Gippsland are high (15.1 clients per 1.000 population) compared to Victoria (11.9). The highest rates were in Latrobe, Bass Coast and East Gippsland. [2]

Neurological and Sense disorders

Neurological and sense disorders is the leading cause of disability (based on Disability Adjusted Life Years) in Bass Coast and East Gippsland, while it is the second leading cause in Baw Baw, Latrobe, South Gippsland and Wellington.[5]

- Neurological and sense disorders is the fifth cause of death in Bass Coast, East Gippsland and South Gippsland.[5]

- Dementia and Alzheimer's disease is the top cause of death for females in East Gippsland, the 2nd cause of death for females in Bass Coast, Latrobe, South Gippsland and Wellington, the 3rd in Baw Baw. For males, it was the 3rd cause of death in Bass Coast, 6th in Baw Baw, Latrobe and Wellington and 8th/9th in South Gippsland/Wellington.[45]

Projections show that 2.0% of the Gippsland population are expected to have dementia by 2020, compared to 1.6% in Victoria; with even higher rates in Bass Coast (2.3%), East Gippsland (2.4%) and South Gippsland (2.1%).[17]

Palliative Care

Palliative care

Palliative care and pain management were identified as themes in stakeholder feedback and pain management was identified as a service gap. Community input note palliative care as a service gap, including pain management, grief and bereavement. Recent changes to Victorian legislation is having an impact on the service landscape.

- A national report on palliative care notes that:[53]
  - There was a 28.2% increase in palliative care-related hospitalisations between 2011–12 and 2015–16, compared to a 14.6% increase in hospitalisations for all reasons over the same period
  - 50.5% of all hospitalisations in which the patient died, the patient had received palliative care in 2015–16
  - 48.3% of palliative care hospitalisations involved cancer as the principal diagnosis in 2015–16
  - In 2015–16, about 1 in 1,000 GP encounters reported for the BEACH collection was palliative care-related
  - GPs' understanding of what constitutes palliative care and end of life care varies widely
- The total number of deaths in Gippsland has increased and was 2,556 in 2016;[29]
  - Bass Coast 326

○ Baw Baw 375
○ East Gippsland 494 ○ Latrobe 725
○ South Gippsland 253 ○ Wellington 384
• There were a total of 1,126 admissions to hospital with a recorded palliative care diagnosis for Gippsland residents in 2016-17;[54]
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○ Bass Coast 123
○ Baw Baw 160
○ East Gippsland 236 ○ Latrobe 242
○ South Gippsland 163 ○ Wellington 202
24.5% of admissions were to a hospital outside Gippsland.
• The Aged Care Funding Instrument estimates that 1 in 50 aged care residents need palliative care.[55]
• Palliative care was identified as a theme in stakeholder feedback. [78]
• Pain management was identified as a service gap in stakeholder analysis as well as by the Gippsland PHN Clinical Council.[77]
• Grief and bereavement was mentioned as an issue in the community survey. [79]
• Palliative care was mentioned in both the community survey and interviews as an issue and as a service gap, [79] and has been identified as a priority by the Latrobe Health Advocate (personal communication). "Demand outstrips the capacity of community services associated with palliative care ... respite ..."
• Comments provided in the 'Have your say' web survey included a need for a hospice in Gippsland.[79]
• The Medical Treatment Planning and Decision Act 2016 was enacted in Victoria in March 2018. This legislation recognises the importance of advance care planning, and the need for people to plan for their future, and have these plans respected and followed, in the setting of life limiting illness.
• The Voluntary Assisted Dying legislation will apply from 1 July 2019. Health Services will be developing policies procedures and guidelines related to the introduction of this legislation
• Statewide and regional projects reinforce the Victorian Government's End of life and palliative care framework, 2016, with an emphasis on early referral to palliative care, and strengthening specialist palliative care capacity (personal communication GRPCC). They enable identification of opportunities for quality improvement / or change and will inform future palliative care policy;
○ The palliative care consortiums in Victoria are undertaking a quality improvement project to achieve consistent pathways for referral to palliative care services across the rural regions.
○ The 'Gippsland Palliative Care Skills matrix project' is addressing workforce capacity of district and palliative care nurses with an aim to achieve a consistent level of palliative care skill across the region.
○ Community Palliative Care services work closely with the Gippsland Palliative Care

The total number of deaths in Gippsland has been around 2,300 per year (2010-14), with a decreasing trend in South Gippsland and to a lesser extent in Baw Baw, while other LGAs have an increasing trend.[45]

Annual deaths in 2014 in Gippsland was 2,393, with deaths by LGA; ○ Bass Coast 314

○ Baw Baw 327 ○ East Gippsland 452 ○ Latrobe 685 ○ South Gippsland 253 ○ Wellington 362

Comments provided in the 'Have your say' web survey included a need for a hospice in Gippsland.[40]

Population >60 years

People 65 years or over

The proportion of Gippsland's population aged 65 years and older is high and is also increasing at a high rate. A high proportion of Gippsland's older population is on an age pension and / or are HACC clients.

Stakeholders identified some existing service gaps related to the ageing population and identified the challenge to provide services to this growing population. Community input from older people noted access to GPs, specialist and mental health services as main gaps with transport an important barrier for access. Mental health issues and pain were noted as issues not well managed.

The experiences of older people highlight the importance of empathy and effective communication by service providers for older people to stay engaged with health and social service providers as their health declines.

- *The proportion of the Gippsland population aged 65 years or more is 22.4% compared to 15.6% in Victoria; with Bass Coast (27.7%) and East Gippsland (28.2%) especially high.[10] At the smaller geographical level (SA2) there is great variation; from 11.8% in Longford – Loch Sport to 48.6% in Paynesville. The Australian estimate is 15.1% and 18 of Gippsland's 25 SA2s have a higher proportion than this, while 7 have a lower estimate.*
- *• The population over 65 years is increasing faster than any other age group in Gippsland.[16]*

- *Life expectancy among males in Gippsland is low (78.4 years) compared to Australia (80.4), while female life expectancy is 83.0 compared to 84.6 in Australia.[26] Life expectancy in Latrobe is even lower for both males (76.9 compared to 80.3 in Victoria) and females (82.2 compared to 84.4 in Victoria). There is even a decline in life expectancy for Gippsland in recent years.*
- *• The rate of HACC clients aged 65 years or over is high in Gippsland, especially in Bass Coast, East Gippsland and South Gippsland. [8]*

- *The top ambulatory care sensitive conditions among people aged 60 years or older were diabetes complications (29%), chronic obstructive pulmonary disease (12%), inflammation of the kidney (12%), congestive heart failure (11%) and hypertension (10%).[54]*

- *Some 25% of Category 4 and 5 primary care type presentations (semi-urgent, non-urgent) to emergency departments in Gippsland were for people aged 60 years or older.[17]*

- *Some 25% of Category 4 and 5 primary care type presentations (semi-urgent, non-urgent) to emergency departments in Gippsland were for people aged 60 years or older.[17]* with that and they don't want to listen past what your complaint is." "Being invisible and being talked down to."

- *Pain management was identified as a service gap in stakeholder analysis as well as by the Gippsland PHN Clinical Council. [78]*
- *• Older people ranked cancer screening / services as the 3rd most important health issue in the community survey. [79]*
- *• Service use reported by older people was higher compared to all respondents for nursing in the home, pharmacy visits and allied health according to the community survey. [79]*

- *The most common health issues that had not been well managed reported by older people were mental health issues, followed by pain and a range of other less frequent issues. [79] Most of the issues were related to GPs, with ED the second most common service provider.*

"I've been prescribed medication I should never have been on. I kept telling my doctor things weren't right as I was getting worse and feeling suicidal."
"we put too much trust in GP's and don't ask enough questions, a lot of people don't know what questions to ask anyway…"
"…perhaps we need more nurse practitioners to do the "caring talk" like GP's used to, its really like a conveyor belt at the moment..."

- *The top health issues for older person (60+) identified in interviews was transport, including transport/schemes that assist with access to health services. The second most important issue was access to GPs, specialists and mental health. [79]*
- • Top service gaps identified in interviews for older people were GPs, dental, transport and specialists. *[79]*
- *• A survey of aged care stakeholders in Gippsland identified that access to services for older people was the top theme. Dementia and cognitive issues and concerns about exploitation were also commonly mentioned in relation to older people.[35]* Main service gaps were; o Mental health services
- o Transport
- o Specialist services
- o Allied health services
- o Carer support
-

"Transport to get to medical appointments is a huge issue"

- *• A survey of allied health stakeholders in Gippsland identified that issues around aged care was a top concern, especially coordination between providers. [35]*

- People over 60 also had the following suggestion to improve health. *[79]*

"Exercise programs that are affordable - I don't exercise but I would if there was an affordable exercise class here"
"Transport"
"Programs for people who are getting older"
"Script days at the Drs - where you don't have to pay $50 just for a script"
"Should be more hospital in the home …
"Another Dr's surgery"
"More money in the health system"

- *• 51% of the activity at Gippsland GP practices was for people aged 60 years or older with an average of 12.6 activities per patient;[3]* o 39% recorded a cardiovascular condition
- o 14% recorded a musculoskeletal condition
-

The proportion of the Gippsland population aged over 60 years is 27.3% compared to

20.6% in Victoria; with Bass Coast (31.5%) and East Gippsland (33.3%) especially high.[13]

- The population over 60 years of age is increasing faster than any other age group in Gippsland. [13]

- Estimates of the population 65 years or older as a proportion of the total population shows that there is great variation by SA2; from 11.8% in Longford – Loch Sport to 48.6% in Paynesville. The Australian estimate is 15.1% and 18 of Gippsland's 25 SA2s have a higher proportion than this, while 7 have a lower estimate.[46]

- The rate of age pension recipients is high in Gippsland, especially in Bass Coast, East Gippsland and Latrobe. [2]

Life expectancy among males in Gippsland is low (78.1 years) compared to Victoria (80.3) and life expectancy in Latrobe is low for both males (76.9) and females (82.2 compared to 84.4 in Victoria). [2]

- Projections show that 2.0% of the Gippsland population are expected to have dementia by 2020, compared to 1.6% in Victoria; with even higher rates in Bass Coast (2.3%), East Gippsland (2.4%) and South Gippsland (2.1%).[17]

- The rate of HACC clients aged 0-64 years is high in Gippsland, especially in Bass Coast, East Gippsland, South Gippsland and Wellington, while it is low in Latrobe. [2]

- The rate of HACC clients aged 65 years or over is high in Gippsland, especially in Bass Coast, East Gippsland and South Gippsland. [2]

- The rate of prescribing of anti-depressant medications for people aged 65 and over is high in Latrobe, while anxiolytic and antipsychotic prescribing for this age group is lower than the Victorian rate across Gippsland. [8]

- Rates of anticholinesterase prescribing for persons aged 65 or over is low in Gippsland. [8]

- Some 65% of potentially preventable hospitalisations in Gippsland are for people aged 60 years or above.[19]

- The top ambulatory care sensitive conditions among people aged 60 years or older were diabetes complications (26%), hypertension (20%), inflammation of the kidney (12%), congestive heart failure (11%) and chronic obstructive pulmonary disease (11%).[19]

- Some 22% of primary care type presentations to emergency departments in Gippsland were for people aged 60 years or older.[20]

- There are 3,039 aged care beds available in Gippsland (2015); Bass Coast (476), Baw Baw (409), East Gippsland (577), Latrobe (916), South Gippsland (288) and Wellington (373). [2]

- There were 3,522 Aged Care Assessment Program (ACAS) assessments completed in

Gippsland in 2014-15.[80] The mean number of days between referral and end of assessment varied between 14.6 (Wellington) and 22.8 days in East Gippsland.

The top health issues for older person (60+) identified in interviews was transport, including transport/schemes that assist with access to health services. The second most important issue was access to GPs, specialists and mental health. [30]

- Top service gaps identified in interviews for older people were GPs, dental, transport and specialists. [30]

- A survey of aged care stakeholders in Gippsland identified that access to services for older people was the top theme. Dementia and cognitive issues and concerns about exploitation were also commonly mentioned in relation to older people.[39] Main service gaps were;

○ Mental health services ○ Transport

"Transport to get to medical appointments is huge issue"

○ Specialist services ○ Allied health services ○ Carer support

Reproductive Sexual Health

Reproductive / sexual health

The birth rate among girls aged 18 years or younger is high in Gippsland. Smoking during pregnancy is common and low birth weight babies are also more common in large parts of Gippsland.
Chlamydia notifications are high for people under 25 years of age, especially females.
Sexual and reproductive health services are a health need identified by community members and other stakeholders, especially among youth. Service gaps and access issues exist for reproductive and sexual health services in general with affordable and confidential access to emergency contraception and terminations of pregnancy a specific need.
• The fertility rate is high in most of Gippsland (2.2 children per 1,000 women in Bass Coast, Baw Baw, East Gippsland and South Gippsland) compared to Victoria (1.9).[7]
• Gippsland has a high proportion of girls aged less than 19 years becoming mothers (14.0 live birth per 1,000) compared to Victoria (9.5) and even higher in Bass Coast (15.4) and Latrobe (21.5). [7] These 2015 rates are lower than in 2012 (20.8 births per 1,000).
• Chlamydia notifications in Gippsland have reduced over recent years, except in Baw Baw were the rates have increased; in 2017 there were 336 notifications per 100,000 people, higher than Victoria (322). [56]
○ Chlamydia notification rates for females under 25 years are higher than Victoria across Gippsland (2013 – 2014 data request).
• Low birthweight babies (<2,500 grams) were more common than in Victoria (6.3%) in parts of Gippsland; East Gippsland (8.6%), Latrobe (7.2%) and Wellington (6.8%).[25]
• 20.0% of mothers in Gippsland smoke during pregnancy compared to 11.0% in Australia, with Latrobe especially high at 25.6% and East Gippsland 21.7%.[26]
• The number of registered births to Gippsland women was (2016): [7]
○ Bass Coast – 340
○ Baw Baw – 651
○ East Gippsland – 492 ○ Latrobe – 962
○ South Gippsland – 309 ○ Wellington – 508
• 53% of women in Gippsland attended at least one antenatal visit in the first trimester compared to 65% in Australia. Baw Baw and Wellington had rates over 70% with only 25% in East Gippsland.[26]
• 'Family planning support' and 'STD and safe sex' were the 4th and 5th most commonly reported service gaps in a Gippsland wide survey by Gippsland Women's Health; 'IVF' was also noted as a service gap.[32]

• Reproductive and sexual health was a theme in consumer input and other stakeholder input, especially in relation to youth.[79]
• Service gaps were identified for pregnancy termination, access to specialist obstetricians and gynecologists and accessible sexual health clinics. [79]
• The Gippsland PHN Clinical Councils identify reproductive and sexual health as a priority. There are recent concerns about access to appropriate terminations of pregnancy services in Gippsland.

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• Sexual health and family planning was rated as having relatively low importance by survey respondents, but young people rated it as more important. [79] Some comments were also made;

"GP was uncomfortable discussing sexual health/family planning; it made me feel uncomfortable to discuss anything with her again."

"Women need improved access to comprehensive sexual and reproductive health services." "Teen pregnancy ... because its someone to love"

• A service gap identified in interviews was sexual assault and rape services. [78]
• A Latrobe practice nurse reported being "very concerned about the increase in repeated risky sexual behaviour of people in the Valley" (information from regular practice visit by practice support officer).
• 5.5% of South Gippsland Dairy Expo survey respondents reported having a sexual and reproductive health issue in the past 12 months; results also suggest more support for sexual or reproductive health are needed for people aged 60 or over.[35]
• A survey of pharmacies in Gippsland in 2018 found (68 pharmacies, response rate 71%);[57]
  - Good access to long acting reversible contraception
  - Emergency contraception pills were dispensed by 97% of pharmacies, however age restrictions were reported by up to a third with varying criteria
  - Medical terminations of pregnancy medications were supplied by 42% of pharmacies; many did not keep these medications in stock
  - Potential delays of 1-3 days of pharmacy items not in stock
• A survey of general practices in Gippsland in 2018 found (75 clinics, response rate 48%);[57]
  - Screening and treatment for Sexually Transmitted Diseases were provided by close to 100% of practices
  - Long acting contraceptives were provided by all practices
  - Intra uterine devices could be provided by 73% of practices
  - Medical terminations of pregnancy were provided by 48% of practices;
    - the majority of non-providers stated lack of training as the main reason; small numbers reported conscientious objection to termination, concern about the practice being identified as a termination clinic and one noted the long distance to a hospital
    - 48% of referrals were to Melbourne, 17% to a local hospital; 35% did not specify
  - 61% of practices provided surgical terminations of pregnancy or a referral;
    - 44% of referrals were to Melbourne, 30% to a local service/hospital, 26% did not specify

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  - The majority of practices did not bulk bill these services, except for pregnancy testing and screening for sexually transmitted diseases or for health care card holders or pensioners
  - Fertility services were offered by 47% of practices
• Comments provided in the 'Have your say' web survey included a need for; [79]

"Indigenous Women's Health Clinic"

"Easier access to medical and surgical termination of pregnancy"

• Hysterectomy hospitalisations were common in Latrobe and Baw Baw (481 and 409 per 100,000 women, 15 years and over); compared to Victoria (281), 2014–15. [31]
• Endometrial ablation hospitalisations were common in Latrobe (234 per 100,000 women, 15 years and over) – the highest rate for a Victorian SA3; compared to Victoria (98), 2014–15. [31]
• Caesarean section hospitalisations were less common in Baw Baw (142 per 100,000 women, 15 years and over) – the lowest rate for a Victorian SA3; compared to Victoria (262), 2014–15. [31]

The fertility rate is higher across Gippsland compared to Victoria, especially in Bass Coast, East Gippsland and South Gippsland. [2]

• Gippsland has a high proportion of teenage girls becoming mothers (20.8 live birth per 1,000 people); twice that for Victoria (10.4) and even higher in Bass Coast (25.6), East Gippsland (23.3) and Latrobe (25.5). [2]

- Chlamydia notifications are high in Latrobe. [2]

- Chlamydia notification rates for 2013 and 2014 are higher than Victoria across Gippsland for females under 25 years.[49]

- 'Family planning support' and 'STD and safe sex' were the 4th and 5th most commonly reported service gaps in a Gippsland wide survey by Gippsland Women's Health; 'IVF' was also noted as a service gap.[35]

Young People (12-25 Years)

The proportion of 12-18 year olds in Gippsland is higher than for Victoria as a whole.[21]

- The proportion of 15-19 year olds who are earning or learning is low in Gippsland (79% compared to 84% for Victoria); Bass Coast (77%), East Gippsland (78%) and Latrobe (77%) have even lower rates.[6]

- Only 19% of 17-year olds in Gippsland are participating in higher education

Gippsland has a high proportion of teenage girls becoming mothers (20.8 live birth per 1,000 people); twice that for Victoria (10.4) and even higher in Bass Coast (25.6), East Gippsland (23.3) and Latrobe (25.5). [2]

- Prescribing rates for anti-depressants, antipsychotics and ADHD medicines in Gippsland are high, with some variation between LGAs. [8]

- Prescribing of asthma medicines for 3-19 year olds is high in most Gippsland LGAs. [8]

compared to 36% for Victoria. [6]

- In Gippsland, 22% of adolescents report being bullied, compared to 18% for Victoria; the rates are even higher in East Gippsland (30%) and Latrobe (23%).[2]

Same Sex Attracted and Gender Diverse (SSAGD) people

While little information specific to Gippsland is available for SSAGD people, strong evidence exists that this group experience unique barriers to accessing health care and this is likely to also apply in Gippsland.

- *LGBT people are between 3.5 and 14 times more likely to attempt suicide compared to the national average.*[23]
- *Non-heterosexual people are more likely to suffer a range of mental health problems, including anxiety, affective disorders and substance abuse.*[23]
- Drug and alcohol use is more common among SSAGD people.[23]
- *SSAGD people have poorer health outcomes because of systemic stigma and discrimination. SSAGD people suffer from higher rates of violence, social isolation and alienation which are associated with reduced physical and mental health.* [23]
- *SSAGD people under utilise health services and delay seeking treatment due to actual or anticipated bias from service providers.* [23]
- In Victoria, 21% of headspace clients identified as LGBTI. [23] *Gippsland data indicate a similar proportion of clients identify as LGBTI.*
- *Mental health and AOD services generally have a lack of understanding of issues specific to LGBTIQ+ people.* [60]

Blood borne viruses

Hepatitis C infection rates in Gippsland are high.

• Gippsland had 53 Hepatitis C (unspecified) notifications per 100,000 people (2017); high compared to Victoria (35); highest rates were found in Latrobe (87), East Gippsland (61) and Wellington (57).[56]
• Education and training about new treatments for people with Hep C (introduced in 2016) providing patients and GPs access to new treating clinical guidelines and antiviral medication.

Regional planning aligned to a stepped care mental health model

A high proportion of the Gippsland population experience mental health issues with 29% of the population reporting anxiety and depression. The burden of disease is high and especially significant among people aged under 50 years. High or very high psychological distress is experienced by up to 1 in 5 people.
Stakeholder consultation identified mental health as a top priority across age groups and in all areas of Gippsland. The overlap between mental health and AOD issues were prominent and social determinants such as poverty, community connectedness and stigma were key themes in the community.
Difficulty accessing services is most pronounced in more remote parts of Gippsland and leads to a great reliance on GPs.
• Mental health is the leading cause of disability (based on Disability Adjusted Life Years-DALY) in Baw Baw, Latrobe, South Gippsland and Wellington LGAs and the second cause in Bass Coast and East Gippsland.[28]
• For the nation, mental and substance use disorders was the third highest cause of burden of disease (as DALY) at 12%.[27]
• Mental and substance use disorders is the leading cause of non-fatal burden for males and females. [27]
• Mental and substance use disorders and injuries were the largest disease groups in terms of DALY in the younger age groups (from childhood through to age 49 years). [27]
• The proportion of persons experiencing high or very high psychological distress was high in Gippsland (14.3%), compared to 12.6% in Victoria in 2014; especially in South Gippsland (20.5%), Latrobe (17.0%) and Bass Coast (15.4%).[73]
• 28.7% of the population in Gippsland reported depression and anxiety, compared to 24.2% in Victoria.[73]
• National data estimates that perinatal depression affects around 10% of new mothers and is more common among mothers who were; younger (aged under 25), smokers, came from lower income households or were overweight or obese.[58]
• People with a disability are two to three times more likely to have a mental health illness but are less likely to receive treatment. [71]
• People with a mental illness are more likely to die early due to poor management of their physical health. Many common chronic diseases such as cardiovascular disease, respiratory disease and diabetes are twice as common among people with mental illness.[71]
• The rate of registered mental health clients in Gippsland are high (15.1 clients per 1.000 population) compared to Victoria (11.9). The highest rates were in Latrobe, Bass Coast and East Gippsland.[8]
• There were 110 overnight hospital admissions per 10,000 people (age-standardised) for mental health in Gippsland in 2015-16; higher than national rates at 102. Overnight hospital admission rates involving bipolar and mood disorders and anxiety and stress were among the highest in the nation.[26] Latrobe had the highest rates of hospitlisation due to mental health in Gippsland.
• According to national data for 2015–16 (BEACH), 12.4% of all GP encounters were mental health related.[59]
○ Depression was the most commonly managed problem at mental health related encounters (32%).

○ Management of mental health problems were most commonly managed by medication (62%).
• GP data from Gippsland practices indicate that of people with an activity in 2017-18;[3] ○ 21.7% recorded a mental health diagnosis
○ 6.0% of 0-14-year olds recorded a mental health diagnosis
○ 18.7% of 12-25-year olds recorded a mental health diagnosis
○ 22.5% of people 65 years and over recorded a mental health diagnosis ○ Depression was the most common mental health diagnosis (9.8%)
- Attention deficit hyperactivity disorder was the most common mental health diagnosis among 0-14-year olds (1.5%)
- Depression the most common mental health diagnosis among 12-25-year olds (5.0%)
- Depression was the most common mental health diagnosis among people 65 years and over (11.1%)

• Engagement with mental health and AOD consumers in Gippsland highlighted underlying factors related to mental health and AOD issues;[60]
○ Homelessness

- Lack of community spaces and social activities
- Poverty
- Shame and stigma
- Family violence
- Family breakdown
- Lack of affordable housing

Low Intensity Mental Health Services

Additional work is required to learn what consumers would like and if there is knowledge among professionals and the public about available low intensity mental health options.

Further planning work at local level, including through applying the National Mental Health Service Planning Framework to understand demographics of at-risk groups across Gippsland is required.

- Estimated total number of people in Gippsland at risk of mental illness is 62,661 (23.1% of total Gippsland population 271,261, based on National Mental Health Commission stepped care model.[71]
- A pilot program is underway in Wellington LGA to address local needs associated with changes to employment and business opportunities likely to lead to increased distress. For the period January to June 2018, 617 occasions of service delivered, with the main presenting issues being grief and bereavement, workplace issues and stress.[61] A lack of referral options has been identified, especially for children/young people.
- A pilot program (Calm Kids Central) is underway in Gippsland to provide free online services to children, their parents and carers, and health professionals. Data for the first two months (July to August 2018) showed strong interest and uptake with 45 parent/caregivers and 27 professionals joining and accessing the program.[62]
- Consideration of population groups with specialised needs and/or high risk (e.g. LGBTIQ, men,

Aboriginal, trauma impacted) is required.[79]
- An estimated 2.7% of the adult population in Gippsland has been trained in Mental Health First Aid compared to 3.4% nationally.[63]

Children and Young People

High rates of prescription of antidepressants, antipsychotic and ADHD medications for young people aged under 17 is a feature in Gippsland, possibly linked to gaps in alternative interventions such as therapeutic treatment options.

Community input confirms mental health as a top health issue for children and young people in Gippsland. There was concern about over-reliance on medication to address mental health issues and a lack of affordable support unless you are in crisis.

- Modelled estimates of 12-month prevalence of mental disorders among 4-17-year olds in Gippsland shows rates comparable to the Australian average. Modelled estimates by SA3 level indicate East Gippsland has the highest prevalence at 17.1%, compared with Gippsland average of 14.3%. By age group, East Gippsland also has the highest modelled prevalence estimate for 12-17-year olds at 19% compared with Gippsland average of 14.4%. Latrobe Valley has the highest modelled prevalence estimate for 4-11-year olds at 16.2% versus 14.3% Gippsland average.[64]
- Gippsland headspace data for the 2017-18 period showed:[65]
  - 13.6% of Gippsland headspace participants reported tenuous housing situations, compared to a national Centre average of 9.8%
  - 71.9% of Gippsland headspace participants are aged 12-17 years, compared with the national headspace center average of 54.1%
  - There was a considerably lower average of young people from CALD backgrounds attending Gippsland headspace centers (3.6%), compared to the national headspace center average (9.9%)
  - The proportion of young people attending Gippsland headspace centers identifying as LGBTQI (22.6%) was similar to the national headspace center average (22.2%)
  - Mental health was the primary issue for 77.7% young people, comparable with the national headspace center average of 76.9%.
- Young people presenting for care to the four local Youth Access Clinics in Gippsland:[66]
  - Are young, with a mean age of 16 years
  - Present with high levels of self-harm, mental ill-health, suicidal ideation, family conflict, exposure to trauma, and alcohol and substance misuse
  - engage in sexual behaviours at a young age
  - Are witness to, or experience, interpersonal violence
  - Are experiencing or are part of families that are experiencing, financial struggles
  - Come from a variety of living situations with a large number of single parent families
  - And that males are less likely to access care than females
- The proportion of children with emotional or behavioral problems at school entry is high in Gippsland (7.4%), compared to 4.6% in Victoria. The highest proportions are in Latrobe (8.5%), South Gippsland (7.8%) and East Gippsland (7.7%). [67]
- Mental health was rated as the most important health issue in community interviews. There was specific mention of postnatal depression, anxiety, youth and sexual assault services.[79]

"..there are a lot of dysfunctional families...this has led to a dramatic increase in anxiety (of both

children and parents)”

Hard to Reach Populations

The level of socioeconomic disadvantage in Gippsland is high and is a recognised risk factor in mental health.
Local pressure on Gippsland communities affected by job loss and financial pressures due to drought are noted.
Further planning work at local level, including by applying the National Mental Health Service Planning Framework to understand demographics of mild and moderate mental illness across Gippsland is required.

• Estimated total number of people in Gippsland experiencing mild mental illness is 24,413 (9% of total Gippsland population 271,261, based on National Mental Health Commission stepped care model). [71]
• Estimated total number of people in Gippsland experiencing moderate mental illness is 12,478 (4.6% of total Gippsland population 271,261, based on National Mental Health Commission stepped care model). [71]
• Data from 2017-18 Gippsland PHN funded Primary Mental Health Care services (Psychological Therapies and Severe and Complex) showed:[68]
○ 35.1% of clients identified as holding a Health Care Card ○ 55.2% of clients identified as not currently employed
○ 64.7% of clients identified as female
○ 54.3% of clients were aged 25-64 years
• Mental health was rated as the second most important health issue in the community interviews and rated highly in every LGA; in East Gippsland mental health was the top health issue. Specific population groups such as farmers are also at risk.[79]
“Mental Health - would be the no 1 shortfall in this area - we fill the gaps that paid services can't provide” [Community House]
“Farming people have Mental Health problems due to what is happening in the dairy industry”
• Mental health was rated as the most important health issue by people with financial worries in the community survey,[79] in line with national data[71]. The cost of accessing mental health services was a key barrier across respondents and more remote locations were more likely to report long waiting times and access issues for services generally due to transport issues and fewer local options.
“Mental Health - probably 1⁄2 the people who come here... [Centrelink]”
• Drought conditions are becoming more severe in East Gippsland and Wellington, leading to added pressure on farmers in these areas. The entire communities are affected. [127]

Severe Mental Illness

Hospital admissions for mental health related conditions are variable and warrant further investigation in Gippsland. The variation may be related in part to limited capacity of regional mental health beds.
Further planning work at local level including through applying the National Mental Health Service Planning Framework to understand

• Estimated total number of people in Gippsland experiencing severe mental illness is 8,409 (3.1% of total Gippsland population 271,261, based on National Mental Health Commission stepped care model). [71]
• There were 110 overnight hospital admissions per 10,000 people (age-standardised) for mental health in Gippsland in 2015-16; higher than national rates at 102. Overnight hospital admission rates involving bipolar and mood disorders and anxiety and stress were among the highest in the nation.[26] Latrobe had the highest rates of hospitlisation due to mental health in Gippsland.
• Demographic data for Gippsland Partners in Recovery participants (2013-18):[69]
○ 59% identified as female

demographics of severe mental illness across Gippsland is required.
○ 80% of clients between 25 and 54 years of age
○ 45% of clients lived alone
○ 47% of clients had been living in their place of residence for less than one year
○ 31% of clients identified as having a formal or informal carer
○ Top three principal diagnoses were mood disorders (44%), schizophrenia (16%) and personality disorders (8%)
○ 10% of clients’ mental health legal status was identified as involuntary
○ 55% of clients identified as not in the labour force
○ 52% of clients identified the Disability Support Pension as primary source of income
• PIR providers report community issues including;[127] ○ A need for education
“Understanding a person’s depression and mental illness when you are close to them”
○ Exclusion due to stigma in the community and by family and friends
“Advising friends you have a mental illness and being seen differently to other community members, and that your opinions do not matter”
○ Social issues;
“Men and mental health”
“Young people who disengage from learning, peers and employment”
• The top five areas of unmet need for PIR participants during 2013-18 were psychological distress, daytime activities, company/social life, physical health, and employment/volunteering.[69]

• Approximately 32% of Mental Health Community Support Services (MHCSS) clients reside in Latrobe, 17% East Gippsland, 16% in Wellington, 14% in Baw Baw, 12% in Bass Coast and 10% in South Gippsland.[70]

Suicide Prevention

The suicide rate in Gippsland is high, especially for males. The rate of intentional injuries is also high.
• Suicide accounts for 1.5% of all deaths in Gippsland and 2.5% of male deaths.[29]
• Suicide is the 10th cause of death for males in Gippsland (Australia 9th), while it is not among the top 20 for females.[29]
• The suicide rate for Gippsland is 14.1 deaths per 100,000 people, high compared to Victoria (10.0).[29]
• Male suicide rates are higher than female rates in rural and remote regions generally.[71] The suicide rate for males in Gippsland is high (23.9 per 100,07900 males) compared with Victoria (15.3). The highest is in East Gippsland (32.9).[29]
• The rate of intentional injuries treated in hospital is high in Gippsland at 4.4 per 1,000 people, compared to 3.0 for Victoria. Rates are particularly high in Wellington (6.7), Latrobe (5.1) and East Gippsland (4.5).[17]
• Emergency Department presentations in Gippsland involving a suicide attempt / ideation are most common for 15 to 54-year olds, accounting for 87% of presentations.[17]
• It is estimated that for every death by suicide, as many as 30 people attempt to end their lives (Lifeline

Aboriginal and Torres Strait Islander people

A high proportion of Aboriginal and Torres Strait Islander people are impacted by mental health issues.
A higher proportion of the Indigenous population were admitted to hospital for mental health issues compared with non-Indigenous people.
• Mental health and substance use disorders are leading contributors to burden of disease, causing 19% of total disease burden among Aboriginal and Torres Strait Islander people.[27]
• Suicide rates are twice as high for Aboriginal and Torres Strait Islander people. [71]
• The Bairnsdale headspace center reported a higher number of Aboriginal and Torres Strait Islander people receiving services at 9.8%, compared with the Morwell center at 7.5% and the national average of 8.4%.[65]
• Referrals to Partners in Recovery (PIR) show that Indigenous clients made up 4% from the commencement of program in 2013 to 30 September 2018.[69]
• In 2017-18, 3.4% of clients accessing Gippsland PHN funded Primary Mental Health Care services (Psychological Therapies and Severe and Complex) identified as Aboriginal and/or Torres Strait Islander.[68]
• The rate of hospitalisations for mental and behavioral disorders was six times higher for Aboriginal clients compared to non-Aboriginal clients.[28]
• 22% of Aboriginal adults report 'high or very high' levels of psychological distress nationally compared with 11% for non-Aboriginal people.[94]
• Admissions for mental health conditions for Aboriginal people 15 years and over was 2,942 per 100,000 people (East Gippsland/Wellington) and 1,729 in Latrobe compared with 1,608 (Victoria) and 3570 (Australia).[95]
• A much higher proportion of Indigenous children aged less than 15 years are in jobless families compared to non-Indigenous children (17%); Latrobe (49%), East Gippsland / Wellington (43%), Baw Baw (40%) and Bass Coast / South Gippsland (33%).[94]
• Evidence indicates that Aboriginal clients are more likely to have first contact with the mental health system at the acute end. [71]

Alcohol and Other Drug Treatment Needs

Identified Need
Key Issue

Description of Evidence

Alcohol and Other Drugs (AOD) – general

A high proportion of the Gippsland population consume alcohol at risky levels, likely to cause long term harm and injury. Alcohol sales are high and crime rates linked to illicit drug use are also high, especially in Latrobe. This includes family violence. Service use for alcohol and illicit drugs is high as is the alcohol related death rate. Cannabis is common among young people while amphetamine use is increasing, especially among 20-44-year olds.

Stakeholder input clearly identifies alcohol and other drugs as an important health issue with numerous service gaps. Community input confirmed AOD as an important health issue.

• Alcohol sales (wholesale) are high in Gippsland at 12.6 liters per person 18 years or older, compared to Victoria (10.0).[72] The highest sales are in Latrobe (15.7), Bass Coast (15.2), East Gippsland (14.0) and Wellington (10.9).

• Alcohol-consumption at levels likely to cause long term harm (>2 standard drinks per day) among adults is higher than Victoria (59%) in Bass Coast (63%), East Gippsland (61%), Latrobe (61%) and Wellington (76%).[73]

• 45.1% of adults consumed alcohol at levels likely to increase the risk of alcohol-related injury (>4 standard drinks) is higher than Victoria (42.5%); especially in Wellington (52.5%).[73]

• The crime rate for drug offences is high in Latrobe (960 offences per 100,000), East Gippsland (550), Baw Baw (485) and Wellington (524).[74]

• Alcohol-related family violence rates in four of six Gippsland Local Government Areas (LGAs) is well above the Victorian rate; Bass Coast, East Gippsland, Latrobe and Wellington.[75] The highest rate was seen in the 25-39-year age group and the rate for women was twice as high as for men.

• The rate of ambulance attendances involving alcohol-intoxication was higher than Victoria (351 per 100,000 people) in Bass Coast (381), East Gippsland (484), Latrobe (451) and Wellington (384).[75]

• The rate of alcohol related emergency department presentations was higher than the Victorian rate (13.8 per 100,000 people) in East Gippsland (18.5) and Wellington (21.8).[75]

• For males, the alcohol related hospital admission rate was among the top 25% in Victoria for three Gippsland LGAs; Bass Coast, East Gippsland and Wellington. [75]

• For females, the alcohol related hospital admission rate was among the top 25% of rates for four Gippsland LGAs; Bass Coast, East Gippsland, Latrobe and South Gippsland. [75]

• The alcohol related death rate was higher than the Victorian rate (1.7 per 10,000 people) across Gippsland's six LGAs, especially in Baw Baw (4.8), Latrobe (3.3) and South Gippsland (3.9).[74] The rates for men were more than twice the rate for women.

• The rate of ambulance attendances for illicit drug use were higher than the State rate (180 per 100,000 people) for Latrobe (252) and Wellington (175).[75]

• The highest rates of hospital admissions for illicit drug use were seen in East Gippsland (25.3 admissions per 10,000 people), Latrobe (21.0) and Wellington (24.9), compared to Victoria (25.3). [75]

Hospital admission rates in Gippsland are likely affected by limited local capacity of detox beds.

• Average annual rate of overdose death 2009-2016 for Victorian LGAs show that Latrobe has the second highest rate of regional LGAs in the State at 10.2 average annual deaths per year per 100,000 people; Bass Coast, East Gippsland and Baw Baw also had a higher rate than Victoria.[76]

• Alcohol and other drugs was a key theme across both consumer and other stakeholder feedback in existing reports.[77]

• Interviews with key stakeholders identified;[78]

- alcohol and other drug addiction as a key health issue, and
- the importance of mental health and alcohol and other drug comorbidity.

• Alcohol and Other Drugs were rated as the least important health issue in the community survey.[79]

However, this is likely to be due to many people in the community not directly affected. One respondent with a health issue that they felt had not been managed well noted that:

"Alcoholism [was not managed well] because there are only services in the city e.g. detox and rehabs, which compounds the stress on yourself and family."

• Alcohol and Other Drugs was identified as the 4th most common health issue in community interviews, especially among young people, Indigenous people and for families.[79]

• Priorities identified in the 2019 Catchment Based Plan are:[80]

- Increasing the awareness of AOD services and how to access them; both for community and professionals

"Frontline services are not familiar enough with referral pathways and local services"

"Consumers often do not know 'where to start' when seeking help"

- Improved collaboration between AOD services providers
  - general fragmentation between services
  - lack of step-down supports
  - long wait times
  - perpetual cycle of referrals

- access difficulty relating to size of region and geographic isolation of smaller communities
- Co-design with consumers

• State funded services for AOD treatment episodes of care in 2015-16; [87]

- 71% were for clients aged between 20 and 44 years
- 67% were for males
- 33% of episodes of care were for clients with alcohol as the principal drug of concern,

followed by 22% cannabinoids, 18% amphetamines, 3% heroin and 20% miscellaneous drugs of principal concern

- Some differences in principal drug of concern by age group were noted;

10-19-year olds 20-44-year olds
53% cannabinoids
27% alcohol, 22% amphetamines, 21% cannabinoids
64% alcohol
45+ years

- 53% of episodes of care were for clients who had never injected drugs
- 30% of episodes of care were for self-referred clients, with 25% for clients on a court diversion and 23% for clients referred by correctional services (also referred to as forensic clients)
- The main treatment type was counselling for 64% of episodes of care, 19% assessment; support / case management 16%, withdrawal 15% and rehabilitation 1.5%.
- LGA of clients shows that 38% of episodes of care were for clients in Latrobe, followed by 21% for clients in East Gippsland
- The rate per 1,000 population was highest in Latrobe (22.2 episodes of care per 1,000 people), East Gippsland (19.7), Bass Coast (14.2), Wellington (11.6), Baw Baw (8.9) and South Gippsland (8.6). Compared to State rate of 11.3.

• The primary drug of choice for Gippsland clients accessing State funded AOD services remain alcohol at 41% (Jul-Dec 2017), followed by amphetamines (27%) and cannabis (21%).[80] An increasing proportion of clients reporting amphetamines over times is apparent (2015-2017).

• The Alcohol and Other Drug Treatment Services National Minimum Data Set incorporates data from seven publicly funded AOD service providers in Gippsland; in 2016-17 there were 4,533 episodes of care (differences in State reporting to be noted):[81]

- 68.9% were for males (66.2% in Australia)
- 11.0% were for Indigenous people (14.8% in Australia)) ○ Age distribution (Australia);
  - 8.0% were 10-19 years (12.7%)
  - 30.4% 20-29 years (27.8%)
  - 30.7% 30-39 years (27.1%)
  - 19.5% 40-49 years (19.2%)
  - 8.3% 50-59 years and (8.9%)
  - 3.1% were 60 years or older (4.3%)

- Setting (Australia);
  - 67.1% were in non-residential facility (66.6%)
  - 9.9% outreach (13.0%)
  - 6.2% residential (12.2%)
  - 1.0% home (1.0%) and (15.8% other; 7.2% Australia)
- Treatment type;
  - 47.6% were counselling (40.0%)
  - 32.8% were support and case management (14.1%)
  - 15.1% were withdrawal management (11.9%)
  - 0.2% information and education only (8.4%)
  - 1.4% rehabilitation (5.6%) and (2.0% other; 4.4% Australia)
- Principal drug of concern in Gippsland (Australia):
  - 29.0% alcohol (32.3%) – downward trend
  - 25.3% amphetamines (25.7%) – upward trend
  - 22.8% cannabis (21.7%) - steady
  - 17.9% other (heroin 5.2%)

• National data based on interviews with drug users highlight some changes over time;[82] ○ Consistent high use of cannabis, alcohol and tobacco
○ Heroin use was stable
○ Increase in the use of crystal methamphetamine (reduced use of powder)
○ Use of both a stimulant and depressant was common
○ Around one quarter reported a non-fatal overdose
○ Almost half self-reported experiencing a mental health problem in the past six months ○ Awareness of Naloxone among over half of injecting drug users

Aboriginal and Torres Strait Islander people

Indigenous Australians have higher rates of drug and alcohol use compared to non- Indigenous Australians, but a lack of available data on AOD service use and AOD needs for Indigenous Australians hinders efforts in describing their specific needs. In addition to a shortage of AOD treatment services, there are a range of other barriers

• 5% of Gippsland clients of State funded AOD services identified as Aboriginal or Torres Strait Islander.[91]
• 11% of Gippsland clients identified as Indigenous in 2016-17.[81]
• The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) provided the following points about AOD issues among Aboriginal people:[83]
○ Data gaps exist.
○ Aboriginal people in remote areas were less likely to have used an illicit substance in the previous year (23% compared with 19% in less remote areas).
○ 63% of Aboriginal and Torres Strait Islander people in remote areas said they had never used an illicit substance, compared with 49% of those in non-remote areas

to accessing services relating to social and /or cultural factors including geographic isolation, lack of transport and affordability of services, cultural beliefs around AOD use, shame and fear of the justice and child protection system. AOD services need to advertise their services more to the Indigenous community; and promote referral pathways to their services to medical staff.

○ Rates for both alcohol use and drug use are higher for Aboriginal and Torres Strait Islander people compared to the general population.
○ Aboriginal people drink at riskier levels than the general population.
○ Alcohol is reported as a principal drug of concern, followed by marijuana (97% of organisations), tobacco (64%), multiple drug use (54%) and amphetamines (43%). ○ New HIV diagnoses attributable to injecting drug use was higher among Aboriginal Australians compared with the general population, at 16% versus 3%.
○ Rates of HIV and hepatitis C virus notifications were higher among Aboriginal compared with non-Aboriginal persons at 5.9 versus 3.7 per 100,000 and 164 versus 35 per 100,000 respectively.
• Mental disorders are more common among Aboriginal people than for non-Aboriginal people of all ages, except for women aged over 75 years. The major causes of admission for mental disorders are schizophrenia, mood disorders, alcohol and drugs and neurotic disorders. The Aboriginal rates of admission for alcohol and drugs, schizophrenia and neurotic disorders are more than twice the non- Aboriginal rates.[84]
• AOD was identified as the top ranked health issue, including tobacco use.[79]
“Closing the gap has focused on 0-5-year olds and 21-year olds and older - there are big issues with 6-24-year olds - early intervention, AOD use, smoking are all big issues.”

Young People

Drug and Alcohol use is a significant issue for young people and their parents, but it needs to be seen in the context of other mental health and family issues.
There is a lack of awareness by young people of the potential harm of illicit drug use.

• AOD treatment episodes delivered by State funded services show that 53% of 10-19-year olds were treated for cannabinoids as the main drug of concern.[70] Alcohol and amphetamines became more prevalent with age.
• A youth survey in Baw Baw in 2015 indicated that drug and alcohol was ranked second (after mental health) as the issue of most importance to young people.[85]
• 25% of parents in Baw Baw did not think young people were safe in the community, and suggested drug issues are normalised.[85]
“...drug and alcohol use among our youth is almost ‘normal’ in the eyes of a lot of youth and their families...”
“I believe people have become complacent about the long-term impact drugs and alcohol have on our youth.” (parent)
• In Bass Coast, more than half of youth rated ‘other drugs’ as the top issue affecting young people and 4 in 5 parents/carers rated ‘other drugs’ as an issue of concern for young people.[86]
• Young people in Gippsland identified AOD as a health issue.[79]
“Drugs – it’s one of the major things that affects health and wellbeing”

• The State consultation notes that:[123]
"Young people who use drugs are ill-informed about the potential harms associated with illicit drug use"
• Analysis of AOD treatment episodes delivered by State funded services in 2015-16 show that cannabinoids was the drug of principal concern among people 24 years or younger, especially for people 19 years or younger. Amphetamines became more of a concern for the 20-24-year age group.[87]
• The Communities That Care program[88] is in place in Baw Baw and East Gippsland LGAs with a focus on addressing AOD and underlying issues among young people in the community.

Families and carers

There is a need for greater collaboration between AOD and other agencies working with families. The needs of carers is an important consideration in AOD work as they can provide important support if equipped to do so.

• The Gippsland Integrated Family Violence Service Reform Steering Committee identified that; "Stronger links need to be made between MBCP, AOD, mental health agencies and GCASA"[89]
• Carers have reported having difficulty obtaining information about both AOD and MHCSSs. One carer stated that they; "...have had to tell the story seven or eight times. This includes speaking to the GP, psychiatrist and other health services". [90]
• Carers want access to carer support groups.[90]
• 19% of clients accessing State funded AOD services in Gippsland lived with dependent children (Jan-Jun 2017).[91]

Hard to Reach Populations

There are a range of populations that may be at particularly high risk and/or have high treatment needs. These include Indigenous people, geographically isolated people, CALD people, vulnerable children and families, clients of the justice system, homeless people, people with comorbid mental health problems and/ or cognitive impairments and poly drug users. Funding models do not factor in the additional support needs of hard to reach population and vulnerable groups.

• Specific populations with additional needs include; [123]
- People in regional and rural settings
- People from other cultures such as Aboriginal people, CALD communities
- Brief interventions for early onset
- recently released from prison are at high risk of drug related overdose
- alienated from healthcare and distrustful of mainstream services
- from CALD backgrounds
- poly drug users who use a cocktail of different drugs in an opportunistic manner
"...whatever is available or on offer at the time."
• State funded service data shows that;
○ 5% of clients had an acquired brain injury[121]
○ 3% of clients were homeless or at risk of homelessness
• The service mapping and brief survey conducted in 2016 highlighted the following in relation to hard to reach populations:[90]
- absence of youth AOD services in remote East Gippsland
- absence of Indigenous specific AOD services in remote East Gippsland

- models of AOD service delivery do not fund the true costs of AOD outreach so it is not occurring in remote areas of Gippsland
- remoteness of parts for the Gippsland catchment excludes access to the one-day rehabilitation program in the region

Dual Diagnosis - mental health and alcohol and other drugs

Consumers and carers see a need for more widespread knowledge among clinicians about dual diagnosis and coordination of treatment services.

• Consultation with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) indicated that dual diagnosis is common and advocate for a more holistic approach.[123]
• Harm Reduction Victoria (HRV) highlights people with a dual diagnosis as a high-risk group. [123]
• In Gippsland, 43% of clients accessing State funded AOD services were recorded as having a psychiatric diagnosis (Jan-Jun 2017).[91]
• Gippsland PHN Partners in Recovery data to the end of September 2018 shows that of the 737 accepted referrals, 2% were from AOD services; 10% had unmet needs in relation to alcohol and 11% in relation to prescribed drugs.
• Dual diagnosis clients can be challenging for the service system, especially in the child, youth and family sectors due to limited dual diagnosis awareness and capacity.[90]

Indigenous Health (including Indigenous chronic disease)

Identified Need

Key Issue

Description of Evidence

Indigenous health – health and wellbeing

Gippsland has a high Aboriginal and Torres Strait Islander population and health service use is significantly higher compared to non- Indigenous people for many health conditions, including end-stage renal disease, diabetes, mental and behavioral issues, cardiovascular diseases, dental conditions and respiratory diseases.

There is a high rate of low birth weight babies and low participation in maternal and child health for children under 12 months. Indigenous children are more likely to be developmentally vulnerable, especially in some LGAs.

Community consultation revealed work and study opportunities as a top-rated health issue among Indigenous people. Mental health, dental services and AOD were commonly mentioned as issues. Barriers to service access include cost and wait times (as for all respondents), but transport and 'feeling comfortable to access the service' were more common for Indigenous people.

• Estimates of the Aboriginal and Torres Strait Islander population in Gippsland was a total of 5,207 people in 2016. The proportion of the total population identifying as Aboriginal of Torres Strait Islander is 4.2% in East Gippsland, 2.0% in Latrobe, 1.9% in Wellington, 1.3% in Baw Baw and 1.0% in South Gippsland and Bass Coast. [10]

• Approximately 10% of Victoria's Indigenous population live in Gippsland. [10]

• Hospital admissions are twice as common for Aboriginal people compared to non-Aboriginal people.[28]

• The participation rate for young Aboriginal children in maternal and child health is lower than for non-Aboriginal children; 90% compared to 97% at 2 weeks and 71% compared to 79% at 12 months.[92]

• Aboriginal and Torres Strait Islander women in Gippsland have a high rate of low birth weight babies (13.2%), compared to Australia (10.6%).[26]

• Concerns documented for Victoria are likely to also be relevant for Gippsland. [93]

- Indigenous women are three times more likely to smoke during pregnancy – an estimated 52% in Gippsland [26]
- Low birth weight babies were more than twice as likely from Indigenous mothers
- Indigenous women have low rate of access to antenatal care in the first trimester
- End-stage kidney disease is increasing and 4.5 times more common among Indigenous Australians
- Indigenous Australians are almost five times as likely to be hospitalised for injury due to assault
- Unemployment among Indigenous Australians is much higher than among non-Indigenous Australians

• In a national analysis, it is highlighted that the death rate for diabetes (underlying and/or associated cause) was more than 4 times as high among Indigenous Australians as non-Indigenous Australians.[40] This report also highlights many other indicators for diabetes among Indigenous Australians.

• Indigenous health was not ranked highly in stakeholder analyses, but was identified in relation to chronic disease management, mental health and socio economic determinants of health such as employment and housing.[77, 78]

• Aboriginal unemployment was high across Gippsland; 26.7% in Latrobe, 21.0% in Baw Baw, 17.7% in East Gippsland / Wellington and 14.9% in Gippsland South-West, compared to 14.0% in Victoria.[94]

• The proportion of Aboriginal children who are developmentally vulnerable on two or more domains is much higher than for all children (11.5% Gippsland) in Latrobe (46.7%), Bass Coast – South Gippsland (18.8%) and East Gippsland – Wellington (36.1%).[94]

• The proportion of children aged less than 15 years in jobless families is much higher than for all children (13.8% Gippsland) in Latrobe (51.8%), East Gippsland –Wellington (37.6%), Baw Baw (38.8%) and Bass Coast – South Gippsland (34.8%).[94]

• Aboriginal participation in full-time secondary schooling is lower than Victorian levels (75%) in Baw Baw (63%) and East Gippsland/Wellington (70%), but higher in Latrobe (94.4%) and Gippsland South- West (100%).[94]

• Immunisation rates for Aboriginal children (fully immunized 2016-17);

- 1-year olds - 87.4% (94.9% of all children)
- 2-year olds – 87.0% (93.6%)
- 5-year olds – 96.4% (95.7%).[26]

• The health issue rated as most important for Indigenous people was work and study opportunities, mental health and heart and lung health as identified in the community survey.[79]

• 44% of Indigenous survey respondents reported that nothing stopped them from getting health care they needed in the past 12 months, compared to 48% for all respondents. Main barriers were: [79]

- Cost 44%
- Long wait for appointments 41%
- Didn't feel comfortable accessing the service 18%
- Couldn't get there 15%
- Didn't understand how to access the service 8%

• 18% of Indigenous survey respondents reported that they did not think they could get the help they needed if they had a health problem (compared to 10% of respondents overall). [79]

• Overall, survey respondents did not rate Work and Study Opportunities among the most important issues for health, but for young people and Indigenous people it was in the top three. [79]

• Alcohol and other drugs was the top ranked health issue identified in interviews, including tobacco use, and noted as a specific issue for youth. [79] Other issues of note include obesity / overeating, heart disease, diabetes and respiratory issues.
• A national study found that Indigenous Australians experience a burden of disease that is 2.3 times the rate of non-Indigenous Australians.[27]
• A national survey of Aboriginal and Torres Strait Islanders found that in Victoria;[93]
○ 37% felt that they had been unfairly treated at least once in the previous 12 months because

they were ATSI
○ 57% identified with a clan, tribal or language group
○ 51% were employed
○ 21% had experienced or been threatened with physical violence in the past 12 months
• The national 2017 Bringing Them Home report identifies a need to do a comprehensive assessment of the contemporary and emerging needs of Stolen Generations members and to better understand intergenerational trauma to allow change for young Aboriginal and Torres Strait Islander people in the future.[95]
• Community engagement by the State government in Gippsland in 2018 noted;[96]
○ Community needs a direct voice to set priorities and plan, not through ACCHOs
○ It is the Government's role to provide resources for capacity and meeting targets ○ Government and representatives need stronger cultural competency, respect and
understanding of Aboriginal culture and protocols
○ A need for improved access to affordable, culturally appropriate health services ○ Lack of non-Aboriginal understanding of intergeneration trauma
○ Importance of housing for good health (overcrowding)
○ Recognition of racism affecting health
○ Address drug and alcohol use, including fetal spectrum disorder
○ Education needs to include Aboriginal ways of learning
○ Community based prevention of crime, including strong Aboriginal role models ○ Importance of cultural land recognition by all who visit Gippsland

Indigenous health – chronic disease

Chronic disease including diabetes, cardiovascular disease and mental health issues are all more common among Indigenous people. It is important to consider the whole person and family experiences including trauma to help address these issues.

• Conditions where hospitalisations for Aboriginal people are much more common than for non- Aboriginal people;
○ Renal dialysis – 26 times
○ Diabetes – 7 times
○ Mental and behavioral disorders – 6 times
○ Cardiovascular diseases – 4 times
○ Hospitalisations attributable to alcohol or tobacco – 3.4 times ○ Hospitalisations attributable to tobacco – 2.7 times. [28]
• The top Ambulatory Care Sensitive Conditions leading to a hospital admission in Gippsland are: ○ Diabetes (28%)
○ Dental conditions (17%) ○ COPD (12%)

○ Convulsions / epilepsy (9%) ○ Asthma (9%)
○ Angina (8%) [28]
• Hospitalisation rates for Aboriginal people (15 years or older) were high in East Gippsland-Wellington (81,904 hospital admissions per 100,000 population, age standardised rate 2012-13) and Latrobe (68,838) compared to Victoria (49,020); [94]
○ Digestive and circulatory system diseases were high compared to Victoria
• Chronic diseases as a group accounted for almost two-thirds (64%) of the total disease burden for
Indigenous Australians. Disease groups causing the most burden was mental & substance use disorders (19% of the total), followed by injuries (including suicide) (15%), cardiovascular diseases (12%), cancer (9%), respiratory diseases (8%) and musculoskeletal conditions (7%).[27]
The biggest difference to non-Indigenous was for cardiovascular diseases (19% of the gap), mental & substance use disorders (14%) and cancer (9%).[27]
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Indigenous health – mental health

See Primary Mental Health and Suicide prevention

Indigenous health – Alcohol and Other Drugs

See Alcohol and Other Drug Treatment Services section

Access to services

Accessing health services can be a challenge in a regional and remote area due to the vast distances and challenging terrain. Transport was mentioned as an issue for many people even in the least remote parts of Gippsland due to few public transport options.
Economic factors are an important consideration for many people in accessing services, especially for people with low socio-economic status.
Access to specialists is an issue and private hospitals are very few.
Community input shows that access to health services is most difficult for people with social or financial worries, parents and people with a disability. Main barriers are cost, long wait times and transport, while not feeling comfortable accessing a service
• The ABS remoteness category is Inner regional for much of Gippsland, but Outer regional for Wellington and East Gippsland.[8]
• The population density ranges between a low of 2.2 persons per km^2 in East Gippsland to 52.1 in Latrobe (average for Victoria 27.2).[10]
• 34.0% of the Gippsland population are within 400 m of tram/bus or 800 m of train, compared to 73.9% of Victorians; even lower proportions in South Gippsland (8.5%), East Gippsland (19.5%), Baw Baw (20.9%) and Wellington (26.6%).[8]
• 1.5% of journeys to work in Gippsland are by public transport compared to 12.6% across Victoria. [10]
• 16.1% of families are one parent families (Victoria 15.3%); the highest proportion is in Latrobe with 19.9%.[10]
• 16.4% of people in Gippsland needed to see a GP but did not according to a national survey (Australia 14.1%).[26]
• 37.0% of people in Gippsland could not access their preferred GP in the preceding 12 months, antenatal as estimated by a national survey (Australia 28.5%).[26]
• The average number of GP attendances varies across Gippsland; it is high in Latrobe and Baw Baw (6.5 per person per year) but low in East Gippsland (4.5) compared to Australia (6.1).[26]
• The proportion of people who did not claim a GP attendance in 2016-17 was 9.8% in Gippsland, compared to 12.5% nationally; highest proportions were in Wellington (13.2%) and East Gippsland (11.9%).[26]
• The average number of specialist attendances varies across Gippsland; it is low in East Gippsland with 0.71 per year per person and highest in Latrobe with 1.11 compared to 0.95 for Australia. [26]

and lack of information about available services are also relevant, especially for some groups. Access to GPs was the top health issue in interviews but access to medical specialists, dental services and mental health service were also common. Variation between groups and geographical areas is noted.
• The proportion of bulk billed attendances at GPs in Gippsland is high at 86.7% compared to Australia (85.1%), especially in Latrobe (90.1%), except in East Gippsland (80.3%) and Wellington (82.6%).[26]
• Hospital admissions rates are high in Gippsland (409 per 1,000 people), especially for East Gippsland residents (508) and Latrobe residents (443), compared to Victoria (305);[54] Baw Baw had the lowest rate at 308.
• 77% of hospital admissions for Gippsland residents are in public hospitals, compared to 61% for Victoria.[8]
• Emergency department presentation rates in Gippsland are high (398 presentations per 1,000 people), compared to 286 for Victoria.[17] South Gippsland rates are low as there is no funded ED.
• Primary care type presentations to ED (category 4-5) are high across Gippsland (238 per 1,000 people), compared to Victoria (148) except for South Gippsland residents.[17]
• Population groups more likely to experience access issues include;
- Persons with low socio-economic status (see separate priority area).
- Persons with low English proficiency – 0.4% in Gippsland, but 0.7 % in Latrobe and 0.5% in Bass Coast (Vic 2.9%).[25]
- Homeless persons, estimated to be 692 persons in Gippsland.[97]
- Persons with a profound or severe disability, more than 17,000 in Gippsland (see separate priority area).[10]
- Same sex and gender diverse population – we don't know the size of this population.

• Service gaps were identified as the top theme in existing reports with consumer and other stakeholder feedback as well as in stakeholder interviews.[77] Specific issues related to accessing services included:
- Transport which is an issue both due to lack of public transport options in many parts of Gippsland and also due to the sheer distance to access many services even if they exist within Gippsland.
- The cost of accessing services is a major factor leading to disadvantaged groups unable to access existing services (including people with low socio-economic status, Aboriginal and Torres Strait Islanders, and the aged)
- There is a general lack of access to specialists across the region, but the difficulty in accessing becomes greater with increased remoteness.

• Service access by community survey respondents showed some variation across the region, [79]

○ Bass Coast residents reported higher use of GPs, ED, ambulance, allied health and dentists. ○ Baw Baw residents reported higher use of ambulance and nursing in the home.
○ East Gippsland residents reported lower use of GPs and allied health, while ambulance,

community health and nursing in the home use was higher.
○ Latrobe residents reported higher use of GPs, ED, community health services, and pharmacists.
○ South Gippsland residents reported higher use of GPs, pharmacists, allied health and dentists, while use of ED and community health was low.
○ Wellington residents reported lower use of community health and nursing in the home, while use was not high for any service.
• Overall, 48% of survey respondents reported that nothing stopped them from getting health care they needed in the past 12 months. [79]
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• The most ○
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Variation by sub-group shows that only around 30% of people with low SES, parents and people with a disability had nothing stopping them from accessing health care they needed. commonly reported barriers to accessing health care were; [79]
Cost – overall 32% of respondents reported this as a barrier, with even higher proportions reported by people with low SES (55%), people with a disability (48%) and Indigenous people (44%).
“There is a huge difference in affordable services for those that do and do not have a health care or pension card ... middle income earners are falling through the cracks” "I now ask if they do bulk billing and if they don't I'll go elsewhere, but you are ending up with scenarios of people not going to the Drs”
A too long wait for an appointment was reported by 24% of respondents, with up to 40% of Indigenous people, parents and people with a disability reporting this a barrier.
“GP services are very limited in this area which prevents anything but urgent care being attended.”
10% of all respondents reported that they couldn’t get to the health care they needed. For people with a disability, as many as 23% had problems getting there, while around 15% of carers and people with low SES reported this as an issue.
6% of all respondents reported that they did not feel comfortable accessing the service they needed, while 17% of Indigenous people and 14% of young people reported this as an issue. 4% of all respondents reported that they did not know how to access the service, while over 8% of Indigenous people and young people reported this as a barrier.
Some regional differences were also noted with the most significant being a high proportion of East Gippsland residents reporting a long wait for appointments and issues with getting to their service.

• In 2018, 38% of survey respondents reported travelling more than an hour to access health services at least once in the past year.[35]
• Overall, 10% of survey respondents reported that they did not think they could get the help they needed if they had a health problem. [79]
○ People with a disability (26%), Indigenous people (18%) and people with low SES (15%) were more likely to report that they could not get help when needed. Results by LGA show that East Gippsland residents are least confident about getting the help they need if they have a health problem.
• In 2018, 83% of survey respondents knew how to access the health care they needed.[35]
• 43% of all survey respondents reported problems getting an appointment with a GP during business hours. For parents of children aged 0-14 years and carers, around 55% reported problems accessing a GP within business hours. [79] Differences by LGA show that residents of Bass Coast and East Gippsland were more likely to report problems accessing a GP, while Baw Baw residents were less likely to report problems accessing a GP during business s hours (26%)
“No continuity in GP practices, always see a different doctor and differing opinions in the end my illness side effects were missed and I had 5 weeks off work”
• The most common health issue identified in community interviews was access to GPs. [79] Other common issues were;
○ transport, often mentioned as “transport to access health care” and in association with affordability
○ access to medical specialists
○ access to health care (general).
• The most common service gaps identified in community interviews was GPs and this was commonly mentioned in association with continuity of care, bulk billing and after-hours access. [79] Other service gaps were;
○ medical specialists, including cardiologist, rheumatologist and ophthalmologist
○ dental services, especially affordable dental
○ transport, often mentioned as “transport to access health care” and in association with affordability

- mental health services, including child mental health, counselling (affordable) and youth services
- specialist health care, including early assessment and intervention for children, diagnostic services, chemotherapy, maternity, dialysis, rehabilitation and youth health services

- allied health services, especially pediatric allied health, audiology, speech and podiatry (affordable)

• Access to specialist services was rated as a top service gap identified in feedback provided via the Gippsland PHN web site. There was specific mention of; mental health services, including youth specific, cancer treatment, orthopedics, ophthalmologists and pediatricians; [79]

"Mental health services - complex to access"

• Access to GPs was rated as a top service gap identified in feedback provided via the Gippsland PHN web site. [79]

• A local community engagement project was undertaken in Mallacoota to learn more about the community's health needs.[98] Key themes included;

- the community were supportive and appreciative of current service providers
- GP access is limited due to a sole practitioner
- aged care services are largely not available (a high proportion of residents are 55+)
- community palliative care services are needed
- face-to-face mental health services are needed
- ambulance services are limited due to limited staffing
- health service provision is limited by reliable transport, power and telecommunications, especially in emergencies
- lack of coordination between existing service providers is a significant barrier; "all of these services should be under one umbrella"
- tourism leads to much greater demand for services in peak season

• A project to inform the Gippsland South Coast Primary Health Plan (Bass Coast and South Gippsland LGAs) was undertaken in 2018 and included engagement with local general practices.[99] Themes included;

Long waits for public allied health and mental health services

- Limited space and lack of infrastructure funding is a barrier to expansion of services at general practices
- After-hours access is limited and costs to consumers and remuneration of GPs are barriers, leading to increased pressure on ED services where available. South Gippsland does not have a funded ED, but three Urgent Care Centers.
- POLAR can be used more effectively within the practices to identify patients' needs
- The area has a large population increase over the summer holiday period without increase in capacity to meet demand for primary care

Aged Care

See attached Report Mallacoota gap analysis.pptx

Mallacoota 2016 Census Statistics Mallacoota 2016 Census Statistics.docx