Gippsland PHN Health Needs Assessment

November 2021

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Acronyms

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
ACAT	Aged Care Assessment Team
ACSO	Australian Community Support Organisation
ACCO	Aboriginal Community Controlled Organisation
ACP	Advance Care Planning
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AHHA	Australian Healthcare and Hospitals Association
AIHW	Australian Institute of Health and Welfare
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	Alcohol and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
BCH	Bass Coast Health
CALD	Culturally and Linguistically Diverse
CCV	Cancer Council Victoria
CDAMS	Cognitive Dementia and Memory Service
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DALY	Disability Adjusted Life Years
DET	Department of Education and Training
DH	Victorian Department of Health
DoH	Department of Health (Commonwealth)
DHHS	Department of Health and Human Services (Victoria) – replaced by DH and DFFH in 2021
DFFH	Department of Families, Fairness and Housing (Victoria)
DISS	Doctors in Secondary Schools
DPA	Distribution Priority Area
DVA	Department of Veterans Affairs
ED	Emergency Department
EMHSS	Enhancing Mental Health in Secondary Schools
ENT	Ear Nose and Throat
GADSPA	Gippsland Alcohol and Drug Service Providers Advisory
GCASA	Gippsland Centre Against Sexual Assault
GEGAC	Gippsland and East Gippsland Aboriginal Co-Operative
GLCH	Gippsland Lakes Complete Health
GIS	Geographic Information System
GMHA	Gippsland Mental Health Alliance
GP	General Practitioner
GPHN	Gippsland Primary Health Network
GPHN CC	Gippsland Primary Health Network Clinical Council
GRICS	Gippsland Regional Integrated Cancer Services
GRPCC	Gippsland Region Palliative Care Consortium
GSHS	Gippsland Southern Health Service
GWH	Gippsland Women's Health
FTE	Full Time Equivalent
HNA	Health Needs Assessment
HPV	Human Papilloma Virus
IDDS	Indigenous Dual Diagnosis
IRSD	Index of Relative Socio-economic Disadvantage
ITC	Integrated Team Care
LAIB	Long-acting injectable buprenorphine
LCHS	Latrobe Community Health Service
LEAP	Law Enforcement Assistance Program

LGA	Local Government Area
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer
LHA	Latrobe Health Advocate
LHN	Local Health Network
LRH	Latrobe Regional Hospital
MARAM	Multi-Agency Risk Assessment and Management
MBS	Medicare Benefits Schedule
MDMA	Methylenedioxymethamphetamine
MDS	Minimum Data Set
MH	Mental Health
MHCSS	Mental Health Community Support Services
MHNIP	Mental Health Nurse Incentive Program
MHR	My Health Record
MMM	Modified Monash Model
MPHWP	Municipal Public Health and Wellbeing Plan
MSHC	Melbourne Sexual Health Centre
MUHREC	Monash University Human Research Ethics Committee
NCAS	National Community Attitudes Survey
NDIS	National Disability Insurance Scheme
NDSHS	National Drug Strategy Household Survey
NGO	Non-Government Organisation
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
NPSM	National Psychosocial Support Measure
OCP	Optimal Care Pathway
PBFF	Place Based Flexible Funding
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PHaMs	Personal Helpers and Mentors
PHIDU	Public Health Information Development Unit
PIP	Practice Incentive Payment
PIP QI	Practice Incentives Program Quality Improvement
PIR	Partners in Recovery
POLAR	Population Level Analysis and Reporting
PPH	Potentially Preventable Hospitalisations
PSP	Psychosocial Support Program
RACF	Residential Aged Care Facility
RWAV	Rural Workforce Agency Victoria
SA3	Statistical Area 3
SEIFA	Socio-Economic Index for Areas
SES	Socio-Economic Status
SHS	Shared Health Summary
STI	Sexually Transmitted Infection
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAED	Victorian Admitted Episodes Dataset
VCAMS	Victorian Child and Adolescent Monitoring System
VEMD	Victorian Emergency Minimum Dataset
VIF	Victoria in Future
VMO	Visiting Medical Officer
VPHS	Victorian Population Health Survey
YSAS	Youth Support and Advocacy Service

What we did

Overview

Gippsland PHN's 2022-23 – 2024-25 Health Needs Assessment builds on the previous Health Needs Assessment by using recently released data, input from ongoing stakeholder consultation, and learnings from the monitoring and evaluation of commissioning activities. Population health planning is an ongoing activity at Gippsland PHN, with a number of organisational processes that support the Health Needs Assessment including:

- Evaluation of previous assessments and supporting documents;
- Health Planning Governance Framework which emphasises this work as a cross organisational and on-going responsibility;
- Population Health Working Group, overseeing development and progress;
- Population Health Planning Adviser roles, filled by representatives from the Gippsland PHN Community Advisory Committee and three sub-regional Clinical Councils who are called on for advice, including engagement activities, resource development, co-design activities and tender evaluations;
- Contributions and involvement from teams across the organisation;
- Ongoing updates and improvement to population health planning data hub (GPHN 2021a) and other resources that are publicly available; and
- Links to other Victorian PHNs via the Victorian/Tasmanian PHN Alliance.

The *Gippsland PHN Population Health Planning Governance Framework* (GPHN 2021b) describes methods and principles guiding the ongoing work to understand the health needs in the Gippsland community. Priority areas for Gippsland PHN were first identified during 2016. They were modified slightly as part of the 2018 needs assessment update (which was approved to inform the 2019-20 to 2021-22 financial year period), (GPHN 2018). The 2021 Health Needs Assessment process involved a full review and re-setting of priorities using some improved methods that are further described below.

Stakeholder consultation

Gippsland PHN developed a stakeholder engagement plan for the Health Needs Assessment process to ensure broad and strategic consultation occurred. These groups and individuals were consulted through a variety of mechanisms such as workshops, group meetings, one-on-one meetings, interviews, surveys and emails, see **Table 1**. Where possible, Gippsland PHN utilised established arrangements (for example existing meetings of particular groups and stakeholder engagement opportunities arranged by other Gippsland PHN teams).

Table 1. Overview of stakeholder consultation informing the Gippsland PHN Health Needs Assessment 2021.

Group	Timing	Method	Summary results
Gippsland PHN Clinical Councils and Community Advisory Committees	February, May and August 2021	Workshops at quarterly meetings of 3 Clinical Councils and 1 Community Advisory Committee	Identification of emerging issues and involvement in priority setting and suggested options to address priority areas
Key partner organisations	March 2021	CEO letter inviting involvement in HNA 2021 process Follow up	Involvement of key partner organisations including health services, universities, training providers, RWAV, Gippsland Region Public Health Unit and service providers
Community, consumers and carers	June – August 2021	Survey with follow up interviews and submission of stories (see additional detail below) Community Contacts process to stay in contact with interested individuals and organisations	1,383 survey responses 21 interviews (phone and Zoom) Four submitted stories 70 Community Contacts for ongoing engagement
Mix of professional stakeholders and community, consumers and carers	August 2021	Place-based interactive workshops with involvement by each of the six Local Government Area (LGA) planners	Six workshops (three Zoom, two face to face and one mixed mode); 85 attendees + an additional 36 engagements outside workshops
Local Government	On-going	Existing structures to support the Municipal Public Health and Wellbeing Planning (MPHWP) process	Alignment between LGA MPHWPs for 2021-25 and the Victorian Public Health and Wellbeing Plan 2019-2023, and Gippsland PHN priority areas
Clinicians and other professional stakeholders	On-going	Existing meetings including Gippsland Alcohol and other Drug Service Providers Alliance, Gippsland Mental Health Alliance, Gippsland Sexual and Reproductive Health Alliance	Up to date intelligence and service mapping information gathered
Expert Advisory Group for Priority Setting	June and August meetings	Advice and review of documents and completion of priority setting matrices; Zoom meetings with involvement of key partner organisations and community representatives	Improved robustness and transparency of the priority setting process
Other PHNs	December 2020 to February 2021	Research project to improve priority setting methodology (GPHN 2021c)	Detailed information for seven PHNs informed an updated Gippsland PHN priority setting method
Gippsland PHN	Monthly Quarterly	Internal intranet updates Population Health Working Group	A whole of organisation approach

The ***Tell Gippsland PHN about healthcare in your community*** engagement project (GPHN 2021d) informed the 2021 Health Needs Assessment and was designed to learn more about two key topics; people's experiences of care coordination and use of digital health. Open ended questions also invited respondents to share what was working or not working well with healthcare services in their local area.

The project included three components; a survey, open 4 June 2021 - 24 August 2021, follow up interviews and online submissions of healthcare stories. Ethics approval for the project was provided by Monash University Human Research Ethics Committee (MUHREC).

The survey could be completed online (via weblink or QR code) or on a paper version distributed with reply-paid envelopes as unaddressed mail to the least populous postcodes in the region. The survey was promoted widely through Gippsland PHN usual communications processes including newsletters, emails, social media, flyers and a media release and supported by many partner organisations. Distribution of flyers and other collateral was facilitated by Gippsland PHN Community Advisory Committee members, staff and other organisations and community groups. In-person community engagement and distribution of the survey was limited by ongoing restrictions due to the COVID-19 pandemic.

Survey respondents who indicated an interest in further contact from Gippsland PHN were invited to tell us more by participating in an interview or by providing a written submission.

The survey was completed by 1,383 respondents and 21 interviews were conducted via phone call or Zoom; four participants submitted a healthcare story. 51% of respondents completed the paper version.

Quantitative data were analysed using Qualtrics and Excel, while qualitative data were coded and analysed using NVivo. Respondents with missing data for some items were excluded from affected analyses.

About the survey respondents:

- 69% females, 29% males, 1.4% preferred not to say and 0.5% had a different response (using an open ended question)
- 4% were aged 18-25 years, 20% 26-45 years, 35% 46-64 years, 25% 65-74 years and 14% 75 years or older; 3% were less than 18 years
- 13% resided in Bass Coast, 12% in Baw Baw, 28% in East Gippsland, 18% in Latrobe, 15% in South Gippsland and 13% in Wellington (1% lived outside Gippsland)
- 40% had a bachelor's degree or higher as their highest education level, 19% diploma, 15% certificate III or IV, 10% year 12 or equivalent and 15% year 11 or below.
- Number of respondents by group:
    - 362 people with a long-term health condition, limiting daily activities moderately or a lot
    - 229 carers or family member of someone with a disability or ongoing health concern
    - 221 parents or guardians of a child aged 0-14 years
    - 202 people with a disability
    - 51 people from a culturally or linguistically diverse background
    - 49 LGBTIQ+ people
    - 19 Aboriginal and/or Torres Strait Islander people

Patient journeys were created based on information from all consultation methods and are intended to highlight identified needs and opportunities. Each step in the journey can be seen as a barrier or an enabler where people may choose, or be unable to, continue and providers can enable or be a barrier to the continuation of a journey which will lead to a good outcome for the person. All names of individuals have been changed and every journey is based on multiple, different data sources.

Results of all consultations are reported under the relevant priority areas within the health needs assessment.

Health and service needs analysis

Gippsland PHN reviewed a wide range of quantitative data to understand health and service needs. This is complemented with qualitative data obtained through stakeholder consultation.
Quantitative data sets analysed include:

- Australian Bureau of Statistics (ABS): Census of Population and Housing

- Australian Institute of Health and Welfare (AIHW): Mortality Over Regions and Time (MORT) books; Australian Cancer Database; National Non-admitted Patient Emergency Department Care Database; National Hospital Morbidity Database; Medicare Benefits Schedule; Pharmaceutical Benefits Scheme
- Public Health Information Development Unit (PHIDU): Social Health Atlas of Australia
- Victorian Department of Health (DH) / Department of Families, Fairness and Housing (DFFH): Victorian Local Government Profiles; Victorian Population Health Survey; Infectious Disease Surveillance Unit
- Commonwealth Department of Health: HeaDS UPP Needs Assessment tool; National Health Workforce Dataset, Healthdirect healthmap
- Australian Commission on Safety and Quality in Healthcare: Australian Atlas of Healthcare Variation
- POLAR Explorer: general practice data
- Turning Point: AOD Stats

Gippsland PHN also completed an updated service mapping activity as part of the 2021 Health Needs Assessment. This involved the following stages:

- Situation analysis of internal/external sources of information
- Decide priority areas for mapping
- Determine services to be mapped and service sub-categories
- Determine the data to collect
- Finalise service mapping template
- Data collection
- Creation of raw data maps
- Complete gap analysis of missing data
- Collect missing data
- Prepare information with GIS mapping for visualisation

Detailed analysis of data and service mapping information is included where relevant in the sections on identified priorities. A full list of references is available at the end of this document.

Triangulation and prioritisation

The process of triangulation and priority setting used by Gippsland PHN (GPHN 2021c) was informed by a research project and included the steps identified in the table below. Health needs and service issues based on available data and information, including input from key stakeholders were considered and the priorities of the previous Health Needs Assessment were reconsidered. Potential priority areas that progressed to the more formal assessment in Stage 1 below were identified based on quantitative data, needs expressed by community members or based on professional stakeholder intelligence in any combination.

The key steps in the priority setting process included:

	Step
1	Define the scope of the priority setting exercise and who will play what role
2	Establish a steering body and a process management group
3	Decide on approach, methods, and tools
4	Develop a work plan for priority setting and assure the availability of the necessary resources
5	Develop an effective communication strategy
6	Inform the public about priority setting and engage internal / external stakeholders
7	Organise the data collection, analysis, and consultation / deliberation processes
8	Identify or develop a scoring system
9	Adopt a plan for monitoring and evaluating the priority setting exercise
10	Collate and analyse the scores
11	Present the provisional results for discussion; adjust if necessary
12	Distribute the priority list to stakeholders
13	Assure the formal validation of recommendations of the priority setting outcome
14	Evaluate the priority setting exercise

The main stages to priority setting were:

Stage	Description / purpose
1	Assess health problems based on analysis of data and information to reduce the number and identify priority areas.
2	Assess how well existing PHN commissioned services meet the needs they are intended to address.
3	Assess options to address health problems for inclusion in the Health Needs Assessment (include both those with existing investment and new options for investment).

Five criteria were used to score each potential priority in a Stage 1 matrix, using a ten point scale and detailed definitions:

- Size and severity of issue, including mortality, prevalence, incidence and impact on health
- Community consumer and carer reporting of need in this area
- Professional stakeholders reporting of need in this area
- Alignment with PHN role and partner priority areas
- Opportunity for change

Scoring was completed by members of the Expert Advisory Group for Priority Setting and average overall scores were calculated and used to identify priority needs for Gippsland.

Stakeholder engagement at each stage involved:

- Gippsland PHN advisory groups (three sub-regional Clinical Councils and one Community Advisory Committee) had a key role across the three stages. One hour workshops were incorporated into their quarterly meetings in February, May and August to advice on emerging issues, priority setting and options to address priority areas.

- Gippsland PHN Expert Advisory Group for Priority Setting had a strategic advisory role in shaping each stage of the recommended method of priority setting. Interested members were invited to rate potential priorities using an agreed matrix for Stage 1.
- Commissioned services contract managers contributed to assessments in Stage 2.
- Work with key stakeholders, including community representatives in local planning areas. This included a series of community workshops where emerging priority areas were presented to gain feedback from a broad range of stakeholders in a series of place-based workshops.

All input from stakeholders was brought together with results from scoring exercises to inform recommended priority areas. These were presented to the Population Health Working Group which added a final layer of PHN decision making before finalising Gippsland PHN priority areas for 2022-25.

The Gippsland PHN Board reviewed and endorsed the Health Needs Assessment method and revised priorities. This is a standing annual action item prior to Health Needs Assessment updates to the Department.

Evaluation

Following the submission of the Health Needs Assessment, Gippsland PHN will undertake an evaluation of the process to inform an improved process for the next Health Needs Assessment deliverable. This will include:

- reviewing feedback obtained through stakeholder consultation processes;
- conducting a Health Needs Assessment team meeting about strengths and areas for improvement within the process;
- other contributing teams within the PHN to be given an opportunity to provide feedback;
- consideration of project plan and whether tweaks to approach or methodology are required; and
- utilise PHN Network collaboration to inform different ways of approaching aspects of the Needs Assessment.

Key points for improvement will then be shared with the Executive, and relevant process documents will be updated in preparation for working on the next update to this deliverable in 2022.

Notes on data and process

Gippsland PHN notes updated guidance documents and significant improvements in relevant data for the Health Needs Assessment being made available. This includes PHN level analyses and work undertaken by the Australian Institute of Health and Welfare (AIHW) using PHN and smaller geographies for the most relevant indicators and providing these in files that are easy to manipulate.

Remaining limitations are often related to Gippsland PHN's relatively small population which leads to limited reliability of some estimates for the region, especially where sample size has not been set to allow for LGA/SA3 level analysis and when analysing measures with small numbers. In addition:

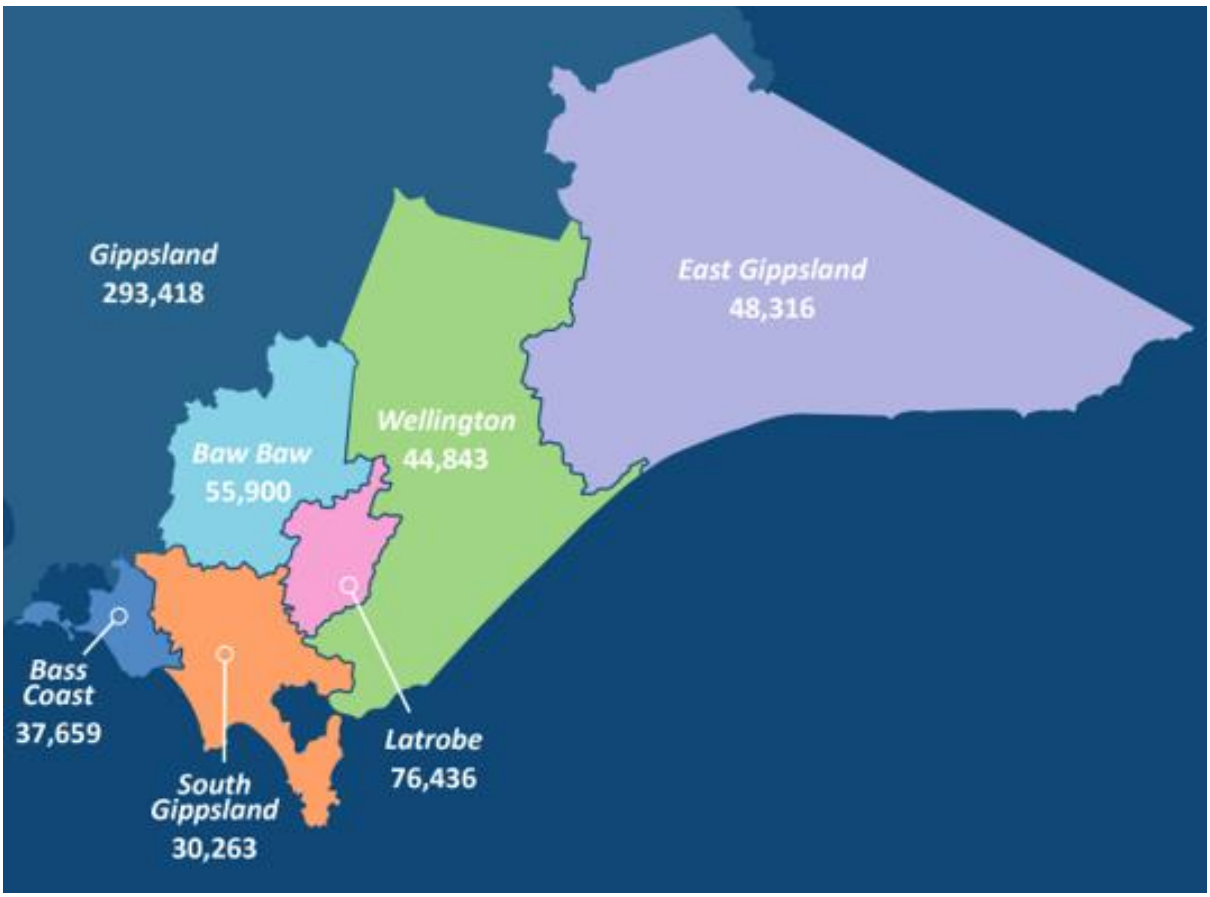
- Limitations in reporting health needs in the Indigenous population are affected by under-reporting of Indigenous status in most statistical collections in Australia (PHIDU 2021a). This includes population estimates such as the census and health related data sets including deaths or hospital admissions. Data coverage is also likely to vary between geographical areas.
- Consideration of PHN geography and breakdown to LGA/SA3 when conducting national surveys such as the Disability, Ageing and Carers survey, National Health Survey and others. Even better, collaboration with State surveys such as the Victorian Population Health Survey to maximise sample size and ensure consistency in methods.

- Analysis of data from the National Disability Insurance Scheme (NDIS), My Aged Care in a format suited to analysis by PHNs (files that allow filters and sorting with comparison rates for State and National).
- Timely provision of new and updated data.
- Analysis of patient numbers as well as occasions of service wherever possible.
- Additional detail for data sets such as the MBS and PBS would be helpful.
- Improved ability to identify population groups with poor health outcomes across data sets, including disadvantage, LGBTIQ+, carers and CALD.
- Consolidate the mapping platforms available for data visualisation. Currently there is overlap between AIHW, PHIDU Social Health Atlas and GEN Aged Care. A common platform would be beneficial to minimise duplication in resource allocation and allow visualisation of multiple data sets and their associations.
- Inclusion of additional data sets such as pathology and family violence.
- Inclusion of information on federally funded programs delivered in the community sector, including counselling programs.
- Inclusion of data on calls made to federally funded telephone support services including Lifeline.
- There is a need for financial information relating to health, including actual and comparative unit costs of health care delivery at community and institutional care level.

Gippsland population profile

The Gippsland region is home to over 293,000 people, up from 271,000 in 2016, and consists of six local government areas (LGAs): Bass Coast, Baw Baw, Latrobe, South Gippsland, Wellington and East Gippsland. See **Figure 1**. Statistical Areas 3 (SA3) are also used throughout the report (ABS 2016) as much data are reported in this way. Gippsland is made up of five SA3s which align with LGA geography but combines Bass Coast and South Gippsland into Gippsland South-West.

Figure 1. Estimated Resident Population in Gippsland LGAs, 2021.



The age distribution of the Gippsland population compared to Victoria is shown in **Figure 2**, highlighting an older population in Gippsland with a high proportion of people aged 55 year or older. A low proportion of the Gippsland population is aged 15-49 years.

The Indigenous population in Gippsland has a much younger age distribution compared to non-Indigenous people, see **Figure 3**. Only about 5% of the Indigenous population are 65 years or older compared to around 20% of non-Indigenous people. A high proportion of the Indigenous population Gippsland is aged 0-24 years.

Details of population by age can be found in **Table 2**. The median age of people in Gippsland is 45 years compared to 37 years in Victoria. The median age of Indigenous people in Gippsland is 22 years.

Figure 2. Age distribution of the Gippsland population compared to Victoria, by gender, 2020.

Source: PHIDU (2021b)

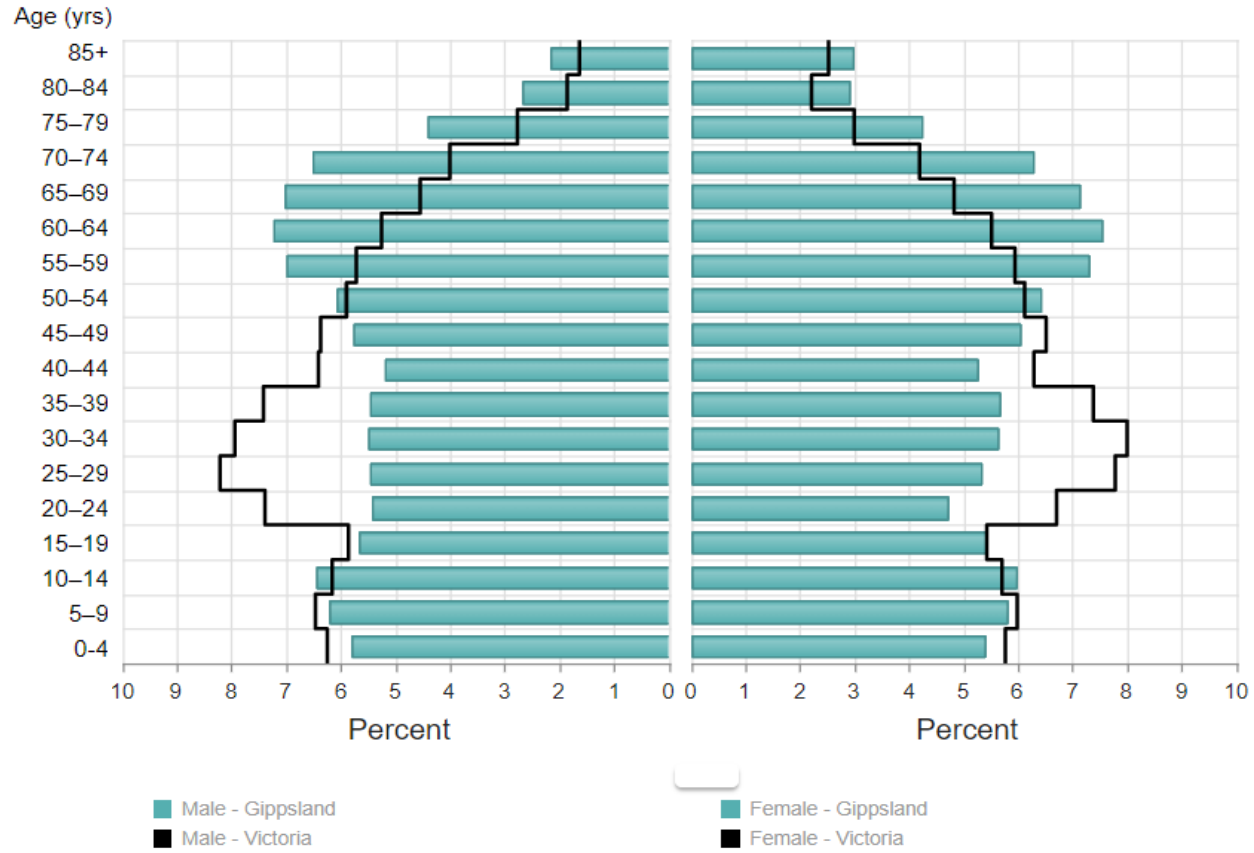
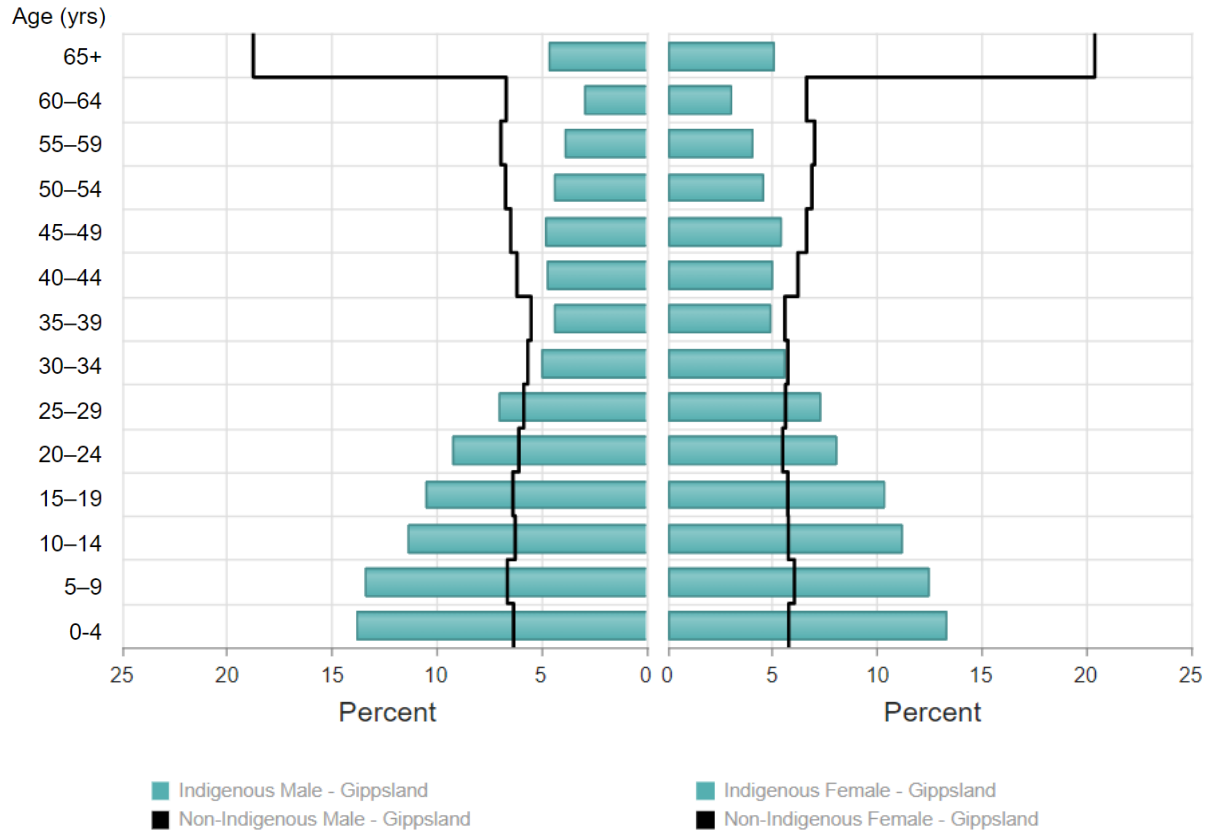


Figure 3. Age distribution of Indigenous population in Gippsland compared to non-Indigenous, by gender, 2016.



Source: PHIDU (2021b)

The Gippsland population is expected to have grown to 310,624 in 2026 and to 328,861 in 2031, see **Table 3**. Baw Baw and Bass Coast have a higher growth rate than Victoria.

An estimated 5,042 Aboriginal and Torres Strait Islander people lived in Gippsland in 2016, see **Table 4**. The proportion of the total population identifying as Aboriginal of Torres Strait Islander was 3.5% in East Gippsland, 1.9% in Latrobe, 1.9% in Wellington, 1.1% in Baw Baw, South Gippsland and Bass Coast. Approximately 8.7% of Victoria's Indigenous population live in Gippsland.

Table 5 shows that Gippsland has a high proportion of single person households at 29.9%, compared to 24.7% across Victoria.

Table 2. Gippsland population by age group and LGA, estimated resident population in 2021.

Population – age group	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND
0-4 years	1,825	1,541	3,535	4,347	2,480	1,504	16,232
5-14 years	4,298	3,909	7,670	9,345	5,396	5,490	36,107
15-24 years	3,327	2,886	6,046	8,731	4,330	4,610	29,930
25-44 years	6,931	5,823	12,942	18,864	9,067	10,635	64,262
45-64 years	10,460	8,551	14,141	19,563	12,834	11,905	77,454
65-74 years	6,074	4,532	6,633	8,773	8,088	5,859	39,959
75+ years	4,744	3,021	4,933	6,813	6,121	3,841	29,474
TOTAL estimated resident population	**37,659**	**30,263**	**55,900**	**76,436**	**48,316**	**44,843**	**293,418**
Median age (years) *Victoria 37 years	**50**	**47**	**42**	**41**	**50**	**43**	**45**

Source: DELWP (2019) *ABS (2016)

Table 3. Gippsland population by LGA, estimated resident population in 2021 and projected populations.

Population	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND
Estimated resident population 2021	37,659	30,263	55,900	76,436	48,316	44,843	293,418
Projected population 2026	41,212	31,478	62,427	78,576	50,752	46,179	310,624
Projected population 2031	44,810	32,727	69,317	80,899	53,418	47,690	328,861
Annual average growth rate 2016-17 to 2025-26*	2.0%	0.1%	2.1%	0.4%	0.8%	0.0%	Victoria 1.4%

Source: DELWP (2019) *DH (2018)

Table 4. Aboriginal and Torres Strait Islander population by local government area, number and per cent of total population, Gippsland LGAs and comparison to Victoria and Australia, 2016.

Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA	Australia
364	328	565	1,438	1,576	782	5,042	57,767	798,365
1.1%	1.1%	1.1%	1.9%	3.5%	1.9%	1.8%	0.9%	3.3%

Source: PHIDU (2021c)

High compared to Victoria, >25% higher rate

Table 5. Community characteristics by local government area in Gippsland and comparison to Victoria, 2016.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Average household size (persons)	2.17	2.31	2.42	2.31	2.31	2.30	2.29	2.51
One parent families	16.5%	13.3%	15.0%	19.9%	14.5%	14.3%	16.1%	15.3%
Single person households	33.0%	29.1%	25.4%	31.1%	30.8%	29.7%	29.9%	24.7%
Population density (persons/km^2)	38.5	8.8	12.2	52.1	2.2	4.0	NA	27.2

Source: ABS (2016)

Gippsland main health issues

Burden of disease

Disease burden is measured using the summary metric of disability-adjusted life years (DALY), which includes both years of healthy life lost due to death and due to disease and injury. The AIHW Australian Burden of Disease Study 2018: key findings (AIHW 2021a), note that in 2018, 48% of burden was due to dying prematurely and 52% due to living with illness. The top five disease groups accounted for 65% of total burden in Australia, they are:

- Cancer – 18% of total disease burden
- Musculoskeletal conditions – 13%
- Cardiovascular disease – 13%
- Mental and substance use disorders – 13%
- Injuries – 8.4%

In 2018, 38% of the burden of disease could have been prevented by reducing or avoiding exposure to the modifiable risk factors examined in this study. The risk factors contributing the most burden in 2018 were:

- tobacco use (8.6%),
- overweight (including obesity) (8.4%),
- dietary risks (5.4%),
- high blood pressure (5.1%), and
- alcohol use (4.5%).

No recent burden of disease data for small geography are available but remote and very remote areas have a total burden 1.4 times that in major cities and the lowest socioeconomic group has a burden 1.6 times that in the highest socioeconomic group (AIHW 2021a).

Mortality

Total life expectancy for people in Gippsland is 80.6 years, with females living for 83.0 years and males 78.9 years (2015-17). National life expectancy is 82.5 years, comprising females at 84.6 years and males at 80.5 years (AIHW 2019a).

Coronary heart disease is the leading cause of death for both men and women in Gippsland (AIHW 2021b). The top ten leading causes of death for men and women in Gippsland for 2015-19 are listed in **Table 6**.

Table 6. Top ten leading causes of death for males and females in Gippsland and total average annual deaths, 2015-19.

Males	Number	Females	Number
1.Coronary heart disease	185	1.Coronary heart disease	129
2. Lung cancer	95	2. Dementia and Alzheimer's Disease	110
3. Chronic Obstructive Pulmonary Disease	69	3. Cerebrovascular disease	87
4. Cerebrovascular disease	62	4. Chronic Obstructive Pulmonary Disease	65
5. Prostate cancer	65	5. Lung cancer	63
6. Dementia and Alzheimer's Disease	62	6. Breast cancer	52
7. Colorectal cancer	46	7. Accidental falls	41
8. Diabetes	39	8. Colorectal cancer	40
9. Accidental falls	33	9. Diabetes	37
10. Suicide	32	10. Heart Failure and complications of ill-defined heart disease	37
Average annual deaths - males	**1,365**	**Average annual deaths - females**	**1,251**

Source: AIHW (2021b)

Avoidable deaths are shown in **Table 7**. They refer to deaths for people under 75 years of age from conditions that are potentially avoidable through prevention, primary or hospital care. It can be noted that circulatory system disease and cancer are the top two conditions with the highest rate of avoidable deaths. Latrobe has a high rate of avoidable deaths for all conditions.

Table 7. Avoidable deaths (0-74 years) for Gippsland residents by local government area, average annual age-standardised rates per 100,000, 2015-19.

Condition*	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA	Australia
Circulatory system diseases	38.8	35.9	31.5	47.4	39.5	39.0	39.4	32.5	34.7
Ischaemic heart disease	25.9	26.1	19.6	30.0	24.5	27.3	25.8	20.7	21.9
Cancer - *Highest PHN*	34.2	33.8	30.4	37.8	33.8	42.8	35.6	28.2	28.5
Breast cancer - *Highest PHN*	19.4	19.9	23.1	19.7	13.4	21.6	19.4	15.7	15.2
Colorectal cancer	10.3	13.1	6.7	13.9	11.8	12.1	11.8	10.1	10.2
Respiratory system diseases	8.7	7.4	7.8	23.8	11.8	13.2	13.1	9.1	10.5
Chronic obstructive pulmonary disease	8.2	6.9	7.1	22.7	11.4	12.7	12.7	8.5	9.8
External causes (includes falls, fires, suicide)	13.4	16.6	13.2	20.4	24.2	15.0	18.1	13.1	14.8
Other external (transport accidents, drowning etc)	17.8	21.5	16.8	21.8	24.4	23.1	21.2	14.0	15.7
Cerebrovascular diseases	6.4	7.2	6.3	12.4	11.7	5.5	8.8	7.6	7.9
Diabetes	4.9	5.2	2.1	9.3	4.1	4.7	5.3	4.9	6.6

Source: PHIDU (2021d)

High compared to Australian LGAs, among 25% highest rates

Low compared to Australian LGAs, among25% lowest rates

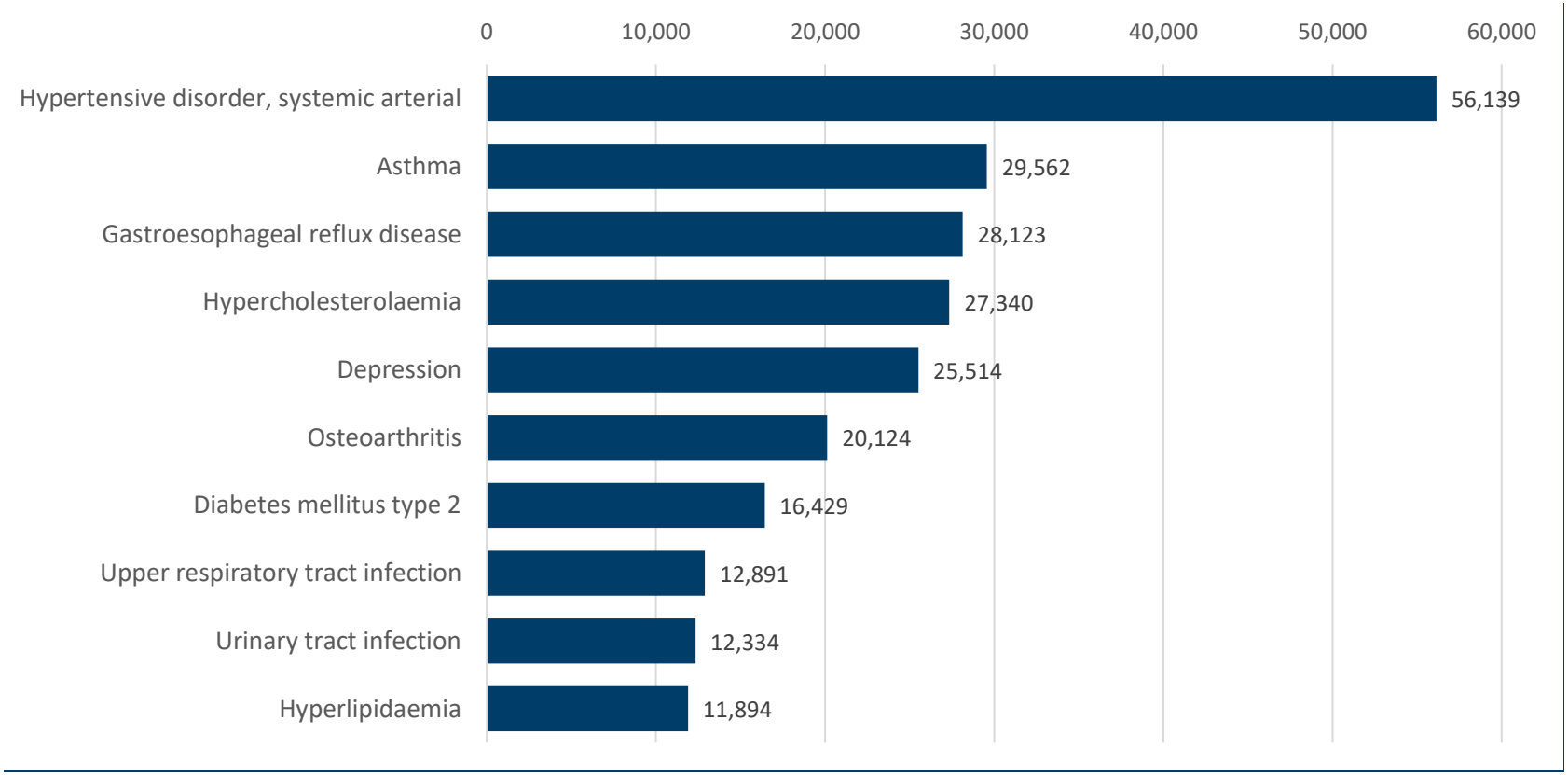
* Additional details about several of these conditions can be found in relevant sections of this report.

General practice

Gippsland PHN uses de-identified general practice data shared by 88% of practices via the POLAR system (Outcome Health n.d.). Data reported here do not show unique patients and a person may be included in the analyses more than once if they are active in more than one general practice.

The top diagnoses seen among general practice patients in Gippsland were hypertension, asthma, gastroesophageal disease, high cholesterol and depression. See **Figure 4**. Additional details are included within the report.

Figure 4. Top 10 active diagnoses among Gippsland patients in general practice, 2020-21.



Source: GPHN (2021e)

Gippsland health services

Gippsland is serviced by 12 public hospitals and three private hospitals. See **Figure 5**. In addition, there are 39 locations with a community health service, six bush nursing services and 89 general practices, including six locations services by Aboriginal Community Controlled Organisation (ACCO), (see **Table 8**).
There are 70 community pharmacies across Gippsland.

See also the **Health workforce section**.

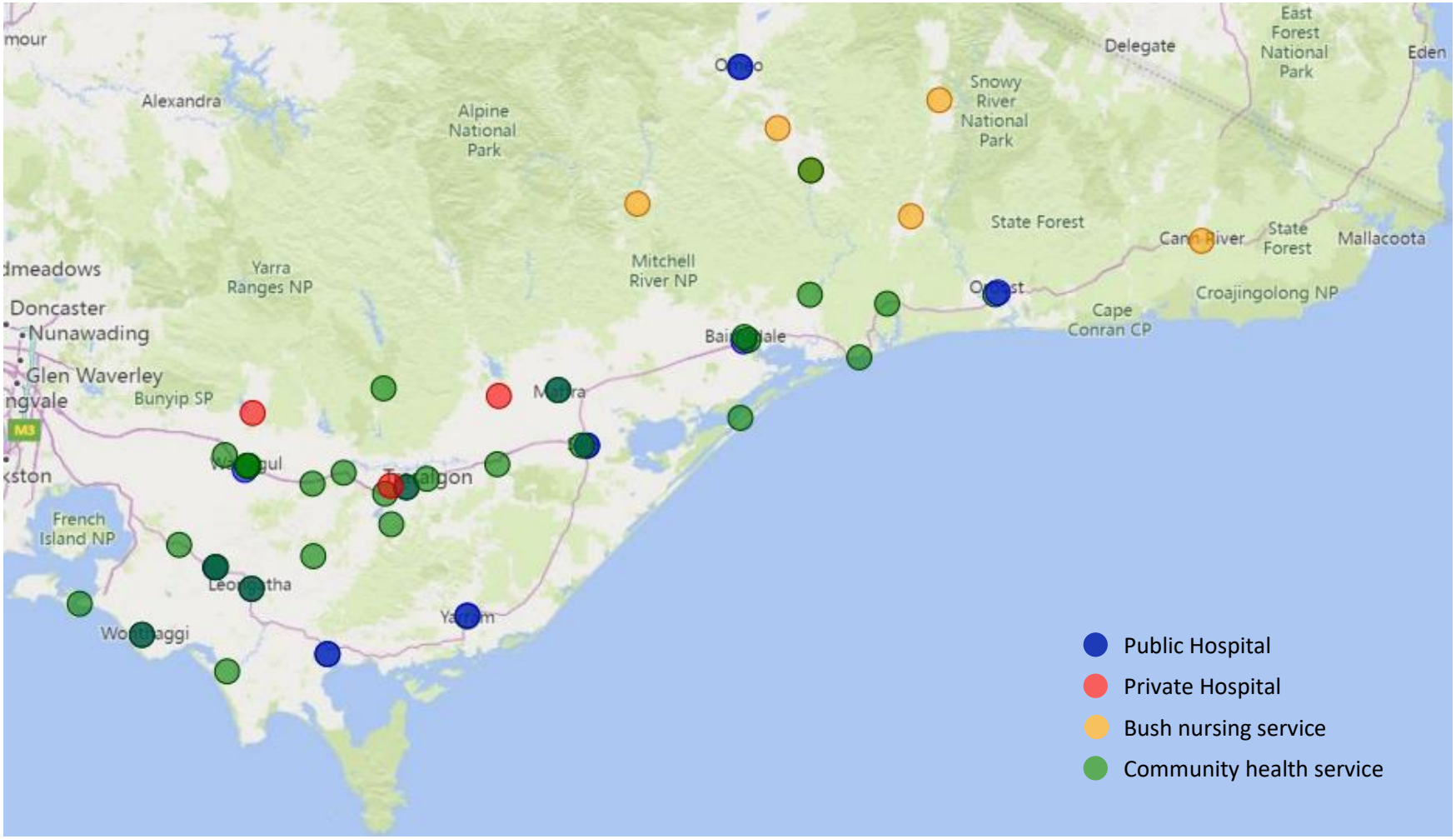
Table 8. Number of health service provider locations by LGA in Gippsland, 2021.

LGA	General practice locations*	ACCO locations	Hospital – public	Hospital - private	Community health	Community pharmacy	Additional services#
Bass Coast	8	0	1	0	7	8	Philip Island Hub
South Gippsland	7	0	3	0	7	11	Three Urgent Care Centres
Baw Baw	19	0	1	1	6	10	
Latrobe	24	1	1	1	5	16	
East Gippsland	19	4	3	0	8	13	Five bush nursing services
Wellington	11	1	2	1	6	12	One bush nursing service
Gippsland	**89**	**6**	**12**	**3**	**39**	**70**	

* Note that Gippsland PHN provides support for an additional two general practices located in Cardinia LGA (which is outside the Gippsland region) as there is significant outflow of Gippsland patients to these practices.

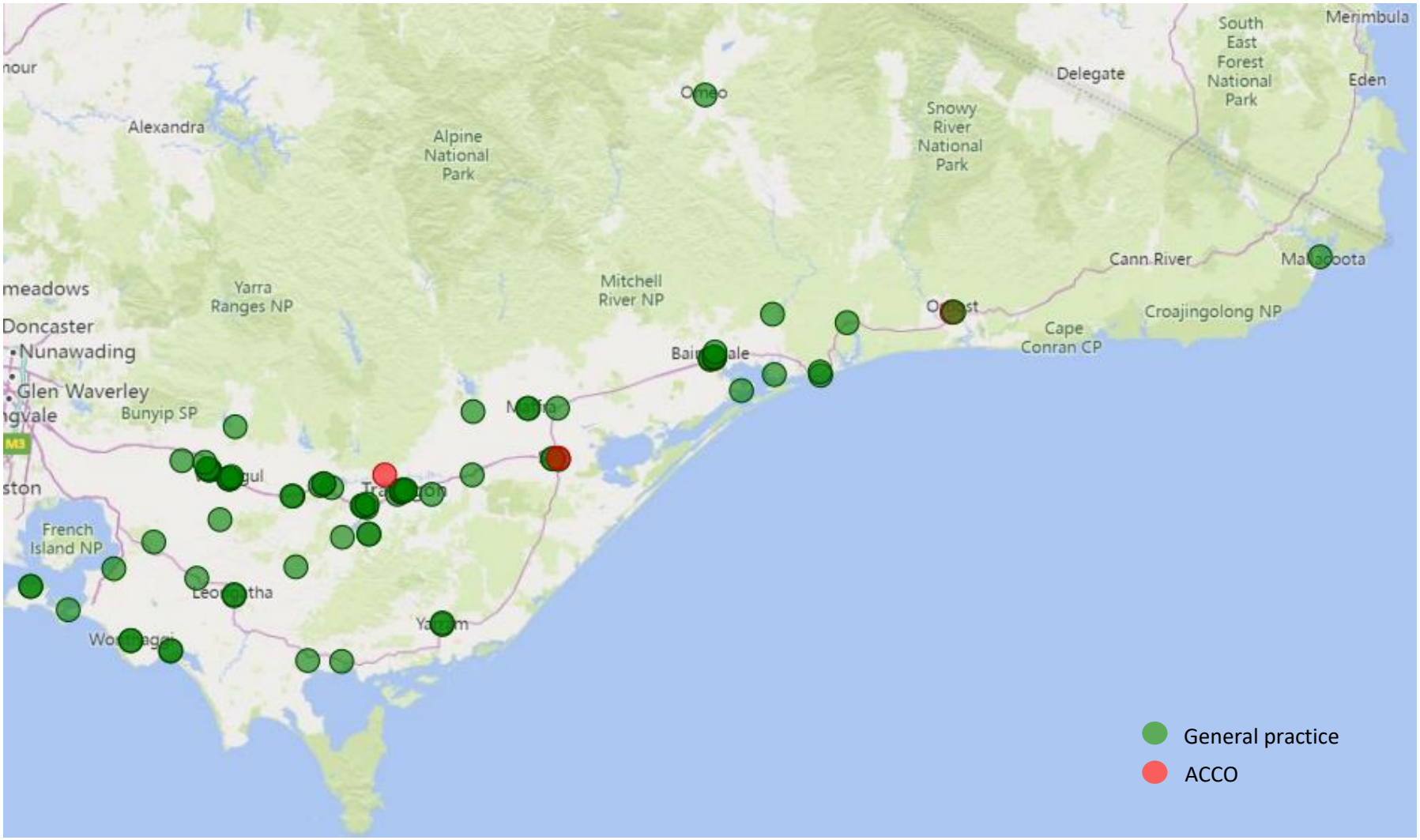
See **13. Access to care that meets people's needs** for more details, including after-hours service options

Figure 5. Main health services in Gippsland, 2021.



Source: DH (Victorian Department of Health), personal communication, and mapping by Gippsland PHN, 2021.

Figure 6. General practice locations in Gippsland, 2021, 89 locations with general practitioner available, including five locations operated by an Aboriginal Community Controlled Organisation (ACCO).



Source: GPHN (2021l)

Summary of Gippsland PHN priorities 2022-25

Table 9. Gippsland PHN priorities 2022 – 2025.

Gippsland PHN priorities		Key issues	Example expected outcomes
1	Aboriginal and Torres Strait Islander health and wellbeing	• Median age of Aboriginal and Torres Strait Islander people in Gippsland is 22 years compared to 45 years for the total Gippsland population. • Aboriginal and Torres Strait Islander people are less likely to be comfortable using a health service that they need compared to other community members. • 5,133 potentially preventable hospitalisations per 100,000 Indigenous people (3,010 for total Gippsland population). • 13.5% of the Indigenous population in Gippsland had a Health Check in 2019-20; down from 17.7% on 2018-19 (14.7% in Victoria).	*"I am respected for who I am and for the cultural values I bring with me."* *"I feel comfortable and willing to talk to a health organisation- a measure of welcoming."* *"I want the choice of an indigenous or non-indigenous clinician."*
2	People 65 years and over	• Almost 1 in 4 people are 65 years or older compared to 1 in 6 in Victoria. • Older people use health services more but are less likely to use digital tools. • 117 lower urgency Emergency Department (ED) presentations per 1,000 population (80 in Australia).	*"I have regular and affordable access to health care… within my local community."* *"I can work out how the health system works and how to get the health care I need."* *"I [want] a one stop shop where you tell your story once."*
3	Children and young people (0-25 years)	• 10.9% of children in Gippsland are considered vulnerable for emotional development when starting school (8.1% in Victoria). • Mental health is the most common health concern. • Work and study opportunities are important. • Parents want affordable access to GPs, including after-hours access. • Youth mortality rate of 41.4 deaths per 100,000 population aged 15-24 years (31.9 in Victoria). • 265 lower urgency ED presentations per 1,000 population aged 15-24 years (144 in Australia).	*"I want skilled child mental health clinicians in all parts of Gippsland."* *"I want specially targeted services for children 0-10."* • Improved early diagnosis and supports for children with a disability. • Increased access to affordable child and adolescent mental health services that meet population needs.
4	People with a disability	• Gippsland has higher rates of people living with a severe or profound disability (6.7% compared to 5.4% in Victoria). Many of these people live with multiple health issues (comorbidities).	*"I want health professionals who understand my needs and help me advocate for the best possible outcome."*

		• People with a disability are most likely to report poor health service quality (lack of respect, poor communication). • Uptake of National Disability Insurance Scheme (NDIS) is low in Gippsland: 6,740 people in Gippsland participating in NDIS (approximately 39% of people in Gippsland living with a profound or severe disability).	• Increased numbers of NDIS participants with active plans per population. • Better access to infrastructure and NDIS supports with trustworthy, ethical and skilled disability workforce. • Improved support for carers and collaborative care options.
5	Alcohol and other drugs	• Adults in Gippsland consume alcohol at riskier levels than the rest of Victoria. About 50% of adults in Gippsland drink alcohol at levels likely to cause injury, compared to 43% in Victoria. • Drug and alcohol services are not well connected with mental health services. • Alcohol related death rate in Gippsland LGAs is high ranging from 1.4 to 2.6 deaths per 10,000 population (1.3 in Victoria). • Opioid prescribing rates are > 78,000 per 100,000 population across Gippsland (58,125 in Victoria).	*"I want services when I need them and not when a vacancy comes up."* *"I am able to access withdrawal, counselling and rehab services when I am ready to make a change."*
6	Cancer	• Avoidable deaths from cancer are higher in Gippsland than in Victoria (35.6 per 100,000 population compared to 28.2). • There should be more advertising of bowel, breast and cervical cancer screening to promote access. • 43.5% of Gippsland women aged 25-74 years up to date with cervical screening (46.2% in Victoria).	*"I have access to timely health care options."* *"I want to be an equal partner in treatment decisions."* *"I can access services easily and without travelling."* • Improved access to care that addresses physical and mental aspects of living with cancer. • Better linkage to cancer units in Melbourne. • Increased screening rates; breast, bowel, cervical.
7	Mental health and wellbeing, including suicide prevention	• Adults in Gippsland experience higher psychological distress compared to the rest of Victoria (17.5% of adults in Inner Gippsland report high or very high psychological distress compared to 15.4% in Victoria). • Mental health was the most reported health need with significant service gaps, especially for children and young people.	*"I have access to quality preventative and therapeutic services which target diagnosis, treatment and long-term support..."* *"I am supported to find the right service to meet my needs after seeking help anywhere in the system."*

		• 125 mental health related ED presentations per 10,000 population in Gippsland (98 in Victoria).	

8	Chronic disease	• Gippsland has high rates of avoidable deaths (compared to Victoria) for:
		  ○ Chronic Obstructive Pulmonary Disease 12.7 deaths (8.5)
		  ○ Diabetes 5.3 (4.9)
		  ○ Circulatory system diseases 39.4 (32.5)
		• Having a regular GP helps to identify problems and manage health care better.
		• 1,513 potentially preventable hospitalisations for chronic conditions per 100,000 population (1,306 in Victoria).
		• Risk factors noted in general practice include 16.8% current smokers and 9.3% drinking above guidelines.
			"I want affordable, ongoing care."
			"I would like to see targeted funding to focus on prevention not cure."
			"I can access health related supports for the physical and mental consequences of my chronic disease related conditions."
			
			• Increased education to raise community awareness around risk factors.
			• Increased choice of health care providers for patients in their local area.

9	Dementia	• An estimated 7,488 people live with dementia in Gippsland. • Dementia is the second cause of death for people in Gippsland (behind coronary heart disease). • Health professionals, of all backgrounds, continue to have a lack of knowledge.	*"My healthcare supports understand the essence of what it is like to live with dementia."* • Increased engagement by health care services with carer/ consumer to obtain feedback regarding supports. • Improved access to an earlier diagnosis of dementia. • Improved access to specialist dementia services and supports.
10	Reproductive and sexual health	• Gippsland has 34% more teenage pregnancies (aged 15 to 19) than the state average (10.3 per 1,000 people compared to 7.7). • There needs to be easier access to medical and surgical termination of pregnancy. • Mathematical modelling suggests 77% of chlamydia cases remain undiagnosed and there has been an increase in syphilis and gonorrhoea.	*"I want non-judgemental services."* • Improved awareness of available services and how to access them. • Improved access to safe and supportive contraception and abortion services. • Improved quality of care and community awareness so that sexually transmitted diseases are investigated and treated in a timely manner.

11	Health workforce	• Gippsland has a low rate of psychologist availability in the state. There are 46 full-time psychologists per 100,000 people compared to 113 in Victoria. • Timely and affordable access to a GP was the most reported service issue in the community. • Nature of work, ties to the area, and positive workplace culture were the most common encouraging retention factors for Gippsland health workers. • Workplace issues, staffing and skill shortages, and temporary accommodation were commonly cited discouraging retention factors.	• Increased opportunity for timely referrals. • Improved access to peer support, re-location incentives, grants, training and address burn-out. • Improved collaboration to address workforce gaps and issues in a region-specific manner. • Increased local professional development, peer support and training for health workforce. • Increased availability of field work placements and supported graduate programs.
12	Digital health	• People with complex disease often report difficulty in navigating the health service system. • Internet reliability is a major issue and can't be relied on. • Being connected to all health professionals is important. • Digital inclusion involves three elements: access to technology hardware (e.g., computers, tablets, mobile phones, software and programs), access to data (e.g., reliable network coverage, affordable costs), and skills, knowledge, confidence and support to use the technology. • There is inequitable access to data, hardware and skills across communities, business, health services, systems and sectors.	*"I want my team to talk with each other. I don't want information lost."* • Increased education for providers and users on how digital health can streamline services. • Increased availability of telehealth to access general practice and specialist services. • Increased care coordination for complex issues. • Increased secure sharing of health information between primary care and hospitals.
13	Access to care that meets people's needs	• Some admissions to hospital could be avoided with good access and quality care by GPs and other primary providers. • Gippsland has a higher than average rate of potentially preventable hospitalisations (3,010 per 100,000 compared to 2,697 for Victoria). • Cost is a barrier to accessing health care and it can be difficult to access bulkbilling GPs.	*"Rural health is not seen as second rate"* • Increased evaluation of services including patient experience measurement to drive improvement. • Increased access to timely, local services. • Increased access to health and service information for patients. • Increased focus by health services on patient reported outcomes.

			• Improved connection of primary care provider skills and training to local population needs.
14	Family violence	• Gippsland experiences higher rates of family violence incidents, including some of the state's highest rates in Latrobe, East Gippsland and Wellington. • 66% increase in calls to 1800RESPECT during pandemic. • Family violence is recognised as an important factor affecting health with reports of service gaps. • Gippsland services reporting increased trauma in children who have experienced family violence. • Gippsland services reporting increased family violence related homelessness, mental health distress and substance use.	*"I can call someone and go somewhere when it is unsafe to stay at home."* *"I feel supported to make choices that help me, and my family feel safe."* • Increased awareness of the types of domestic violence and impact on health. • Increased access to appropriate support for all who experience family violence regardless of gender.
15	Factors affecting health (social determinants; housing, income, social connections)	• 52.2% of Gippsland households are classified as 'low income' (i.e. bottom 40% of income distribution), compared to 40.9% of Victorian households. • Important to look at underlying causes of illness. • 80.1% of people in Gippsland aged 15-24 years are earning or learning (86.2% in Victoria). • Elements of food insecurity, financial stress and social disadvantage were identified during the COVID-19 response.	• Improved awareness of, and access to, non-clinical services in primary care. • Increased opportunities for people to get connected within their community. • Increased access to financial planning services. • Increased advocacy for investment to improve access to government services.
16	Healthy and safe environment (climate change, pandemics, natural disasters)	• General practices in Gippsland experienced an increase in respiratory presentations as a result of poor air quality caused by the bushfires (January–March 2020). • Increase in mental health concerns related to climate change, bushfires and the COVID-19 pandemic.	• Increased leadership and forward planning at all levels of government. • Improved implementation of clear evidence-based protocols/guidelines during bushfires/pandemics. • Increased engagement with community on planning changes that may affect the liveability of the area. • Increased community understanding of general practice role in an emergency. • Improved connection/trust between community and local primary care providers.

1. Aboriginal and Torres Strait Islander health and wellbeing

"I do not like seeing a new GP that knows nothing about my history." [Survey respondent]

"Being able to access care at local clinic… ability to provide an inclusive and respectful environment." [Survey respondent]

The National Agreement on Closing the Gap (Coalition of Peaks n.d.) came into effect on 27 July 2020:

- Sets out how governments and the Coalition of Peaks will work together to improve the lives of Aboriginal and Torres Strait Islander people.
- The Coalition of Peaks is a representative body of Aboriginal and Torres Strait Islander community controlled peak organisations and members.
- Built around what Aboriginal and Torres Strait Islander people said is important to improve their lives.
- The Agreement identifies Four Priority Reforms to change the way governments work, new government accountability measures and shared monitoring and implementation arrangements:
    - Shared decision-making: Aboriginal and Torres Strait Islander people are empowered to share decision-making authority with governments to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements.
    - Building the community-controlled sector: There is a strong and sustainable Aboriginal and Torres Strait Islander community-controlled sector delivering high quality services to meet the needs of Aboriginal and Torres Strait Islander people across the country.
    - Improving mainstream institutions: Governments, their organisations and their institutions are accountable for Closing the Gap and are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people, including through the services they fund.
    - Aboriginal and Torres Strait Islander people have access to, and the capability to use, locally relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities and drive their own development.

See **Gippsland population profile** for demographics.

The Gippsland PHN offices are located on the lands of the Gunai Kurnai and Bunurong peoples who are the Traditional Owners of the land. The territory of the Gunaikurnai Lands and Waters Aboriginal Corporation (GLaWAC) includes the coastal and inland areas on the southern slopes of the Victorian Alps and extends from West Gippsland, near Warragul, east to the Snowy River and north to the Great Dividing Range. The Bunurong Land Council Aboriginal Corporation covers the areas of Frankston, Mornington Peninsula, Bass Coast and South Gippsland.

Health status

The AIHW national study of Burden of Disease included an analysis of Aboriginal and Torres Strait Islander loss of healthy life, (AIHW 2021c). The findings may not directly translate to Gippsland, but main findings include:

- 53% of total burden was due to living with illness or injury (non-fatal); while 47% was due to dying prematurely (fatal).
- Since 2003, fatal burden has decreased by 27% while non-fatal burden remained steady.
- The top five disease groups causing total burden of disease were:
    - Mental and substance use disorder (23%) – increasing burden due to anxiety disorders, alcohol use disorder and depressive disorders were seen since 2003
    - Injuries (12%) – increase in suicide and self-inflicted injury
    - Cardiovascular disease (11%) – decrease in coronary heart disease, COPD and type 2 diabetes
    - Cancer (9.9%) – slight decrease in lung cancer
    - Musculoskeletal conditions (8.0%) – decrease in rheumatoid arthritis
- Males suffered 1.4 times the rate of fatal burden compared to females, especially due to alcohol use disorders, suicide and self-inflicted injuries and coronary heart disease.
- Mental and substance use disorders was the leading contributor to burden of disease for Indigenous Australians (23%) but made a smaller contribution among non-Indigenous Australians (12%).
- Injuries was the second contributor to burden of disease for Indigenous Australians (12%), compared to 8% among non-Indigenous Australians.
- 49% of Indigenous burden of disease was potentially preventable. The risk factors contributing the most burden in 2018 were;
    - tobacco use (12%),
    - alcohol use (10%),
    - overweight (including obesity) (9.7%),
    - illicit drug use (6.9%) and
    - dietary factors (6.2%).
- The gap in years spent living in full health between Indigenous and non-Indigenous Australians in 2018 was 15.2 years for males and 13.9 years for females.
- Indigenous Australians experience a burden of disease rate that is 2.3 times higher than for non-Indigenous Australians, but the size of the gap is smaller than it was in 2003.

Estimates for Gippsland are not available but data for Victoria estimates disease prevalence among Aboriginal and Torres Strait Islander people (ABS 2019a)

- 26% rated their health as fair or poor
- 76% had one or more long term health conditions, the most common being;
    - 44% eye/sight problems
    - 33% mental / behavioural condition
    - 18% asthma

    - 17% back problems
    - 12% arthritis
    - 4.2% COPD
    - 5.5% diabetes mellitus
    - 5.0% heart, stroke and vascular disease
    - 1.3% kidney disease
- 45% had a disability
- Health risk factors included 73% overweight or obese, 54% exceeded alcohol risk guidelines, 37% current smokers and 18% with high blood pressure

Factors affecting the health of Indigenous people in Gippsland (**Table 10**):

- 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%).
- The proportion of Aboriginal children who are developmentally vulnerable on two or more domains is much higher than for all children (14.2% Gippsland); Latrobe (36.9%) and East Gippsland / Wellington (34.3%).
- Aboriginal unemployment was 20.4% 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.
- 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%).
- Across Gippsland, 32.8% of Aboriginal people rent their home privately, while 23.5% rent social housing. In Gippsland South Coast, only 3.8% rent social housing and 46.1% rent privately.
- The national Bringing Them Home report (Healing Foundation 2017) identifies a need to do a comprehensive assessment of the needs of Stolen Generations members to better understand intergenerational trauma to allow change for young Aboriginal and Torres Strait Islander people.
- In Victoria, 79.6% of Aboriginal children (aged birth to 12) in out-of-home care were in Kinship care, as compared to 59.9 per cent in 2010 (DET 2021).

Table 10. Factors affecting Indigenous health and wellbeing by Indigenous Area, Gippsland 2016 (or as indicated).

Factors affecting health	Baw Baw	Latrobe	Gippsland South-West	East Gippsland Wellington	GIPPSLAND	VICTORIA	Australia
Children aged less than 15 years in Aboriginal jobless families	38.8%	51.8%	34.8%	37.6%	41.6%	36.5%	39.7%
Developmentally vulnerable children on two or more domains - Aboriginal people (2018)	NA	39.6%	NA	34.3%	NA	26.8%	25.8%
Aboriginal participation in full-time secondary school education at age 16	62.5%	94.4%	100.0%	70.3%	73.3%	75.0%	71.3%
Aboriginal persons Learning or Earning at ages 15 to 24 years	75.8%	60.7%	78.6%	69.3%	69.0%	75.7%	65.4%
Aboriginal unemployment	21.0%	26.7%	14.9%	17.7%	20.4%	14.0%	18.2%
Indigenous Relative Socioeconomic Outcomes Index	38	58	24	57	47	25	43
Aboriginal low income families (at least one Aboriginal person at home and with income under $20,799 pa)	14.4%	15.6%	15.0%	13.4%	14.6%	12.6%	13.1%
Privately rented dwellings - Aboriginal persons	27.4%	33.0%	46.1%	29.7%	32.8%	35.2%	32.8%
Social housing - Aboriginal persons in rented dwellings	21.1%	25.7%	3.8%	28.3%	23.5%	17.3%	29.3%
Aboriginal women smoking during pregnancy (first 20 weeks)	34.6%	66.4%	47.8%	46.4%	51.3%	40.6%	43.4%

Source: PHIDU (2021c)

High compared to Australian Indigenous areas, among 25% highest rates
Low compared to Australian Indigenous areas, among 25% lowest rates

- 310 Aboriginal women in Gippsland gave birth during the three years 2016 to 2018 (average of 103 babies per year). (PHIDU 2021c)
- For Indigenous Australians, the prevalence of vision loss was 7% among those aged 40–49, compared with 56% among those aged 80 to 89 (AIHW 2021d)
    - Most of the vision loss experienced by Indigenous Australians is potentially preventable.
    - Screening plays an important preventative role in eye health as early detection and treatment of eye problems, such as diabetic retinopathy and cataract, can prevent vision impairment and blindness.

    - Indigenous Australians were more likely than non-Indigenous Australians to report blindness (2.4 times as likely) or having a cataract (1.7 times as likely) as a cause of sight problems.
    - Refractive error, cataract and diabetic retinopathy are the leading causes of vision loss among Aboriginal and Torres Strait Islander Australians.
- Victorian death data for Indigenous people were not available for analysis (PHIDU 2021c)

Service system

Gippsland has five Aboriginal Community-Controlled Organisations (ACCOs) which deliver health and social care services in six locations. These are Ramahyuck, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Lakes Entrance Aboriginal Health Association (LEAHA), Lake Tyers Aboriginal Health and Children's Services and Moogji Aboriginal Council. Some services are also delivered through outreach, including in East Gippsland and in a limited capacity to Baw Baw. See **Gippsland health services**.

Each ACCO works closely with Gippsland PHN including on quality improvement programs and commissioning of services targeted at the Aboriginal and Torres Strait Islander population. They also share de-identified data through the POLAR system. Important recent ACCO events included:

- Significant staff changes at one ACCO including executive level, with impact on service delivery and proposed changed service model.
- One Gippsland ACCO is second in Victoria to receive the rainbow tick accreditation.

Services commissioned specifically for Gippsland's Aboriginal and Torres Strait Islander population:

- Integrated Team Care (ITC) program provided by a team of Aboriginal and Torres Strait Islander Outreach Workers and Care Coordinators across four Aboriginal Community Controlled Organisations and supported by the Gippsland PHN Indigenous Health program manager. It aims to assist Aboriginal and Torres Strait Islander people to access primary health care, assisting eligible Aboriginal and Torres Strait Islander people with chronic disease/s who require coordinated, multidisciplinary care. It also aims to improve access for Aboriginal and Torres Strait Islander people to culturally appropriate mainstream primary care.
- Indigenous Dual Diagnosis Service (IDDS) supporting Indigenous Australians' experiencing both mental health and alcohol and drug problems, delivered by ACCOs.
- Cultural awareness training is delivered by Gippsland PHN.

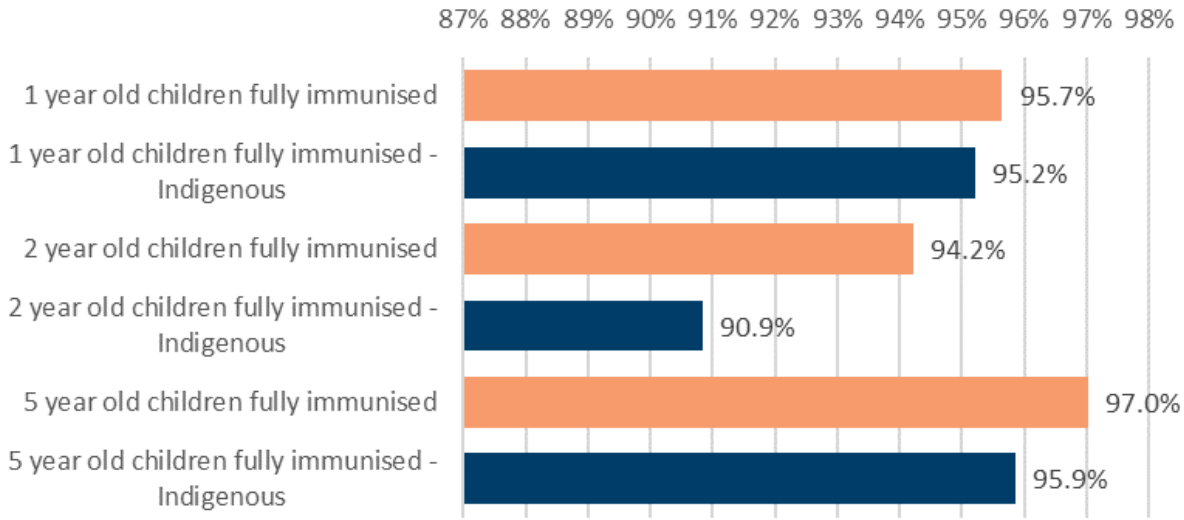
The Gippsland LGAs of Bass Coast and South Gippsland are not serviced by an ACCO. Aboriginal and Torres Strait Islander people who reside in these areas or visit the area rely on mainstream services for their health care. An overview of general practices can be found in **Gippsland health services.**

All Aboriginal and Torres Strait Islander Australians, regardless of age, are eligible for an Indigenous-specific health assessment each year using specific MBS items (715 or 228), including a health assessment provided via videoconference or teleconference (MBS item 92004, 92011, 92016, 92023). Current guidelines recommend a diabetic eye examination annually for Indigenous Australians with diabetes (and at least every two years for non-Indigenous Australians with diabetes).

Service utilisation

- 53.5% of Aboriginal women do not attend antenatal visits during their first 10 weeks of pregnancy (compared to 61.5% in Victoria).
- Immunisation rates for Indigenous children are lower; 95.9% of 5 year olds were immunised compared to 97.0% of all children in Gippsland, see **Figure 7**.
- The number of services provided under the Visiting Optometrists Scheme, which provides specialist eye health services to Indigenous Australians in mainly regional and remote areas, have fluctuated, but overall services more than tripled between 2010–11 and 2018–19. In Gippsland, there were 35 occasions of service per 1,000 people in 2018-19, compared to 19.5 in Victoria (AIHW, 2020e).

Figure 7. Immunisation rates for Indigenous children compared to all children at 1, 2 and 5 years of age, Gippsland, 2020.



Source: DoH (2021a)

General practice

- 5,301 patients, or 1.8% of all patients at Gippsland GP practices in 2019-20 were Aboriginal or Torres Strait Islander, with an average of 7.1 activities per patient. Indigenous status was not specific for 27.4% of patients. Distribution by LGA is shown in **Table 11**.

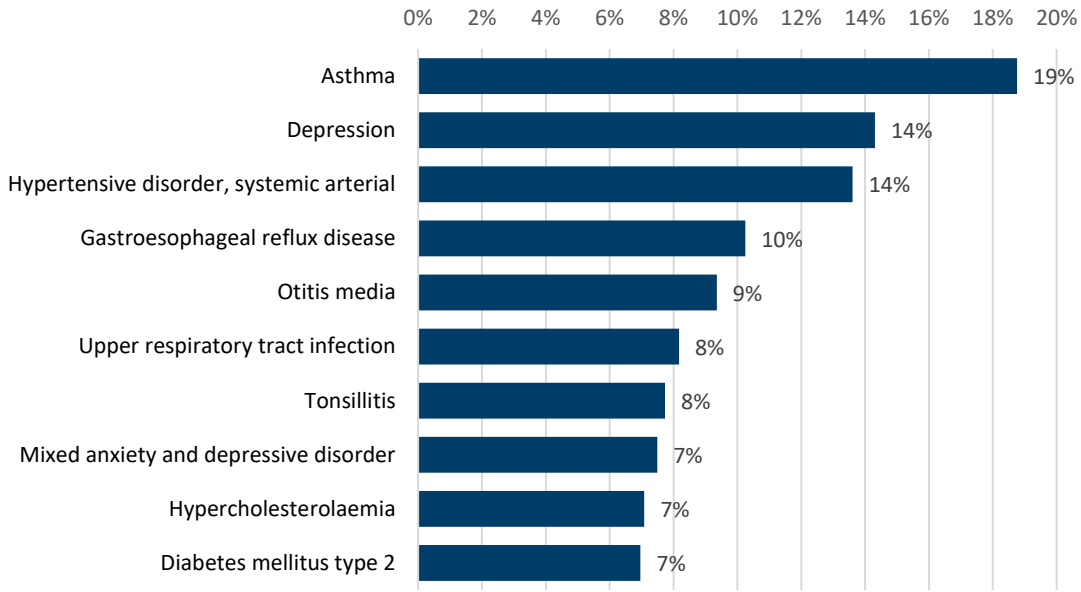
Table 11. Number of Indigenous patients by LGA, 2019-20

LGA	Number of Indigenous patients*
Bass Coast (S)	465
Baw Baw (S)	1,310
East Gippsland (S)	1,231
Latrobe (C)	1,891
South Gippsland (S)	521
Wellington (S)	1,496
Gippsland	5,301

Source: GPHN (2021e)
*Note these are not unique patients - a patient is counted more than once if active in more than one practice

- The top diagnoses among Indigenous patients in general practice were asthma, depression and hypertension. See **Figure 8**. There were an average of 143 new asthma diagnoses for Indigenous patients across Gippsland per year 2017-18 to 2019-20; 114 depression and 76 hypertension.
- The proportion of Indigenous patients with a chronic disease diagnosis:
    - 32% had a mental health diagnosis
    - 24% had a respiratory diagnosis
    - 17% cardiovascular disease
    - 15% musculoskeletal
    - 10% diabetes
    - 5% alcohol and other drugs
    - 4% disability
    - 2% cancer
    - 1% chronic kidney disease

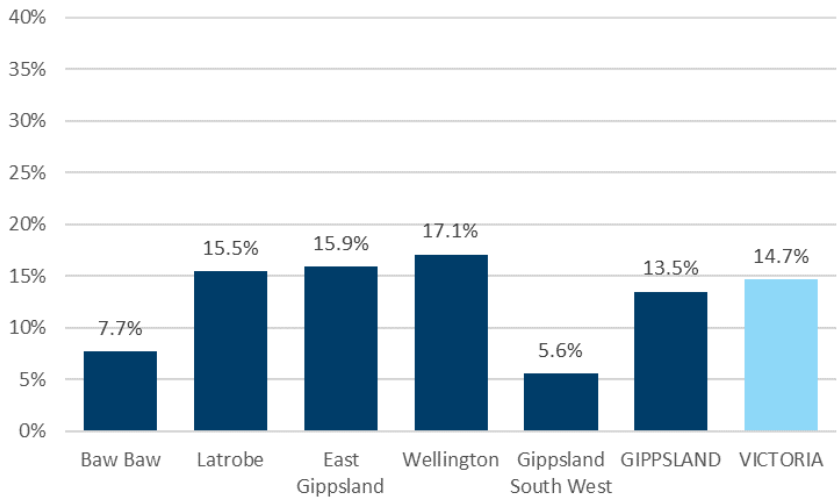
Figure 8. Top 10 active diagnoses for active Indigenous patients, 2020-21



Source: GPHN (2021e)

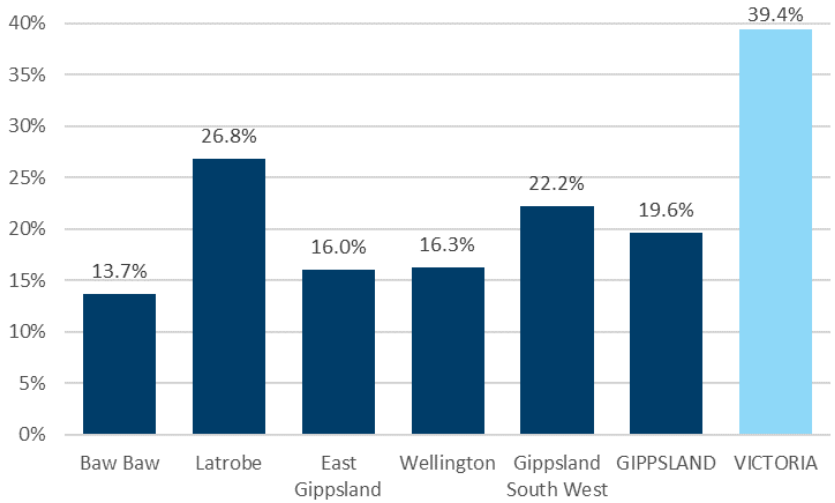
Indigenous-specific health assessments were performed for 13.5% of Indigenous people in Gippsland in 2019-20 (730 services), see **Figure 9**. This is down from 17.7% of people (or 934 services) in 2018-19. The proportion of patients who received follow up services was 19.6% in Gippsland compared to 39.4% in Victoria (**Figure 10**).

Figure 9. Indigenous health checks, per cent of the Indigenous population, Gippsland and SA3, 2019-20.



Source: AIHW (2021e)

Figure 10. Indigenous health check patients who received follow up services within 12 months, Gippsland and SA3, 2018-19.



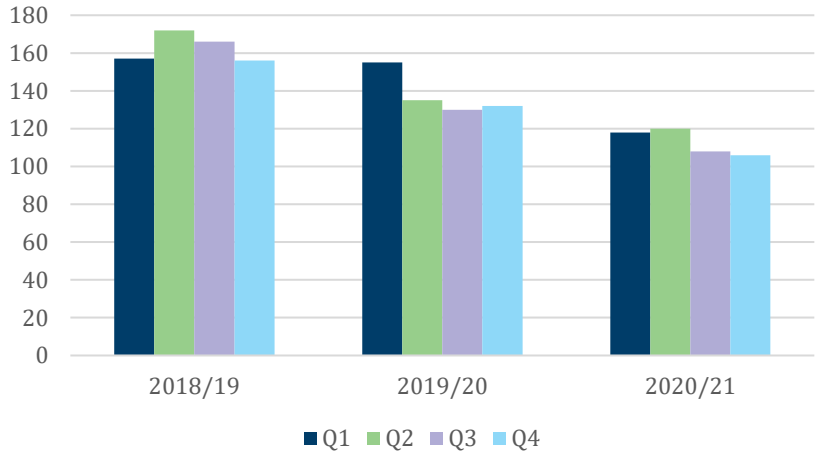
Source: AIHW (2021e)

Commissioned services

Integrated Team Care (ITC) program

- A total of 5,378 ITC services were delivered during 2020-21 including:
    - 2,314 care coordination services for 285 people;
    - 2,947 outreach services for 1,147 people, with pharmacy prescriptions and support to attend appointments the most often used;
    - 77 supplementary services, with podiatry, diabetes education, Aboriginal health, mental health, radiology and endocrinology most often used.
- Cost of ITC service is approximately $120 per session.
- Main referral sources in 2020-21 were General Practitioners, Aboriginal Health Workers and Nurses, Community Health, and self-referrals.
- Service provision over last three years is shown in **Figure 11**, noting the decline is related to COVID-19.

Figure 11. Integrated Team Care program occasions of service in Gippsland, 2018-19 to 2020-21.



See **Mental health and wellbeing, including suicide prevention** for Indigenous Dual Diagnosis and Primary Mental Health services.

Hospital admissions

- Hospital admissions were 2.6 times more common for Aboriginal and Torres Strait Islander people in Gippsland compared to non-Aboriginal people (public hospitals in Victoria in 2019-20) (DH 2021a) This has increased from 2.0 times in 2015-16.
- Total potentially preventable hospitalisation (PPH) rates for Indigenous people were high in Gippsland at 5,133 per 100,000 people (age-standardised rates), compared to 4,258 in Victoria (2016-17 to 2018-19) (PHIDU 2021c). Rates in Bass Coast and South Gippsland were low (1,664). As a comparison, the PPH rate for the total Gippsland population was 3,010 per 100,000 people (2017-18), (AIHW 2020a).
    - There were a total of 840 PPHs for Indigenous people in Gippsland over three years
    - Age group of patients:
        - 19% were for 0–14-year-olds
        - 8.5% 15-24 years
        - 19% for 25-44 years
        - 29% 45-64 years
        - 25% were 65 years or older
    - Top five PPH conditions for Indigenous people were:
        - Diabetes (18%)
        - Chronic Obstructive Pulmonary Disease (17%)
        - Iron deficiency anaemia (9.4%)
        - Dental (9.0%)
        - Convulsions / epilepsy (8.6%)
- Hospital admission rates for Aboriginal and Torres Strait Islander people were higher than for non-Aboriginal people in Gippsland in 2019-20 across all conditions. See **Table 12**.

Table 12. Hospital admissions for Aboriginal and Torres Strait Islander people, and rates per 100,000 people for selected conditions / clinical specialities, compared to non-Aboriginal, 2019-20.

Health condition / Clinical specialty	Aboriginal admissions	Aboriginal rate	Non-Aboriginal rate	Rate ratio*	Trend 2015-16 until 2019-20
Renal dialysis	1,150	49,445	5,374	9.2	Variable between 9.3 and 8.8; increase for males and decrease for females
Gastroenterology	238	9,095	4,308	2.1	NA
General medicine	222	6,532	2,912	2.2	NA
Respiratory	181	6,368	1,730	3.7	NA
Diabetes	168	8,165	1,844	4.4	Variable between 3.2 and 4.4
Obstetrics / antenatal	166	4,431	2,246	2.0	NA
Oncology / radiology	149	6,530	3,125	2.1	NA
Mental and behavioural disorders	121	3,563	731	4.9	Variable between 3.2 and 5.9 with upward trend
Hospitalisations attributable to tobacco	77	3,398	666	5.1	Up from 2.5 in 2015-16
Cardiovascular disease	74	3,499	1,196	2.9	Up from 1.2 in 2015-16
Hospitalisations attributable to alcohol or tobacco	66	2,170	483	4.5	Variable between 3.9 and 4.8

Source: DH (2021a)

* Aboriginal / Non-Aboriginal rate

Emergency Department (ED) presentations

- A total of 4,518 emergency department (ED) presentations for Aboriginal and Torres Strait Islander people in Gippsland in 2019-20 (to public hospitals), up from 3,252 in 2015-16, (DH 2021a).
- Indigenous presentations to ED were 2.7 times more common compared to non-Indigenous people (DH 2021a). This has increased from 2.1 times in 2015-16.

- ED presentation rates for Aboriginal and Torres Strait Islander people were higher than for non-Aboriginal people in Gippsland in 2019-20 across conditions. See **Table 13**.
- Lower urgency ED presentation (semi-urgent and non-urgent) rates for Indigenous people were high in Gippsland at 43,792 per 100,000 people (age-standardised rates), compared to 26,980 in Victoria (2018-19) (PHIDU 2021c). Latrobe had the highest rates (53,878 per 100,000 people). In comparison, the rate for the total Gippsland population was 18,200 per 100,000 people (2018-19), (AIHW 2020b).
    - Triage category of 4,418 total ED presentations for Indigenous people in Gippsland (2018-19), (PHIDU 2021c):
        - Resuscitation and emergency – 573 (13%)
        - Urgent – 1,519 (34%)
        - Semi-urgent – 1,854 (42%)
        - Non-urgent – 472 (11%)
    - Annual number of lower urgency ED presentations by condition for Indigenous people:
        - Diseases of the digestive system (160)*
        - Diseases of the respiratory system (157)
        - Certain infectious and parasitic diseases (148)*
        - Diseases of the musculoskeletal system and connective tissue (131)
        - Mental and behavioural disorders (89)*
        - Diseases of the genitourinary system (80)*

        * Significantly higher than expected compared to national rate

Table 13. ED presentations for Aboriginal and Torres Strait Islander people in Gippsland, and rates per 100,000 people for selected conditions, compared to non-Aboriginal, 2019-20.

Health condition / Clinical specialty	Aboriginal presentations	Aboriginal rate	Non-Aboriginal rate	Rate ratio*	Trend 2015-16 until 2019-20
Injury	827	19,443	9,328	2.1	Up from 1.6 in 2015-16
Mental and behavioural disorders	240	7,046	1,347	5.2	Up from 3.7 in 2015-16
Asthma	82	1,810	471	3.8	Varied between 2.5 and 3.8
Influenza and pneumonia	56	1,727	634	2.7	Varied between 2.4 and 4.1

Source: DH (2021a)
* Aboriginal / Non-Aboriginal rate

Professional stakeholder perspective

Gippsland PHN stakeholder consultations have noted (GPHN 2021f):

- Chronic disease management, mental health and socio-economic determinants of health such as employment and housing were identified as key issues for Aboriginal people.
- Service and workforce gaps including Indigenous health workers and culturally specific services were identified by stakeholders.

  "Holistic / multidisciplinary services are preferred for Aboriginal and Torres Strait Islander people"
- Top service gaps identified in interviews were AOD, dental services, transport to get to health services and access to affordable medical specialists.
- Key findings from the evaluation of the Victorian Koolin Balit, Strategic Directions for Aboriginal health 2012-2022:
  - Connections to Place and Culture are crucial for health and wellbeing, reinforcing the need for a holistic approach to health and wellbeing to help Aboriginal clients and for services to be culturally responsive and culturally safe
  - Government should be more active in some specific areas, including monitoring Aboriginal people's experiences of healthcare and ensuring accountability for improving cultural safety
  - The Aboriginal workforce experiences dangerous levels of racism and trauma and support networks are needed
  - There are opportunities for greater coordination and sharing of good practice through networks
- Workforce challenges experienced by providers, partly related to cumulative impact following bushfires, pandemic and sorry business.
- Services commissioned to provide Integrated Team Care and other services for Aboriginal clients in Gippsland noted;
  - Workforce challenges to fill advertised positions and retain staff, leading to fragmentation and difficulty in building relationships.
  - Current staffing not sufficient to meet demand; risk of burn out of existing staff due to high demand for the service and lack of admin support to enable data capture.
  - A need for staff education to support evidence based chronic disease management.
  - Suggestion for Aboriginal Liaison officer / health worker to support care coordinator:

    "The majority of my Chronic Disease clients need quite a bit of assistance and if we were able to employ someone connected to the Aboriginal community … this would improve trust and client outcomes."
  - Reliance on written feedback forms is a barrier for people who are unable to write:

    "Most of these clients aren't at the stage of self-managing due to inability or unable to read or write."
  - Resources for health promotion and prevention are needed, including young people's health checks.

Key factors to improve Aboriginal and Torres Strait Islander health include;

- Holistic healthcare delivered by both ACCOs and culturally safe mainstream services. (Victorian Government 2018)
- An increase in the Aboriginal and Torres Strait Islander health workforce. (Victorian Government 2018)
- Appropriate housing as a key determinant of health. (AHHA 2021a)

- Genuine engagement where Indigenous people are not considered 'one stakeholder among many', but rather recognised as the traditional owners of country and have a real say (AHHA 2017)

Community, consumer and carer perspective

Previous engagement with Indigenous people has noted the following (GPHN 2016):

- The health issues rated as most important were work and study opportunities, mental health and heart and lung health.
- 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:
    - 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).
- Alcohol and other drugs was the top ranked health issue identified in interviews, including tobacco use, and noted as a specific issue for youth.
- Several things that are working well were identified, including educational community activities and praise for dedicated staff at local services.

Themes from 2021 engagement about what would improve health noted the following themes from Indigenous respondents (GPHN 2021d):

- Availability of appointments without a long wait locally
- Bulk billing
- Trusted doctor who listens to patient issues and concerns

  "Having doctors that looks at you, see you, hear you. Ask in a genuine way what you are needing and your health history, especially why you're there that day."
- Access to specialist care and female doctors when preferred

Gippsland PHN are developing a Reconciliation Action Plan, based on some valuable input from the First Nations people of Gippsland (GPHN 2021g). As an organisation, Gippsland PHN fully commits to Closing the Gap for Aboriginal and Torres Strait Islander peoples. Focus areas of the Reconciliation Action Plan are:

- Relationships – build meaningful relationships though listening to develop a shared understanding of lived experience and build trust.
- Respect - grow the Aboriginal workforce and engagement with Aboriginal services and respect the need to embrace culturally safe and inclusive practices.
- Opportunities - engage with suppliers, communities and organisations that are cultural safe and respectful in order for Aboriginal and Torres Strait communities to grow and thrive.

- Governance - Aboriginal and Torres Strait Islander health is everyone's business and the whole of Gippsland PHN is committed to actions that lead to better health and wellbeing in the Aboriginal and Torres Strait Islander communities.

Findings related to health and wellbeing from engagement with Aboriginal and Torres Strait Islander people in Latrobe (LHA, 2020a) included:

- Koori friendly health services and places for healing; more cultural awareness and education within local services and for health workers to spend time with people in the community; employ Aboriginal people and offer support to go to community events and groups to maintain their connection to culture.
- Cultural connection and mental health comes first; Aboriginal people talked to us about the importance of aligning their spirit, healing from within and taking steps to strengthen their connection to culture.
    - We heard that some of the mental health challenges people are facing can be impacted by addictions, low self-esteem, violence, and the justice system.
- Take steps to look after your health and other mob will follow; many agreed Aboriginal people need to listen to their bodies more and to access the supports, health checks and services that can help them to prevent getting sick. Everyone shared their goals to live a healthy life, often for the benefit of their children, family and friends.
- Working together to achieve equity; solutions to the long-term problems that have impacted their families can be determined at a local level.

See also **COVID-19 impact**.

Figure 12. Mara's journey - Aboriginal and Torres Strait Islander health and wellbeing.

Mara's journey

Mara is 66 years old. She is a Gunai/Kurnai woman and Elder in her community. She has multiple chronic conditions including diabetes, asthma, stress and anxiety. During the COVID-19 pandemic, she's been feeling overwhelmed balancing her responsibilities as an Elder with family commitments and her own wellbeing. She decides to reach out to her GP for support.

Mara tells her GP she's worried for her health and has trouble keeping track of her appointments.

Her GP feels that Mara would benefit from a care coordinator, so she doesn't have to manage this alone.

Her GP refers Mara to the Integrated Team Care (ITC) Program to coordinate her care.

Mara wants to access services at home, so she doesn't risk exposing her family to COVID.

Her care coordinator arranges home visits to check in on her and her family's health.

Having her healthcare team collaborate through the ITC program helps Mara feel on track.

She is also able to access transport to her doctors appointments through the program.

What didn't help?

- Feeling stressed and unable to manage multiple chronic conditions on her own.
- Feeling anxious about keeping her family and community safe during COVID-19 while still looking after herself.

What helped?

- Accessing culturally safe care through the ITC program at the local Aboriginal Community Controlled Organisation.
- Care coordination between her GP, pharmacist, allied health team and Hospital Aboriginal Liaison Officer.

Key messages

- Feeling comfortable accessing health care professionals and services that understand the cultural aspects of Indigenous Health is important.
- There are supports in place to help access services when family and cultural commitments, cost and transport prevent timely access.

Source: GPHN (2021d)

2. People 65 years or older

"…access for seniors is difficult through My Aged Care. What about those who are not digital savvy or too unwell to use telehealth or the phone." [Workshop participant]

"We have an epidemic of older people... This will only get worse as we're all ageing. [Workshop participant]

"Don't make assumptions about ageing and more fragile people being able to even use email, they have no digital access, yet more forms are now only online, cannot fill out hardcopy, this is a big barrier" [Workshop participant]

Health status

It is estimated that 23.6% of the Gippsland population are aged 65 years or older (DELWP 2019), compared to 15.8% in Victoria. An even higher proportion of the Bass Coast and East Gippsland populations are aged 65 years or older; 28.7% and 29.4%.

By 2030, 28.1% of the Gippsland population are expected to be aged 65 years or older with 33.5% of the Bass Coast population and 34.9% of the East Gippsland population, compared to 17.1% in Victoria (PHIDU 2021e)

See also **Gippsland population profile** for demographics.

In 2021, there is an estimated total of about 69,400 people in Gippsland aged 65 years or older:

- Close to 30,000 are aged 75 years or older; 10% of the total population.
- Over 6,400 people were born in a non-English speaking country with the most common countries of origin (and approximate number across Gippsland); Netherlands (1,500), Italy (1,100), Germany (1,075), Malta (375), Greece (175) and Croatia (150) (PHIDU 2021e)
- Some 300 are Aboriginal or Torres Strait Islander with almost an additional 600 Aboriginal or Torres Strait Islander people aged 50-64 years (PHIDU 2021e)

Other facts about people 65 years or older in Gippsland (PHIDU 2021e), (compared to Victoria):

- 25.4% or 14,500 people live alone (25.3%)
- 9.0% or 5,150 rented their home (10.3%)
- 4.9% or 2,800 did not own a motor vehicle (8.4%)
- 57.5% accessed the internet from home (64.8%)
- 11.8% participated in the labour force (12.3%)
- 49.8% on low income (47.1%)
- IRSD of 965 (index score where Australia is 1,000)
- 23.5% volunteered (18.2%)

- 10.9% provided unpaid assistance to a person with a disability (11.9%)
- 16.1% had a profound or severe disability (19.4%)
- 66.7% of people 65 years or older in Gippsland receive the age pension, compared to 58.3% in Victoria. The highest rates are in Latrobe, Bass Coast and East Gippsland. See **Table 14**.

Table 14. Age pension recipients per cent of people 65 or over, Gippsland 2020.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Age pension recipients per cent of people 65 or over	67.4%	59.2%	64.5%	72.2%	66.8%	65.4%	66.7%	58.3%

Source: PHIDU (2021d)

High compared to Australian LGAs, among 25% highest rates

Ageing is often associated with declining health and many health conditions are more common as people get older (AIHW 2018a). Many older people also remain healthy and independent longer than in previous generations. Life expectancy is increasing.

Older Australians are a diverse group, with different ages, socioeconomic backgrounds, life experiences and lifestyles, but overall, an older demographic means there is a growing number of people who are unable to care for themselves at home or require support services to do so. Some groups of older Australians also face disadvantage that affects both their mental and physical health, including people:

- from Aboriginal and Torres Strait Islander communities
- from culturally and linguistically diverse backgrounds
- who are veterans of the Australian Defence Force or an allied defence force (or the spouse, widow or widower of a veteran)
- who live in rural or remote areas
- who are homeless or at risk of becoming homeless
- who are LGBTIQ+

- The rate of falls related hospital admissions was similar in Gippsland compared to Victoria over a five year period (2015-16 to 2019-20), 617 admissions per 100,000 people compared to 635, (DH 2021a). There were 2,070 admissions in 2019-20; 57% were for females.
- The rate of deaths caused by accidental falls in Gippsland was 15.4 per 100,000 population (age-standardised); higher than across Australia at 8.3 per 100,000 people). Rates were highest in Wellington (19.1), Latrobe (18.4), South Gippsland (16.4) and Bass Coast (15.5).

Service system

Aged care service types include:

- Residential aged care – 52 facilities in Gippsland (AIHW 2021g) and one multi-purpose service including residential (Orbost)
- Home Care Packages – 44 providers in Gippsland
- Commonwealth Home Support Program
- There are two short term restorative care services (Neerim South and Sale) and one transition care service (Traralgon)

Key health workforce categories include nurses, personal care workers and allied health professionals. Medical support is generally provided by a general practice.

- There are an estimated 3,492 residential places in aged care in Gippsland; see **Table 15** for distribution by LGA.
- Latrobe and Wellington have a higher number of age care beds per population aged 70 years or older than Victoria as a whole, while the lowest number is found in East Gippsland.

Table 15. Aged care residential places in Gippsland, by LGA, 2020.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Aged care residential places	482	327	524	1,105	524	518	3,486	NA
Aged care residential places per 1,000 people aged 70 years and over	66	63	69	109	53	80	75	78

Source: PHIDU (2021d)

High compared to Australian LGAs, among 25% highest rates

See also **Gippsland health services** for an overview of health care providers in Gippsland.

The Aged Care Assessment Service (ACAS) is required to assess a person's needs before they can access residential aged care and home care packages. ACAS teams conduct comprehensive assessments of the care needs of older adults, accessed via My Aged Care.

Gippsland PHN commissions a Mental Health in Aged Care program for people living in or transitioning into Residential Aged Care Facilities (RACFs):

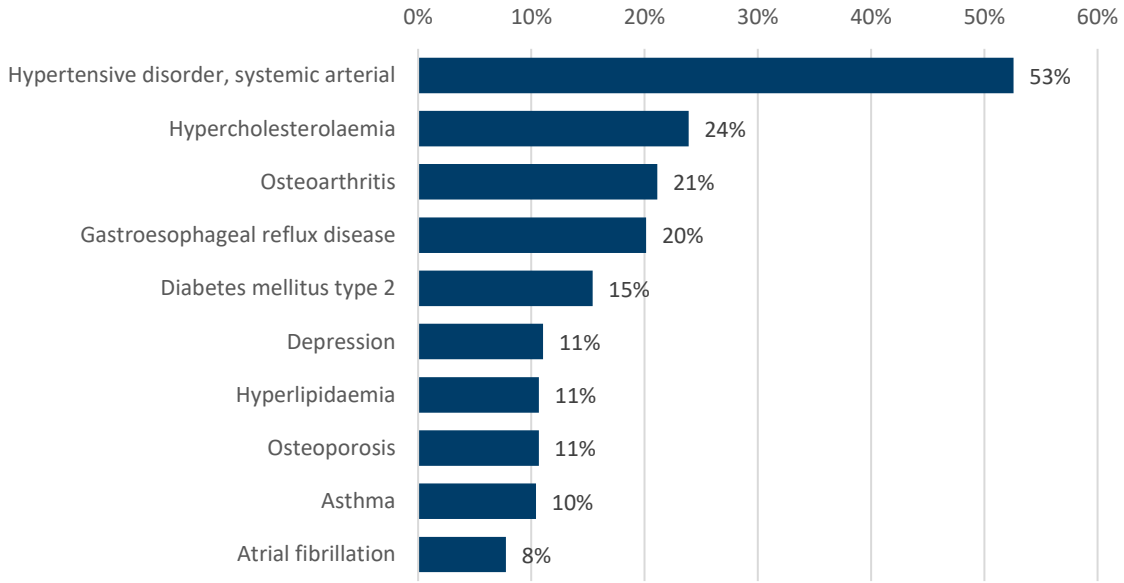
- Early intervention program offering holistic care addressing mental, physical, and social health needs.
- It provides low to mild intensity level of care.
- Individual or group support is provided by mental health and wellbeing support workers, alongside trained peer support workers and local community volunteers.
- Residents requiring more intensive services are handed back to the GP for review and referral to other services as appropriate.

Service utilisation

General practice

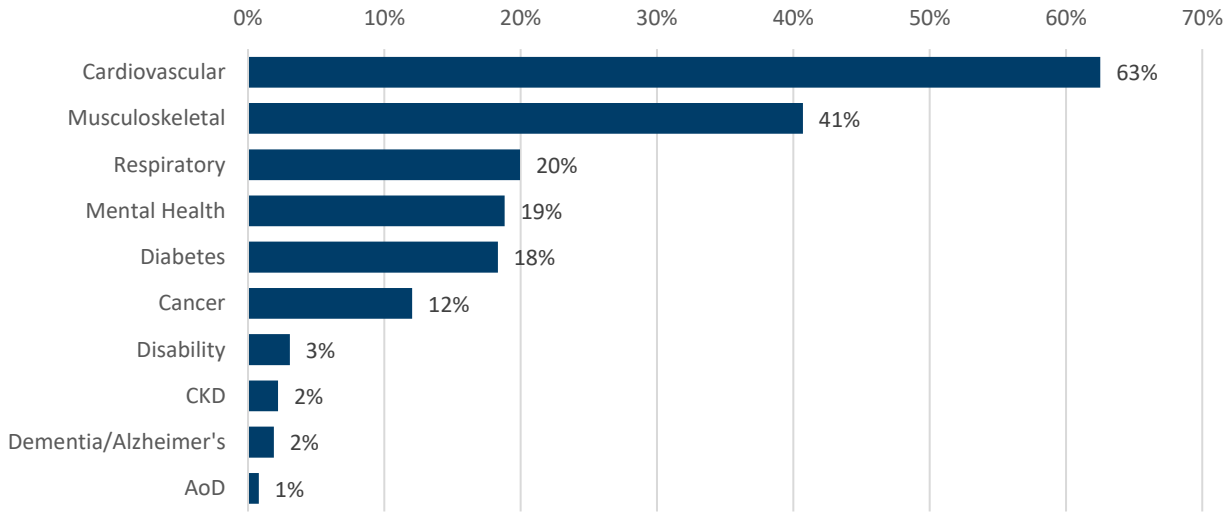
- 46% of the activity at Gippsland GP practices in 2019-20 was for people aged 65 years or older with an average of 13.4 activities per patient.
- The most common diagnosis was hypertension, affecting 53% of people aged 65 years or older. See **Figure 13**. The proportion of patients with a chronic disease diagnosis are shown in **Figure 14**; it can be seen that 63% had a cardiovascular diagnosis, 41% had a musculoskeletal diagnosis, 20% had a respiratory diagnosis and 19% of patients had a mental health diagnosis.
- The number of new diagnoses per year are provided in **Table 16**.

Figure 13. Top ten active diagnoses for active patients aged 65 years and older, 2020-21.



Source: GPHN (2021e)

Figure 14. Prevalence of active chronic disease category diagnoses for active patients aged 65 years and older, 2020-21.



Source: GPHN (2021e)

Table 16. Top 10 new diagnoses for patients aged 65 years and older in Gippsland by year.

	2017/18	2018/19	2019/20
Hypertensive disorder, systemic arterial	42,675	41,194	40,130
Hypercholesterolaemia	19,584	19,002	18,634
Osteoarthritis	18,607	17,717	17,405
Immunisation	16,059	16,428	16,663
Gastroesophageal reflux disease	16,129	15,762	15,733
Diabetes mellitus type 2	13,589	13,099	12,728
Health assessment	11,302	11,282	11,115
Care plan	11,046	10,953	10,468
Depression	10,918	10,382	9,996
Asthma	9,090	8,866	8,683

Source: GPHN (2021e)

- 17.4 GP attendances in aged care per 1,000 aged care residents in Gippsland compared to 17.8 in Australia (AIHW 2021f).
- Low rates of anticholinesterase medication use across most of Gippsland (these medications are often used in the treatment of Alzheimer disease). See **Table 17**.
- Antidepressant medication rates for people 65 years or older were high in Latrobe and similar to Victorias rates for the rest of Gippsland.
- Antipsychotic and anxiolytic medication rates for people 65 years or older were similar to Victorian rates or lower in some locations.
- About 4.6% of people of people aged 75 years and over had a Medication Management Review in Gippsland, compared to 5.4% in Victoria. Lowest rates were in East Gippsland (3.6%) and Gippsland Couth Coast (3.9%).

Table 17. Medications used by the Gippsland population aged 65 years or older, by SA3, age-standardised rates per 100,000 people.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South West	GIPPSLAND	VICTORIA	Australia	Currency
Anticholinesterase medicines	9,077	5,933	9,079	12,154	7,323	NA	14,027	12,650	2013-14
Antidepressant medicines	207,660	214,050	195,907	201,773	190,656	NA	194,225	196,574	2013-14
Antipsychotic medicines	24,105	22,068	23,547	23,271	19,039	NA	29,797	25,788	2016-17
Anxiolytic medicines	37,553	38,928	27,500	36,006	32,489	NA	42,664	37,695	2013-14
Polypharmacy (five or more medications) among people aged 75 years or older	43,282	42,954	39,503	45,408	40,777	41,980	39,786	40,226	2018-19
Medication reviews among people aged 75 years or older	5,925	4,660	3,567	5,557	3,893	4,554	5,937	5,392	2018-19
Proton pump inhibitor medication, 75 years of age or older	459,299	428,198	445,568	464,074	416,064	437,895	420,340	418,360	2018-19

Source: ACSQHC (2021)

High compared to Australian SA3s, top 25% of values

Low compared to Australian SA3s, bottom 25% of values

Gippsland PHN commissioned services data

The mental health in aged care program was delivered in 13 residential aged care homes and 30 residents were participating in program (30 September 2021).

Primary Mental Health Care program

- In 2020-21, 593 people aged over 65 years accessed Gippsland PHN primary mental health services (12.7% of all people accessing program).
- There were 3,555 services delivered to this group, an average of 6 services per person.
- Access to services for people aged over 65 years in 2020-21 by principal focus of treatment:
    - Low intensity mental health services: 293 people or 410 per 100,000 population
    - Psychological therapies: 89 people or 125 per 100,000 population
    - Clinical care coordination: 80 people or 112 per 100,000 population

Hospital admissions and ED presentations

- Potentially preventable hospitalisation rates are higher for people 65 years or older; 8,315 per 100,000 people compared to 2,354 per 100,000 people under 65 years. Gippsland rates were lower than national rate, except in Latrobe (**Table 18**).
- The rate of lower urgency ED presentations for people 65 years or older were high across Gippsland (except in Gippsland South-West, impacted by a lack of funded ED in South Gippsland) compared to Australian rates.

Table 18. Hospital activity for the Gippsland population aged 65 years or older, by SA3.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South West	GIPPSLAND	Australia	Currency
Potentially preventable hospitalisations, 65 years and over per 100,000 people (AIHW 2020a)	8,428	9,316	7,242	7,953	8,442	8,315	9,121	2017-18
Emergency department presentations - lower urgency, per 1,000 population - 65+ (AIHW 2020b)	122	127	117	136	96	117	80	2018-19

High compared to Australian SA3s, top 25% of values
Low compared to Australian SA3sreas, bottom 25% of values

- Top potentially preventable hospitalisation conditions for Gippsland are listed in **Table 19**; the most frequent being COPD, followed by congestive heart failure and iron deficiency anaemia.

Table 19. Top potentially preventable hospitalisation (PPH) conditions for patients aged 65 years and older in Gippsland, 2017-18.

Potentially preventable hospitalisation condition	PPH per 100,000 people (crude)	Number of PPH	Average length of stay (days)
COPD	1525	935	5.2
Congestive cardiac failure	1341	822	5.9
Iron deficiency anaemia	1083	664	1.4
Diabetes complications	918	563	5
Urinary tract infections, including pyelonephritis	830	509	4.5
Cellulitis	656	402	5.7
Angina	476	292	2.2
Pneumonia and influenza (vaccine-preventable)	462	283	7.4
Gangrene	210	129	9.4
Convulsions and epilepsy	171	105	3.2
Hypertension	168	103	2.5
Dental conditions	119	73	1.6
Asthma	116	71	2.8
Ear, nose and throat infections	109	67	2.6

Source: AIHW (2020a)

Aged care data

Based on national data, it is notable that the care needs of people in permanent residential aged care has increased from 35% with high care needs in 2010-11 to 54% in 2019-20 (AIHW 2021g). Groups of people with higher care needs included:

- People with a dementia diagnosis (67% compared to 58%)
- People with a preferred language other than English (68% compared to 62%)

In Gippsland in June 2020 there were (AIHW 2021g):

- 3,004 people in residential aged care
    - 40% had a diagnosis of dementia
    - 132 were using respite care
    - 169 (6%) were aged 64 years or younger; 2,159 (72%) were aged 80 years or older
    - 67% were female
    - 1% were Indigenous
    - 2% preferred a language other than English; 11% were born in non-English speaking country

- 2,545 people using home care (up from 1,469 in March 2018)
    - 20% Level 1 (505 people); 44% Level 2 (1,130 people), 15% Level 3 (388 people) and 21% Level 4 (522 people)
    - 102 (4%) were aged 64 years or younger; 1,427 (56%) were aged 80 years or older
    - 64% were female
    - 3% were Indigenous
    - 2% preferred a language other than English; 12% were born in non-English speaking country
- 30 people using transition care

- There were 3,522 Aged Care Assessment Program (ACAS) assessments completed in Gippsland in 2014-15. The mean number of days between referral and end of assessment varied between 14.6 (Wellington) and 22.8 days (East Gippsland). (AIHW 2021h).

Professional stakeholder perspective

- In a health workforce survey conducted by Gippsland PHN in 2021 (GPHN 2021h), 15 aged care sector respondents provided information about their extended competencies. The majority of respondents cited competencies in infection control which over half reported using all the time or a moderate amount of time. Over half reported competency in mental health. Wound management competency was reported by over a third of respondents.
- The top three categories for preferred professional development topics of the aged care sector were: palliative care, mental health and pain management, and infection control.
- Stakeholders (GPHN 2021f) have identified service gaps including:
    - home care packages in level 4 have very long wait time
    - chronic diseases, diabetes and cardiovascular diseases were key themes closely linked to ageing
    - allied health services, including in Residential Aged Care Facilities
    - podiatry
    - falls clinic
    - respite care, including alternative to RACF
    - access to specialists; neurologist and geriatrician
    - wound care
    - pain management
    - mental health services
    - specialist services
    - carer support
    - culturally appropriate services for Aboriginal and Torres Strait Islander people and CALD people are lacking
- The impact of COVID-19 has led to increased concerns about social isolation, lack of health checks and mental health.

- Significant impact to delivery of Mental Health in Aged Care program due to RACFs not allowing workers into facilities and challenges engaging in telehealth without a prior connection between facility and worker.
- A national workforce survey found that in Victoria 51% of staff were aged 39 years or younger, 23% were not permanent employees and 86% were female. More than 20% of personal care workers do not hold a Certificate III qualification. (AIHW 2021g)
- To improve the care of people aged 65 years or older, the following key themes have been noted (AHHA 2021b);
    - Workforce in aged and community care needs to be supported with good employment conditions and professional development opportunities, especially in the areas of palliative care and dementia.
    - Carefully assess the appropriate staffing ratios in rural and remote areas.
    - Aim towards optimising function so frail people, including those with dementia, can remain as independent as possible.
    - Integrated care service models suited to local context to support older people to be part of their local community. (Gilbert et al 2020)

Community, consumer and carer perspective

Gippsland PHN engagement in 2021 included 313 survey responses from people aged 65-74 years (23% of respondents) and 174 from people aged 75 years or older (13% of respondents). See also under **12. Digital health** and **13. Access to care that meets people's needs**. Many noted that they are "*well looked after*" with good services. Some key themes about what would improve health noted the following (GPHN 2021d):

- Consistent GP every time and ability to access regularly

  "Having the same doctor and keeping the same doctor for a long time"

- Affordable access to specialists with less wait time

  "Reduce the costs of health care"

- There were also mentions of a need for good interaction between providers and improved access to specific services including; palliative care, pain management, emergency care and support for a healthier lifestyle and social supports to stay connected with the community.
- While older people were less likely to want to use digital tools for their health, others have appreciated the benefits:

  "I have loved using telehealth for routine matters. Should only have to go to clinic for matters that can't be handled over the phone or video."

  "…an ageing community who is largely digitally illiterate"

Engagement with people aged 65 years or older in 2018 (HIC 2018) noted the following key findings which continue to reflect older people's needs:

- Loss of capacity and incremental decline was a major concern

  "The depression changed my life a lot. I shut myself up which seems to be typical. I withdrew. I lost interest. I couldn't be bothered watching TV."

- A struggle to maintain their own identity was common

- Health and social service providers' inability to demonstrate empathy and validation was a key barrier

  "Being invisible and being talked down to."
- Concern about doctors not taking the time to explain their diagnoses, reasons for treatments and treatment instructions, both among people with dementia and those with high cognitive function
- The 'traditional' role of older women often extends to a responsibility to access home care and health services for their male partners
- Adult children of ageing parents highlighted the burden of responsibility on families to provide care for people in advanced stages of health decline and dependency
- Access logistics create barriers including; long wait times, cost of services and travel, distance and transport to and from services, limited access to technology and dependence on accommodation near services

  "Dad refuses help and walks to appointments but has had falls on the way." (carer)

  "People are kind, but generally, specialists are completely ignorant of the rural situation, and the inconvenience some of their recommendations and appointments have."
- The importance of health and social service interaction was highlighted as a critical intervention point which can either exacerbate or delay further physical or mental decline

  "We've got endless websites and brochures but it's not helping people." (professional)

Engagement by Gippsland PHN in 2016 continues to be relevant (GPHN 2016):

- 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.
- Main barriers to access services were cost 21%, long wait for appointments 17%, couldn't get there 6%, didn't feel comfortable accessing the service 3%, didn't understand how to access the service 3%.
- 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. 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..."
- A top health issue for older people was transport, including transport/schemes that assist with access to health services.
- Improved access to community support and health services in remote locations were identified as needs.

Key points from engagement by the Latrobe Health Advocate (LHA 2021a) included:

- Important to use different technologies including radio, television, telephones and newer technologies like smartphones.
- Barriers include lack of access to data, technology itself or lack of support to know how to use it. Some stated that navigating websites can be difficult when their hand gets shaky / eyesight deteriorates while others were hesitant or did not trust social media.

- Common interests for this age group - desire to participate in engagement and informal activities like walking groups or social catch ups.
- Some of the barriers to a healthy lifestyle include health conditions such as arthritis, dementia, gambling, care-giving responsibilities, negative attitudes (of self and others), reliance on other people or services.
- COVID-19 lockdowns, hygiene and social distancing measures have created barriers for some people.
- Important to stay connected to others to maintain mental wellbeing and stave off loneliness.

Figure 15. Anne's journey – People 65 years or older.

Anne's journey

Anne is 75 years old and lives independently on a rural property. Anne has enjoyed being a music and singalong volunteer at aged care facilities and would like to remain independent for as long as she can.

Anne has been struggling with her mobility and recently experienced a fall at home.

Anne's daughter discusses transitioning into an aged care facility which upsets Anne.

Anne discusses her concerns about losing her independence with her GP.

Her GP liaises with local services and supports for independent living arrangements.

Anne expresses her desire to have access to a keyboard and sheet music at the facility.

Anne discusses this with her daughter who arranges for it with the GP and facility's help.

Anne feels heard and agrees to transition into the facility when she feels ready.

What didn't help?

- Lack of early communication between Anne and her family to discuss options for Anne to move.
- Feeling like her concerns for her independence were being dismissed by her family.

What helped?

- Her GP listened to her concerns and addressed them in a way that met Anne's need.
- Coordinated care between the GP, local services and the aged care facility helped Anne achieve a smoother transition to her new living arrangements.

Key messages

- Maintaining independence for as long as possible is a goal for many people as they age. What this looks like is different for each person.
- Understanding a person's relationships assists with developing plans and successful transition from independent living into assisted care.

Source: GPHN (2021d)

3. Children and young people (0-25 years)

"If they are not looked after then it affects everything else. I work with youth; it is a ripple effect" [Workshop participant]

"We need the voice of young people about service access…" [Workshop participant]

See **Gippsland population profile** for details about demographics.

Health status

Child health

Child health is closely linked to maternal health, and socioeconomic factors including poverty, housing and employment status, family violence; and whether a person is from a vulnerable community such as rural/remote, indigenous, culturally diverse, or children living in Out of Home Care. See **15. Factors affecting health (or social determinants of health)**. Some selected indictors are highlighted here and in **Table 20**.

- Children need loving relationships, a sense of safety and security at home and in the community, time to play, a toxin free environment and nutrition food for healthy development (Moore et al. 2017).
- The first 1000 days of life are important for health child development. A growing body of evidence suggests that maternal mental health and wellbeing can influence pregnancy, foetal and infant development, and parenting (Lee and Newman 2018).
- An estimated one in five women experience anxiety, depression or both disorders either antenatally or postnatally (Austin et al. 2017).
- The proportion of babies who were low birthweight in Gippsland was 6.3%, similar to Victoria (6.36%), but 15.4% of Aboriginal babies in Gippsland were low birthweight.
- Low breastfeeding rates with all Gippsland LGAs below 50% (except South Gippsland) and very low in Latrobe; 36% compared to 51.4% on Victoria.
- 14.2% of children in Gippsland were developmentally vulnerable in two or more domains at school entry, compared to 10.1% in Victoria.
- The proportion of children who are developmentally vulnerable in emotional domains at school entry is high in Gippsland (10.9%), compared to 8.1% in Victoria. The highest proportions are in Latrobe (15.1%), South Gippsland (10.9%) and Wellington (10.3%).
- Reports of bullying among children are high in Gippsland with over 20% of year 5-6 students reporting being bullied in Bass Coast and Latrobe; compared to 16% in Victoria (DET 2018).

Table 20. Indicators for child health in Gippsland by LGA.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA	Reference
Low birth weight babies (<2,500 grams at birth) (2017)	5.0%		7.0%	7.0%	6.6%	5.6%	6.3%	6.6%	AIHW (2021k)
Low birth weight Aboriginal babies (<2,500 grams at birth) ***Highest PHN*** (2016-18)	NA	NA	16.8%	22.3%	NA	NA	15.4%	10.6%	PHIDU (2021c)
Infants fully breastfed at 3 months ***Latrobe lowest in State*** (2014-15)	49.9%	52.5%	48.8%	36.0%	48.2%	43.5%	NA	51.4%	DET (2018)
Children in low income, welfare-dependent families (2017)	30.7%	21.2%	22.0%	35.6%	31.7%	26.4%	28.8%	19.3%	PHIDU (2021d)
Child protection substantiations per 1,000 population eligible population (2014-15)	20.5	13.7	12.5	25.9	23.2	17.5	19.8	11.4	DHHS, 2014-15
Children aged less than 15 years in jobless families (2016)	14.0%	9.4%	11.1%	18.6%	13.3%	12.4%	13.8%	10.5%	ABS (2016)
Children developmentally vulnerable on one or more domains at school entry (2018)	18.7%	24.0%	20.2%	28.2%	22.4%	26.3%	24.1%	19.9%	PHIDU (2021d)
Children developmentally vulnerable on two or more domains at school entry (2018)	10.2%	15.6%	10.8%	18.8%	13.7%	11.9%	14.2%	10.1%	PHIDU (2021d)
Children developmentally vulnerable in emotional domain at school entry (2018)	8.3%	10.9%	8.3%	15.1%	8.8%	10.3%	10.9%	8.1%	DET (2018)
Children developmentally vulnerable in language and cognitive domain at school entry (2018)	6.1%	7.8%	8.8%	12.0%	7.8%	10.8%	9.5%	6.4%	DET (2018)
Children who report being bullied (year 5-6) (2018)	20.6%	18.4%	17.2%	20.1%	18.4%	18.6%	NA	15.9%	DET (2018)
Estimated number of children aged 2-17 years who were obese (modelled estimates) (2017-18)	10.8%	10.8%	10.7%	10.7%	10.7%	10.8%	10.7%	8.0%	PHIDU (2021d)
Death in infants- average annual Infant mortality rate per 1,000 live births (2014-18)	4.1	NA	2.3	2.8	2.2	NA	2.3	2.9	PHIDU (2021d)

High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

Young people

What we know about young people in Gippsland:

- 80.8% participate in secondary school education (Victoria 86.1%) (PHIDU 2021d), **Table 21**.
- 10.3 live births to mothers aged 15 to 19 years per 1,000, down from 14.9 in 2017, (Victoria 7.7) (AIHW 2019b); the highest rate was 15.3 in Latrobe
- 41.4 youth mortality rate per 100,000, down from 45.2 in 2013-17 (Victoria 31.9; Australia 38.9) (PHIDU 2021d)
- Young people with a disability reported being concerned about mental health, suicide, bullying and emotional abuse. (Mission Australia 2019)
- Young people with a disability are four times more likely to have mental health problems than other children and adolescents (YACVic 2020)
- The Mission Australia Youth Survey compared responses from Gippsland (n=149) with all responses (Mission Australia 2020);
    - The top three issues for young people in Gippsland were all more common than for young people in Victoria:
        - Coping with stress – 55% (Victoria 47%)
        - Body image – 53% (39%)
        - Mental health – 44% (38%)
    - Additional findings include:
        - Treated unfairly due to gender – 47% (53% of females), (Victoria 42%)
        - Treated unfairly due to mental health – 35% in Gippsland (23%)
        - Witnessed unfair treatment due to a person's sexuality – 63% (49%)
        - COVID-19 was rated the most important issue in Australia by 50% of Gippsland respondents, followed by mental health (48%) and equity and discrimination (27%)
        - 22% of respondents from Gippsland reported feeling very sad/sad with their life overall (compared with 9.3% of VIC respondents).
- Alcohol and drug dependence in young people is usually associated with poor mental health (Fildes 2019)
- Increasing rates of young people aged 18-24 years suffering high or very high psychological distress (ARACY 2018)
- Increase in mental ill-health as a result of social isolation and reduced access to employment, education and services (YACVic 2020)
- Young people from rural and regional areas more likely to be concerned about mental health (Fildes 2019).
- Food insecurity affects a large proportion of children in Gippsland with an estimated 21% of parents relying on un-healthy low-cost food, compared to 13% across Victoria.
- Bullying among year 7-9 students was more common than across Victoria (17.5%) in all LGAs except Wellington and reported by over 25% of students in Bass Coast and East Gippsland (DET 2018).

Table 21. Indicators for young people's health in Gippsland by LGA.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA	Reference
Full-time participation in secondary school education at age 16	79.4%	86.3%	81.4%	79.4%	77.7%	81.3%	80.8%	86.1%	ABS (2016)
Learning or Earning at ages 15 to 24 years	81.0%	84.1%	84.3%	76.7%	79.0%	80.1%	80.1%	86.2%	ABS (2016)
Number of live births by mothers aged 15 to 19 years per 1,000 population	3.9		10.3	15.3	11.5	9.6	10.3		AIHW (2019b)
Participation in higher education by school leavers 17 years	17.4%	24.4%	24.5%	21.1%	12.0%	23.2%	20.7%	39.3%	ABS (2016)
Proportion of 15 year old boys who were fully immunised against HPV (2017)	74.1%	86.8%	65.0%	87.7%	96.1%	73.9%	80.4%	76.5%	PHIDU (2021d)
Proportion of 15 year old girls who were fully immunised against HPV (2017)	90.4%	85.3%	73.1%	94.3%	91.7%	78.0%	85.7%	80.0%	PHIDU (2021d)
Year 9 students attaining national minimum literacy standards	90.7%	88.9%	89.8%	87.3%	89.0%	89.7%		92.4%	DET (2018)
Year 9 students attaining national minimum numeracy standards	95.2%	95.9%	97.1%	93.3%	94.2%	96.9%		96.2%	DET (2018)
Adolescents who report being bullied (year 7-9)	25.4%	20.5%	23.4%	24.1%	28.5%	16.7%		17.5%	DET (2018)
Youth mortality (15-24 years) - average annual age-standardised rate (per 100,000) (2015-19)	42.7	45.7	45.7	37.3	64.4	25.2	41.4	31.9	PHIDU (2021d)

High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

The Victorian Child and Adolescent Monitoring System (DET 2018) provides monitoring of selected indicators for students, see **Table 22**. It can be noted that:

- Gippsland has a high proportion of students with special health care needs.
- A high proportion of young people in Outer Gippsland showed high levels of psychological distress.
- Young people in Gippsland had higher rates of smoking, alcohol use and having a trusted adult in their life.
- Access to mental health service estimates are unreliable but Outer Gippsland has low access which appears to be decreasing.
- Access to physical health services is much better than access to mental health services, but Outer Gippsland has lower rates.

Table 22. Indicators from the Victorian Child and Adolescent Monitoring System for Inner and Outer Gippsland and compared to Victoria, DET (2018).

Indicator	Year levels	Inner Gippsland	Outer Gippsland	Victoria	Metro Victoria	Regional Victoria
Young people with special health care needs	8 and 11	21.2%	21.4%	19.5%	19.0%	21.0%
Young people who showed high levels of psychological distress (depressive symptoms)	5, 8 and 11	18.5%	23.1%	20.4%	20.0%	21.5%
Young people who have ever smoked cigarettes	5, 8 and 11	10.1%	12.2%	8.0%	7.0%	10.6%
Young people who have ever drunk alcohol (more than a few sips)	8 and 11	61.1%	72.3%	51.8%	47.3%	64.3%
Sexually active young people who always use a condom	8 and 11	25.1%	23.6%	25.5%	22.2%	33.0%
Young people who report having a trusted adult in their lives	5, 8 and 11	74.4%	70.2%	69.3%	68.2%	72.2%
Young people who can access mental health services (of those with identified need)	8 and 11	48.1%* *(40.0% in 2014)*	25.5%* *(46.0% in 2014)*	37.8% *(41.6% in 2014)*	38.2%	36.7%
Young people who can access physical health services when needed	5, 8 and 11	85.1%	78.3%	83.3%	83.4%	83.0%

Source: DET (2018) * Note: data are unreliable due to relative standard error >25%

Service system

Key services for children and young people include maternal and child health services, provided through local government. Other services include early intervention services, Child FIRST (which links vulnerable children and their families into the relevant services they need), Orange Door provides support for domestic violence and child protection. See also **Mental health and wellbeing, including suicide prevention**.

Services commissioned specifically for Gippsland's children and young people to support region-specific, cross sectoral approaches to early intervention for children and young people with, or at risk of mental illness:

- Four headspace sites:
    - centres in Bairnsdale, Morwell and Wonthaggi and a satellite centre in Sale
    - a GP clinic has been introduced to three headspace sites across Gippsland
    - Youth Advisory Groups are established across three headspace sites
- Primary mental health care:
    - Psychological therapies delivered by range of providers across Gippsland.
    - Calm Kid Central delivered by Developing Minds is an online low intensity service to help children and families with social, emotional or life challenges to learn skills.
- Doctors in Secondary Schools (DISS): general practitioners deliver services in nine secondary schools, providing a range of services including sexual/reproductive health, physical and mental health.
- Enhanced Mental Health Supports in Schools (EMHSS); targeted towards supporting school students to have earlier access for mild to moderate mental health issues; headspace clinicians provide face-to-face counselling to students, within a safe space at their closest headspace center or school. Schools more than 80km from their closest headspace center can access telephone counselling via the Regional Telephone Service.
- A Family Support Program within the stepped care model to provide services and support to families (largely women) around the time of welcoming a baby. These clients are defined as either well/at risk, mild mental illness and moderate mental illness.
- Immunisation program
- Gippsland HealthPathways has a localised referral page to support child mental health referrals, including a child health suite of pathways which consists of 29 clinical pathways to support patient care in Gippsland

Service utilisation

- Immunisation rates for children are generally high across Gippsland (DoH, 2021a), see **Table 23**, with all LGAs meeting the 95% target by age 5 years.
- Medicines and prescribing rates per 1,000 young people in Gippsland LGAs (ACSQHC 2021)
  - Anti-depressants: 62-145 (Victoria 78)
  - ADHD medicines: 13-26 (Victoria 10)

Table 23. Immunisation rates and medication use among children in Gippsland by SA3.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	GIPPSLAND	VICTORIA	Australia	Currency
1 year old children fully immunised	94.1%	95.5%	95.8%	97.0%	96.3%	95.7%	95.1%	94.9%	2020
2 year old children fully immunised	91.2%	94.8%	96.3%	94.6%	94.7%	94.2%	93.2%	92.6%	2020
5 year old children fully immunised	95.7%	97.1%	98.1%	96.7%	97.8%	97.0%	96.1%	95.1%	2020
ADHD medicine scripts dispensed for people 17 years and under, age-standardised rate per 100,000 people*	17,225	26,144	14,900	18,152	13,188	NA	9,847	14,061	2016-17
Antidepressant medicines, 17 years and under, age-standardised rate per 100,000 people*	10,605	8,813	14,159	14,525	6,229	NA	7,789	7,989	2013-14
Antimicrobial dispensing for children 9 years or younger, age-standardised rate per 100,000 people*	75,967	81,331	58,209	72,287	75,156	NA	93,640	97,202	2016-17
Antipsychotic medicines, aged 17 years and under, age-standardised rate per 100,000 people*	2,140	2,089	2,778	2,281	1,485	NA	1,885	2,256	2016-17
Asthma medicines, aged 3 to 19 years, age-standardised rate per 100,000 people*	26,952	37,331	23,613	30,678	24,962	NA	23,810	25,750	2013-14

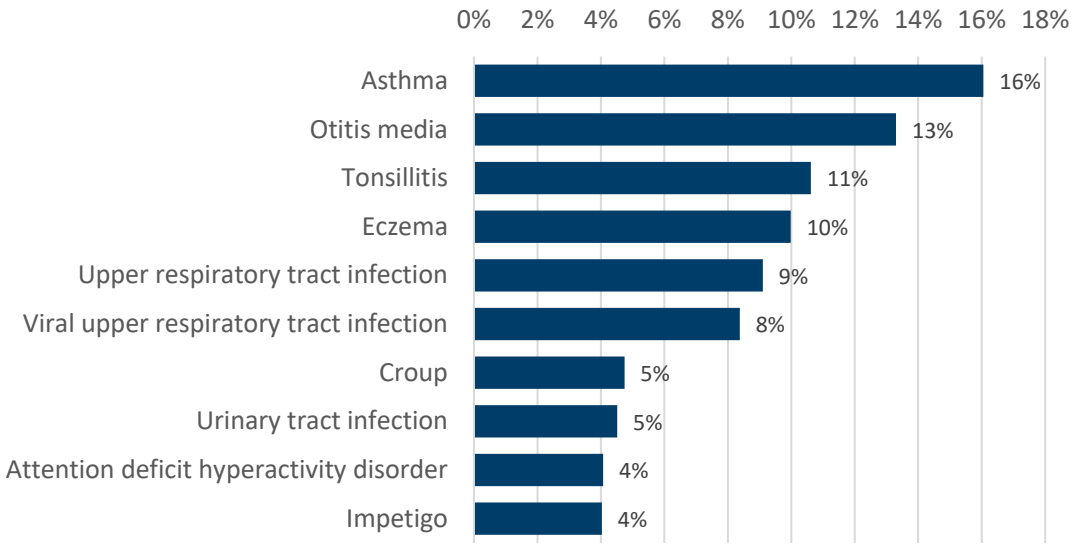
Source: DoH (2021a) and *ACSQHC (2021)

High compared to Australian SA3s, top 25%
Low compared to Australian SA3s, bottom 25%

General practice

- Asthma was the most common diagnosis seen among 16% of 0-25 year olds in general practice, followed by otitis media 13%, tonsillitis 11%, eczema 10% and upper respiratory tract infections 9%. See **Figure 16**; 4% had attention deficit hyperactivity disorder (ADHD).
- The top new diagnoses by year reveal that mental health diagnoses have increased to over 1,000 in 2019-20, see **Table 24**. In 2020-21, there were 1,161 new mental health diagnoses in this age group.
- Immunisation is the most common activity for the 0-24 year age group in general practice.

Figure 16. Top 10 active diagnoses for active patients aged 0-25 years, 2020-21.



Source: GPHN (2021e)

Table 24. Top new diagnoses for patients aged 0-25 years in Gippsland by year

Diagnosis	2017-18	2018-19	2019-20
Viral upper respiratory tract infection	2,115	2,063	1,604
Asthma	1,360	1,414	1,438
Otitis media	1,413	1,275	1,123
Upper respiratory tract infection	1,157	1,165	1,406
Tonsillitis	1,169	1,076	1,039
Viral infection	809	821	905
Mental health	633	836	1,050
Eczema	790	823	826

Source: GPHN (2021e)

Commissioned services

headspace services

- In 2020-21, there was a total of 1,498 active clients accessing headspace services (up from 1,258 in 2019-20) across Gippsland (GPHN 2021i).
- There was a total of 6,115 occasions of services provided in 2020-21 (a slight reduction from 6,406 in 2019-20); average of 4.1 occasions of service per person in 2020-21, (5.1 in 2019-20).
- An estimated 3.6% of people in Gippsland aged 12-25 years received a headspace service in 2020-21. See **Table 25**. East Gippsland and Bass Coast had the highest rates at 5.5% and 5.4%, while the lowest was in Wellington at 1.5% (the Sale satellite service is the newest headspace center in Gippsland, opening in July 2020).
- Mode of service delivery shifted from 77% face to face in 2019-20 to 34% in 2020-21; telephone and video calls became more common, see **Table 26**.
- An analysis of monthly occasions of service between January 2020 and August 2021 showed the highest activity in July -September 2020 with over 600 occasions per month across Gippsland and the lowest activity was in January 2021 (331), December 2020 (430), February 2021 (437) and March 2020 (443).
- Wait times have increased from an average of 4.6 days in August 2020 to 18.6 days in June 2021; 14.9 days in August 2021; Bairnsdale and Sale have longer wait times (23 days), compared to 18 days in Wonthaggi and 6 days in Morwell (2021).

Table 25. Residential LGA of headspace clients and estimated proportion of people aged 12-25 years receiving a service by LGA, 2020-21.

LGA	Number of people serviced by a headspace centre	Population 12-25 years*	Per cent of total population
Bass Coast	215	3,985	5.4%
South Gippsland	168	4,047	4.2%
Baw Baw	286	7,809	3.7%
Latrobe	367	12,714	2.9%
East Gippsland	328	5,985	5.5%
Wellington	101	6,652	1.5%

Source: GPHN (2021i) and *ABS (2016)

Table 26. Mode of delivery of headspace occasions of service 2019-20 and 2020-21, Gippsland.

Mode	2019-20	2020-21
Face to face	76.9%	33.8%
Telephone	16.9%	50.0%
Video call	6.1%	15.5%

Source: GPHN (2021i)

Client characteristics

- 59% were female; 29% were male; 2.1% stated 'other'
- 62% were aged 12-17 years; 36% were aged 18-24 years
- 5.4% were Indigenous
- 96% spoke English as the main language at home
- 33% identified as LGBTIGA+

Service contact characteristics (GPHN 2020a)

- 48% were health care card holders
- 4% were NDIS participants
- 16% had a GP mental health plan

- 63% were structured psychological intervention, 24% assessment and 7.3% clinical care coordination/ liaison
- 24% were employed, 16% unemployed and 14% not in the workforce (46% not stated)
- 15% were in paid employment, 22% were on a pension or benefit, 3% were on a disability support pension, 17% had no income; 38% aged less than 16 years
- 70% were self-referred, 5.4% were referred by a GP and 12% by someone else (12% not stated)
- 85% of service contacts were for a client with a missing or unknown diagnosis (**Table 27**). Anxiety disorders (4.8%) was the most common diagnosed condition, followed by mood disorders (4.7%).
- 34% were with a social worker, 16% with a general psychologist, 5% with a doctor and 2% with a peer support worker; 43% were with another professional.

A significant improvement in outcomes was seen for 33% of 12-17 year olds and 45% of 18-24 year olds. See **Table 28**.

Table 27. Service contact characteristics by principal diagnosis: grouped for Gippsland

PRINCIPAL DIAGNOSIS: GROUPED	SERVICE CONTACTS	
	N	%
Anxiety disorders	308	4.8
Affective (mood) disorders	298	4.7
Disorders with onset usually occurring in childhood and adolescence not listed elsewhere	57	0.9
Other mental disorders	229	3.6
No formal mental disorder but subsyndromal problems	42	0.7
Missing or unknown	5,472	85.4

Source: GPHN (2020a)

Table 28. Client outcomes- child and youth-specific mental health services for Gippsland

CLIENT AGE GROUP	SIGNIFICANT IMPROVEMENT %	NO SIGNIFICANT CHANGE %	SIGNIFICANT DETERIORATION %	EPISODE COUNT
12-17	32.8	51.5	15.7	470
18-24	44.6	47.3	8.0	224

Source: GPHN (2020a)

Doctors in Secondary Schools

- The Doctors in Secondary Schools program delivered 890 services in 2019-20 and 740 services in 2020-21.

Hospital activity

The rate of emergency department attendances in Gippsland is high for both children under 15 years and for 15-24 year olds. See **Table 29**.

Table 29. Emergency department presentations for lower urgency care for Gippsland residents aged less than 15 years and 15-24 years, 2018-19.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	GIPPSLAND	Australia
People 15 years or less, rate per 1,000 people	255	328	233	311	177	262	181
People 15-24 years, rate per 1,000 people	221	302	286	319	191	265	144

Source: AIHW (2020b)

High compared to Australian SA3s, top 25%
Low compared to Australian SA3s, bottom 25%

Professional stakeholder perspective

- The health of children and young people were consistently top rated priority areas by professional stakeholders. (GPHN 2021f)
- A stable clinical workforce supporting the delivery of youth mental health services remains a challenge. In particular, the Enhanced Mental Health Support in Schools (EMHSS) program has been impacted by a lack of available workforce and the COVID-19 pandemic.
- The youth mental health service system in Gippsland has improved in recent years with some good examples of school programs, co-designed resources and improved access to headspace services. However, this is patchy and there is a lack of capacity to manage more complex cases.
- Service gaps for children remain across the catchment and are especially significant in more remote parts of Gippsland.

  "…need paediatric psychologists, we have so many diagnoses in the little people." [Workshop participant]

- Services stressed the need for early intervention strategies for self-harm and suicide, eating disorders and body image issues among young people.

  "Interventions such as free mental health training for students, teachers, families and in between. More local activities, projects, and jobs for youth to get involved in."

- Barriers and enablers for rural mental health services were identified in a study (Orygen 2018)

- Barriers: limited transportation, parent consent, restricted access to services; limited doctors and counsellors; negative social proximity/stigma; staff recruitment and retention issues; non-youth friendly spaces; limited funding.
- Enablers: positive social proximity; community support; bulk-billing drop in services; creation of the consortium; multi-skilled youth friendly staff; mature minor status.
- Recommendations: additional mental health professionals; funded psychologist/mental health nurse; youth friendly spaces with access to mental health first aid courses; increased advertising.
- headspace: consult with four local Youth Access Clinics to gain community knowledge and program delivery expertise; provide additional services and funding through hub and spoke model; provide increased outreach services.

- Feedback from youth specific services commissioned by Gippsland PHN includes the following key themes:
  - 'Do Not Attends' remain a challenge and a main reason is transport issues.
  - During the COVID-19 pandemic, there was an increase in 12-15 year olds accessing a service via telehealth. For others, telehealth can be a barrier for access.
  - headspace waiting lists are managed via a triage and priority method whereby young people remain engaged whilst waiting for a clinical service.
  - Challenges identified include:
    - There is a lack of knowledge by health professionals about local referral options, leading to underuse of some services while others have waiting lists
    - Long waiting lists are a challenge and there are reports that it has become worse, including for psychology and some agencies are no longer taking new referrals
    - Higher reporting of anxiety among young people related to a strain on relationships with families and friendships
    - An increase in reports of violence and anger
    - An increase in discussions about self-harm and suicidal ideation
    - An increase in the complexity of students accessing DISS
    - Inconsistent appointment system for students to access the DISS clinic.
  - Some things have improved:
    - The Doctors in Secondary Schools (DISS) program has matured and strong relationships and collaboration with some school wellbeing teams has benefitted students and enabled improved access to support
    - Acceptance of DISS clinic as a 'normal' part of secondary school activity at some schools, leading to improved engagement with students and parents
    - Access to specialist consults for students through telehealth has reduced waiting times
    - Reports of good outcomes from students who have accessed the service; for example, enabling students to manage conditions such as anxiety and allowing them to continue schooling
    - The 2021 introduction and of the HeadtoHelp services has improved referral options.
- Workers in organisations supporting children and young people are concerned there are 'fewer eyes on kids', with some perceiving the risks faced by vulnerable children and young people during lockdown as outweighing COVID (CCYP 2020).
- Service changes that are needed are suggested:

- wrap around service models with good communications and integration within and between services;
- more comprehensive screening antenatally of alcohol use;
- cultural literacy and culturally sensitive practice;
- greater use of trauma informed practice and family centred practice;
- greater consideration given to health literacy of consumers; and
- better transition from paediatric to adult service systems.

- There is concern about bullying affecting children and young people (GPHN 2021f).
- A Monash School of Rural Health Summer Research Scholar project looked at the need for integrated child and family mental health services in the early years (GPHN 2021j). The focus was on providing early intervention strategies for families who are currently well or at risk of developing mental health issues. The project included eight interviews with professionals in Gippsland and the main findings are summarised in **Table 30**.

Table 30. Main themes from interviews with professionals who work with children and mental health in Gippsland.

THEME	PARTICIPANTS DESCRIBED	QUOTES
RESOURCES REQUIRED	• Gaps in perinatal mental health workforce • Limited pathways for referral • Lack of knowledge of services available • Barriers to accessing services	*"People can't always afford to access private services and even with a mental health care plan there's a lot of out-of-pocket expenses which people struggle with too."*
COLLABORATION BETWEEN SERVICES	• Shared goals, mutual respect and trust between providers • Services have distinct roles and responsibilities • Antenatal hospital-based services • Postnatal care providers including maternal and child health (MHC) nurses and perinatal mental health clinicians • Limited by an overzealous approach to maintaining confidentiality and consent	*"Often within a hospital system …, the information sharing is a bit easier because the medical record tends to go with the client to different units.* *Whereas [MCH] have our own record system and we can't share that, the Health Act prohibits us from sharing that and all of the people who have health records would be in the same position."*
PROVISION OF TIMELY TREATMENT	• Importance of timely treatment for early intervention • Accessing appropriate and timely referral options was difficult • Early intervention strategies including community support such a play groups, parenting groups with links to services	*"The difficulty is we can do the referrals, but people might be waiting for weeks or months to get an appointment. And getting it immediately is of great importance, because the problems are all festering away while they're waiting…"*

Key elements of integrated care for perinatal mental health were identified:

- Perinatal mental health screening is integrated into routine antenatal procedures
- Appropriate perinatal mental health training for service providers including GPs, MCH nurse/ clinicians to identify clients at risk of mental health issues
- Appropriate referral pathways with established protocols for effective case management
- Appropriate care coordination and follow up of patients
- Appropriate measurements of outcomes for program evaluation

AN EXAMPLE OF BEST PRACTICE

Our Place (n.d.) is a holistic place-based approach to supporting the education, health and development of all children and families in disadvantaged communities by utilising the universal platform of a school. The Our Place approach builds on evidence that education is key to addressing the equity gap. The Morwell site uses a partnership approach, including Morwell Central Primary School, Latrobe City, TAFE Gippsland, Victorian DFFH and DET and Goodstart Early Learning. Site priorities build on extensive community engagement and include:

- Children in the Morwell community grow up healthy and happy; including through improved access to a broad range of supports and information about child development and services, including access to a Maternal and Child Health Nurse at school
- Supporting families; including access to medical services at school
- Children can access a range of afterschool activities
- Families in Morwell feel connected to the community; social activities and inclusive of fathers and male carers
- Improve adult learning and employment opportunities

Community, consumer and carer perspective

Consultations with community by Gippsland PHN has identified several service gaps for children and young people in Gippsland:

- Difficulties accessing required services were related to high demand and long wait times, cost and a need to travel long distances when there was no service in the local area.
- Service gaps were noted for parenting support, early intervention services, early psychosis services, child mental health services, cancer support services, paediatric oncology services, public dental services, foetal alcohol screening services, and transgender services.
- Complexity of the services system and fear of stigma, discrimination and referral to the child protection system were also noted by some groups.
- Workforce gaps were noted across a wide range of areas making early intervention challenging. Gaps include lack of access to paediatricians, child psychologists, occupational therapists, speech therapists, hearing health workforce and workers with cultural competency and sensitivity to minority groups. These gaps were especially pronounced in the more remote parts of Gippsland.
- A lack of awareness of autism spectrum disorder among health professionals, especially GPs, and also among culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities
- Key health issues important to parents/carers of children include healthy living, child mental health and suicide, bullying, rising screen time, decreasing physical activity and poor diets, illegal drug use, family violence, child neglect and immunisation.

  "I have a disabled child. Not as much here for child (speech therapy and tutoring) as in [other more central location] and it's very expensive.

  "… we have a visiting paediatrician but to have access to a team of allied health would be fantastic"

  "Early childhood supports are needed: you can get extra early childhood support if you are willing to travel 4 hours for it…"

A Gippsland PHN survey in 2021 included 49 survey responses from people aged 18-25 years (3.5% of respondents). Main themes about what would improve their health (GPHN 2021d):

- Reduce costs of services, including GP, tests and specialists.

  "…affordable services to allow everyone access them."

- Doctors you can communicate well with.

  "…a lot of doctors I have been to especially in bulk billing clinics cannot understand my concerns, nor can I understand their responses."

- Additional factors mentioned were shorter waiting times, after work appointments, more allied health staff, ability to make appointments online and continued free access to telehealth

Figure 17. Suni's journey – Children and young people (0-25 years).

Suni's journey

Suni is 13 years old. She recently transitioned to a new high school and has been struggling with low self-esteem following difficulties making friends. Her mother notices that she may need some help for her mental health and wellbeing.

Suni's mother discusses mental health support with the school's wellbeing team.

Suni accesses support through the Enhancing Mental Health Services in Schools program.

It's Suni's first time accessing mental health support. She feels anxious about the appointment.

Suni reveals that she has experienced anxiety in class and social settings.

She is referred for Cognitive Behavioural Therapy (CBT) to address her symptoms of anxiety.

The sessions address Suni's negative automatic thoughts, mindfulness and stress reduction strategies.

Over six sessions, Suni engages well despite high levels of anxiety in appointments.

What helped?

- Her clinician suggested that despite her anxiety, Suni's engagement was attributed to the support being available in a familiar environment at school.
- A pathway at her school that ensured timely referral to mental health support.

What didn't help?

- Suni lost touch with her friends at her old school and found it difficult to engage with her new peers.
- Her social anxiety led her to disengage from her interests such as sport and theatre.

Key messages

What is important:

- Awareness of pathways to access mental health support.
- Familiarity of the school environment can help young people to better engage with mental health support services.
- Education on stress reduction and relational wellbeing can be helpful for young people to manage their mental health.

Source: GPHN (2021d)

4. People with a disability

"… if it's not physically accessible then the whole thing is useless to me. It all depends on who you are (I have chronic health issues and am a wheelchair user)."
[Workshop participant]

Health status

The definition of disability varies between data sources, and this limits our understanding of the needs of people with a disability. It is estimated that 17.7% of people in Australia have a disability (AIHW 2020c) and about a third of them have a profound or severe disability. Main conditions causing the disability;

- 77% physical conditions, including back problems, arthritis, hearing loss, heart disease, stroke, cerebral palsy and multiple sclerosis
- 23% mental or behavioural conditions, including intellectual and developmental disability, autism, depression and dementia

It is also known that:

- The longer people live, the more likely they are to experience some form of disability; 7.6% of children aged 0-14 have a disability compared to 50% of people aged 65 or over.
- Among children, boys are more likely to have a disability; 9.5% compared to 5.7% for girls.
- 24% of Indigenous people have a disability; 8.8% have a severe or profound disability (AIHW 2021i).

In Gippsland, it is estimated that:

- There are a total of over 50,000 people with a disability (based on 17.7% with a disability).

6.7% of people (or 17,142 people) have a profound or severe disability, compared to 5.4% of people in Victoria. See **Table 31**.

- Around 28,000 people provide unpaid assistance to a person with a disability.
- 8.1% of people (aged 16-64 years) receive a disability support pension, compared to 4.9% in Victoria; the highest rates are in Bass Coast (9.0%), East Gippsland (10.4%) and Latrobe (9.8%).

Table 31. People with a disability by local government area in Gippsland and comparison to Victoria, 2016 (ABS 2016).

	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland	Victoria
Number of people with a profound or severe disability	2,155	1,586	2,694	5,109	3,055	2,543	17,142	301,480
People with severe and profound disability (all ages)	7.0%	6.0%	5.9%	7.5%	7.2%	6.3%	6.7%	5.4%
Provided unpaid assistance to persons with a disability	3,499	3,018	4,963	7,315	4,845	4,291	27,931	560,866
Disability support pensioners (proportion of 16-64 year olds) (PHIDU 2021d)	8.0%	6.3%	5.4%	9.9%	9.9%	7.4%	8.1%	4.2%

High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

People with a disability generally have poorer health compared to people without a disability;

- 24% of adults with disability rate their health as excellent or very good (65% of adults without disability)
- 32% of adults with disability experience high or very high psychological distress (8.0% without disability)
- 72% are overweight or obese (41%)
- 54% have hypertension (27%).

Underlying factors that contribute to poorer health outcomes for people with a disability include (estimates for people 15 years or older);

- only 46% are employed (compared to 80% of people without a disability)
- 51% with a severe or profound disability have a low level of personal income (27%)
- 47% have experienced violence (36%)
- 9.6% experienced disability discrimination
- 16% rent from housing authority (4%)
- 24% lived alone (10%)
- 33% avoid situations due to their disability, including social interactions and seeking healthcare (12%)
- 47% do not eat recommended fruits and vegetables (41%)
- 18% smoke (12%)
- 72% do not meet recommended physical activity guidelines (52%).

Service system

The introduction of the National Disability Insurance Scheme (NDIS) has changed the system to include a larger number of providers to meet a range of needs, aligned with NDIS funding item categories. Funding categories include assistance with personal care, social and community participation, employment, housing, life skills, transport, therapies, early intervention services, accommodation/tenancy assistance and independent living support. Some of these can also be group services. There are providers of equipment and or technology that enable more independence such vehicle modifications, communication aides, home modification, personal mobility. There are also services such as support coordination and plan management, focusing on securing services, and budget management and invoices.

The service system is complex. Some services must be NDIS registered, and there are different rules for participants who manage their own NDIS plans.

In 2021, there were 754 active NDIS service providers across support categories in Gippsland (**Table 32**). The number of participants per provider is lower, making it more challenging for providers to service a broad range of needs. Providers include community health services, other not for profit providers, allied health professionals and sole traders. Not for profit providers include Mirradong, Noweyung, Scope, Interchange Gippsland, Headway Gippsland, Aruma, Wellways, and Mawarra. Link Health is the early Childhood Early Intervention NDIS partner for Gippsland.

In addition to these services there are a number of support groups, as well as peak bodies that people with disabilities and/or their carers have links with.

Table 32. NDIS providers by local government area in Gippsland and comparison to Victoria, 2021.

	Active providers	Participants per provider
Bass Coast	110	6.4
Baw Baw	145	7.8
East Gippsland	94	11.6
Latrobe	200	11.0
South Gippsland	88	6.8
Wellington	117	8.6
Gippsland	**754**	**8.9**
Victoria	**5,571**	**21.6**

Absolutely everyone: State Disability Plan 2017–2020 reflects a social model of disability and is the government's strategic policy on disability. It sets out the vision of an inclusive Victoria that supports people with disability to live satisfying everyday lives and participate on an equal basis with other Victorians.

Victorian carer strategy 2018–22 aims to support carers where they need it most. Its five priority areas: health and wellbeing; be engaged in education, employment and community; access to respite and other supports; financial security; and recognition, acknowledgment and respect.

Local Government and Peak bodies

- Disability Act 2006 requires public authorities and local governments to prepare Disability Action Plans to reduce barriers to employment, promote community inclusion and bring about changes in attitudes and practices. All Councils in Gippsland have Disability Action Plans.
- Many national peak bodies, such as Downs Syndrome Australia, Australian Autism Alliance, Deafness Forum of Australia, Cystic Fibrosis Australia, Cerebral Palsy Alliance, Vision Australia, MS Australia, Muscular Dystrophy Australia and Parkinson's Australia.

Gippsland PHN's Psychosocial Support Program (PSP) is an integrated and strengths-based service delivery model, providing individual and group-based supports with several purpose-built service streams, including transition support services and continuity of support services for former clients of Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMs) program. New clients not eligible for the National Disability Insurance Scheme (NDIS) are serviced under the National Psychosocial Support Measure (NPSM). One of the immediate aims for the PSP is to transition those clients currently being funded under the "Transition" stream provided by the three previous Partners in Recovery program providers to either the National Disability Insurance Scheme (NDIS), the Continuity of Support stream, or another program.

The NPSM provides short-term support to people with severe mental illness and reduced functional capacity. Services are delivered Gippsland-wide through a variety of individual 1:1 and group-based supports available. This program has been designed specifically to meet the needs of people who are not eligible to receive services under the NDIS, but who would benefit but would benefit from receiving a level of specialised, less intensive psychosocial support linked to their needs and goals. Clients presenting with permanently impaired functional capacity associated with their mental health condition should be considered for the NDIS.

Gippsland HealthPathways to support local health professionals access reliable clinical information, assessment tools and referral options

Service use

Some data collections, such as on hospital admissions, do not identify disability at all.

General practice

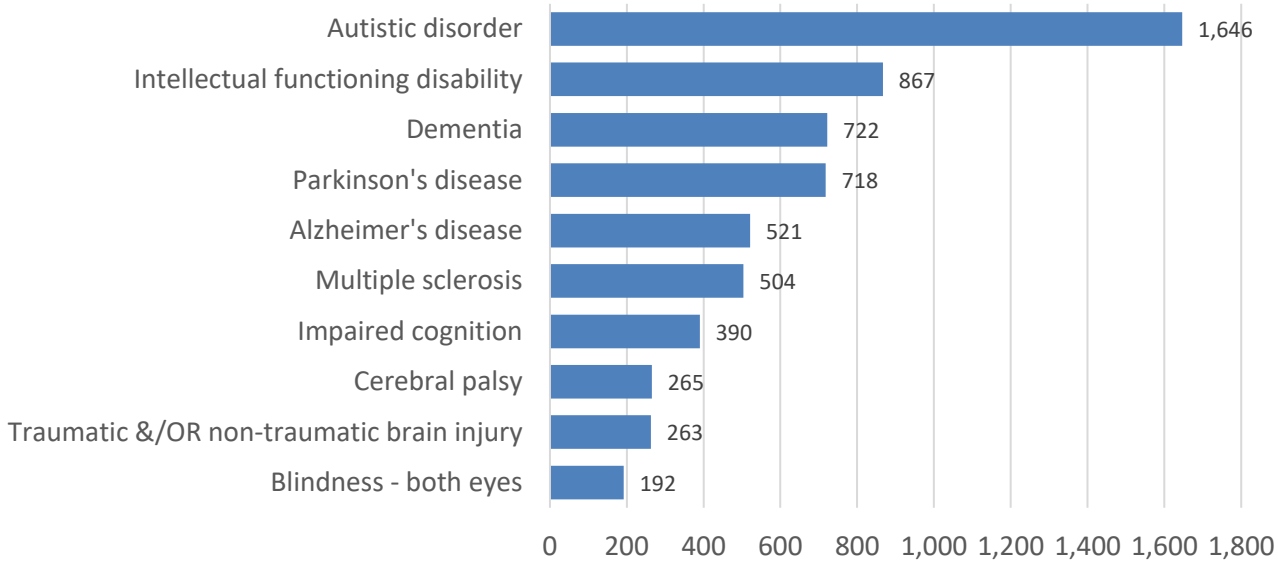
- GP data for Gippsland indicate that the number of people that recorded a new disability related diagnosis increased from 1,535 in 2017-18 to 1,818 in 2019-20; with males recording a higher number compared to females. Latrobe and Wellington recorded the highest numbers.
- New disability related diagnoses were more common among younger (0-29 years) and older patients (60+ years) compared to middle aged patients (30-59 years) (Table xx).
- 2.6% of all active patients in general practice had a disability related diagnosis in 2020-21, higher for males (2.9%) than females (2.2%). The age groups with the highest proportions of patients with an active disability diagnosis were 10-19 years and patients 80 years and older (**Table 33**). Bass Coast had the highest rate at 3.1%.
- The most common active disability diagnosis in 2020/21 was autistic disorder (21.4% of all disability diagnoses), followed by intellectual functioning disability (11.2%) and dementia (9.4%), (**Figure 18**).

Table 33. Prevalence of active patients with an active disability related diagnosis in 2020-21, by age group.

Age group	Number of patients	Proportion of all patients
0-9	512	1.7%
10-19	1,093	4.1%
20-29	671	2.0%
30-39	544	1.5%
40-49	537	1.7%
50-59	696	1.7%
60-69	856	1.8%
70-79	1,155	3.0%
80+	1,644	8.6%
All ages	7,708	2.6%

Source: GPHN (2021e)

Figure 18. Top 10 active disability related diagnoses in general practice, 2020-21.



Source: GPHN (2021e)

Gippsland PHN commissioned services data

- A total of 243 people accessed 3,848 Psychosocial Support services during 2020-21.
- Each person accessed on average 17.68 hours of support at an average cost of approximately $260 per session.
- The average length of time on waiting list before accessing services is 14 to 21 days.

Case study

A male client referred himself for psychosocial support, groups and to access the NDIS. Client has diagnosis of Bipolar, Borderline Personality Disorder, Depression and Anxiety, and is taking prescribed medication. Client referred himself due to his ex-wife divorcing him, becoming homeless and psychiatric hospital admissions. Client's son was attending the program and was accepted for the NDIS, which gave client the courage for self-referral to get the supports he needs.

When client entered the program his only formal support was a General Practitioner. Client was encouraged by psychosocial support facilitator to seek a Mental Health Plan from his GP and to ask for a referral to see a Psychologist and Psychiatrist. The psychosocial support program also facilitated a referral to a Family Violence Support Service and client is now currently accessing their supports.

Client had experienced significant trauma, and the psychosocial program has assisted client with seeking other supports and programs. For example, the client is now attending a therapeutic day rehabilitation program and trauma counselling. Client is getting regular support from the local hospital mental health team. Client is attending art group, walking group, eco therapy groups and wishes to continue attending all groups.

The client is now being supported to gather evidence for NDIS Application, and support with submitting the application/evidence to the NDIA.

National Disability Insurance Scheme

Participants in the NDIS have reported some improvements in health and wellbeing, including less hospital visits and fewer females with high psychological distress (NDIS 2020). COVID-19 has however led to more challenges accessing healthcare.
Data from the National Disability Insurance Scheme (NDIS, 2021) show that in Gippsland (see **Table 34**):

- 6,740 active participants – this is 39% of the estimated number of people with a profound or severe disability in Gippsland
- An average plan budget of between $28,783 (South Gippsland) and $34,622 (Bass Coast).
- A budget utilisation rate of between 62% (Wellington) and 67% (Baw Baw), compared to 67% across Victoria.
- An analysis of utilisation rates by LGA, age group and condition reveal rates below 50% for some sub-groups across Gippsland:
    - Children 0-6 years
    - Developmental delay
    - Hearing impairment

- 4.6% Indigenous participants (2.9% in Victoria); highest rates in East Gippsland (9.9%), Latrobe (5.3%) and Wellington (4.3%)
- 2.6% CALD participants (11.6% in Victoria)
- Age group of participants:
    - 13% of participants in Gippsland were aged 0-6 years (17% in Victoria)
    - 24% were 7-14 years (25%)
    - 14% 15-24 years (14%)
    - 49% 25 years or older (44%)
- Primary disability of participants:
    - Autism 26% in Gippsland (30% in Victoria)
    - Intellectual disability and Down syndrome 22% (20%)
    - Psychosocial disability 15% (13%)
    - Developmental delay 10% (12%)
    - Other disability 28% (25%)
- Level of functioning of participants:
    - 26% of participants in Gippsland had a high level of functioning (29% in Victoria)
    - 45% medium level (43%)
    - 30% low (28%)
- Between 71% (Wellington) and 76% (Bass Coast) of participants in Gippsland reported that the NDIS has helped with choice and control.

Table 34. NDIS participation by local government area in Gippsland and comparison to Victoria.

	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland	Victoria
NDIS participants with active plans	707	600	1,135	2,201	1,093	1,004	6,740	120,375
NDIS participants with active plans - per 1,000 population	18.8	19.8	20.3	28.8	22.6	22.4	23.0	17.5
NDIS participants with active plans - Indigenous	3.3%	2.7%	2.4%	5.3%	9.9%	4.3%	NA	2.9%

Source: NDIS (2021)

Professional stakeholder perspective

Stakeholder consultation by Gippsland PHN (GPHN 2021f) have noted some specific challenges for people with a disability:

- A need to have built infrastructure that enables access to services, mobility, social participation and community connectedness.
- Service gaps were identified in relation to children with autism, especially in the more remote parts of the catchment.
- Workforce shortages related to disability were reported in paediatric speech therapy, paediatric care, and in child, youth and adult mental health.
- Need for increased health workforce skills in working with people with disability.
- It is fundamental to improve health literacy among professionals to enable a suitable approach to face to face communication and in the provision of visual resources around health conditions and their prevention and management. There are good examples recently prepared for COVID-19.
- Comorbidities among people with a disability can result from poor oral and/or personal hygiene, poor diet, lower levels of physical activity, tobacco use, alcohol use and poor management of acute health problems and injuries. Anxiety and depression are also common.
- Possible reasons for low use of NDIS include workforce shortages, and challenges in understanding, accessing and navigating the NDIS.
- There is a need to increase the number of NDIS providers; it can be very hard to find suitable referral options.
- Mainstream services need to be accessible and able to manage people with a disability as part of the broader health system, including GPs and practice nurses who could play a more prominent role in supporting people with a disability, including assistance in accessing NDIS.
- Support for general practice to facilitate patients to link with specialists via telehealth to allow more timely access for people in regional areas.
- Measure outcomes and wellbeing

Nationally, a survey has found that people with disability have been significantly impacted by COVID-19 due to increased expenses, changes to supports, including NDIS supports, and changes to healthcare. As a vulnerable group, dependent on support, the risk is higher (AIHW 2020c).

Community, consumer and carer perspective

Community engagement by Gippsland PHN (GPHN 2016) highlighted barriers for people with a disability;

- Use healthcare services more, including GPs, ED attendances, community health services, allied health services, ambulance service and pharmacy visits.
- Main barriers to access healthcare services:
    - Cost 48%
    - Long wait for appointments 36%
    - Couldn’t get there 23%
    - Didn’t understand how to access the service 7%
    - Didn’t feel comfortable accessing the service 5%
- More likely to report a health problem that had not been well managed; 44% compared to 22%.
- Less confident of being able to access needed healthcare; 26% compared to 10%.

- Parking and wheelchair access are still key issues.

  "Accessibility of services … No, it is not getting better. My GP doesn't have an accessible toilet…"
- Social isolation was noted as especially problematic for people with a disability
- Housing and employment concerns.
- There are service gaps for children with autism.

Themes from 2021 engagement about what would improve health noted the following themes (GPHN 2021d):

- Timely, local appointments with preferred GP

  "…we need more GPs to keep up with demand. It's a 4 to 6 week wait."
- A regular GP who is genuinely interested and knowledgeable about relevant conditions
- "*Keeping telehealth services and electronic scripts for the long term"* was noted as helpful by some, but overall people with a disability were less likely to use a smartphone, smart device or desktop computer; 77% used a smartphone compared to 88% of all participants.
- Transport/travel support to make it easier to access services and supports
- Cost reduction through bulk billing, travel costs, specialist appointments
- Team based care with good communication between doctor, specialist and allied health
- Social supports are very important, including neighbourhood houses.
- Access to support after hours and general practitioners who service aged and disability care homes.

  "… having someone you could call at times."

Figure 19. Sam's journey – People with a disability.

Sam's journey

Sam is 46 years old. He lives with a chronic autoimmune disease and uses a wheelchair. He lives regionally and accesses specialist care from a metropolitan hospital 450 kilometres away. He had a flare up of his condition and is unable to see his usual GP quickly.

Sam sees another GP and is referred to a specialist in the city. He requires transport to get there.

The GP organises this through the patient transport scheme. The round trip takes six hours.

It consists of being driven to the airport, flown to the city and driven to his appointment.

He is unsure of his arrival time making it difficult to book the appointment at a particular time.

He misses his appointment due to travel delays and feels the trip has been wasted.

He could not use his wheelchair for part of the journey. This made Sam feel anxious.

It made him feel as though he had lost his independence. He wants to rectify this next time.

What didn't help?

- Lack of timely access to his usual GP.
- Lack of understanding of the issues he faces as a wheelchair user.
- Lack of awareness of where to provide feedback so he can advocate for himself and readjust his travel arrangements.

What would help?

- Accessing timely interventions that considered Sam's knowledge of his condition and incorporated it into the treatment plan.
- Telehealth specialist appointments facilitated by his GP may help reduce the need for him to travel.

Key messages

- Being heard and able to advocate for themselves and their care is important to people with a disability.
- Finding health professionals who understands them, their disability and their circumstances can be difficult.
- Accessing services and supports that accommodate for their disability and meet their needs is often a challenge.

Source: GPHN (2021d)

5. Alcohol and other drugs

"AOD is closely tied to MH, when people have AOD issues, generally underlying mental health issue. Do we need to cluster the two?" [Workshop participant]

Health status

In Australia, mental and substance use disorders was the fourth highest cause of burden of disease (as DALY) at 12.1% (AIHW 2020d).

- Mental and substance use disorders was the second leading cause of non-fatal burden of disease, contributing to 23% of non-fatal burden.
- Alcohol use disorders was the 15th cause of death nationally; the rate was double the national rate in remote and very remote areas.
- In 2015, 4.5% of the disease burden in Australia was due to alcohol use, making it the 6th leading risk factor contributing to disease burden.
    - Alcohol use contributed to the burden of 30 diseases and injuries including alcohol use disorders, 8 types of cancer, chronic liver disease and 12 types of injury— predominantly road traffic injuries and suicide & self-inflicted injuries.
    - Males experienced a greater amount of burden due to alcohol use than females in most age groups. For males, alcohol use attributable burden peaked during ages 25–44, primarily due to alcohol use disorders and suicide & self-inflicted injuries.
    - By comparison, burden attributable to alcohol use was experienced in older age groups in females, peaking in ages 65–84. The burden experienced was due to a number of diseases including coronary heart disease, breast cancer, liver cancer and chronic liver disease.
- In 2015, 2.7% of the disease burden in Australia was due to illicit drug use. Illicit drug use includes burden from opioids, amphetamines, cocaine and cannabis and other illicit drug use, as well as unsafe injecting practices.
    - Illicit drug use contributed to burden for 13 diseases and injuries; 4 types of injuries, 3 infections, liver cancer, chronic liver disease and 4 types of mental and substance use disorders
    - Of the individual drug use types, opioid use was the leading illicit drug use risk, contributing to 1% of the total burden in Australia in 2015. This was followed by amphetamine use (0.6% of total burden in 2015) and unsafe injecting practices (0.5%).

Nationally in 2019, there were 1,865 drug-induced deaths and 1,317 alcohol induced deaths (AIHW 2021j). An analysis of shows that:

- 67% were accidental and 24% were considered intentional
- 63% of deaths were males
- The highest death rate was for 45-54 year olds
- 52% had mental and behavioural disorders due to psychoactive substance use as an associated cause of death
- 33% had mood (affective) disorders as an associated cause of death; Of the 671 mentions of mood (affective) disorders as an associated cause of death, the majority were for depressive episode and the remaining 16% were for bipolar affective disorder

- More than half of all unintentional drug-induced deaths involved three or more drug types, with less than one-third involving one drug type only (Pennington Institute 2021)
- Opioids were the most commonly identified drug class, present in 3 in 5 (60.5% or 1,129) drug-induced deaths—a rate of 4.6 per 100,000 population. Opioids include a number of drug types including heroin, opiate based analgesics (such as codeine and oxycodone) and synthetic opioid prescriptions (such as tramadol and fentanyl)
- Benzodiazepines were the most commonly identified single drug type, present in over 2 in 5 (43% or 811) deaths. It is important to note that benzodiazepines may not have been recorded as the underlying cause of death and are commonly reported as an associated cause in deaths due to other drug types.
- Other drugs commonly identified in drug-induced deaths included depressants excluding alcohol (51% or 944 deaths) and psychostimulants excluding cocaine (25% or 469 deaths)
- At least one psychosocial risk factor was recorded in 33% of drug-induced deaths. For intentional drug-induced deaths, this proportion was 61%;
    - Personal history of self-harm was the most commonly identified risk factor (12%), followed by relationship issues including: disruption of family by separation and divorce (5%); other risk factors included death or disappearance of a family member, release from prison and limitations of activities due to disability
- According to an AIHW study conducted in 2011, 4.5% of all deaths nationally are from alcohol and illicit drug use (AIHW 2018b).

The alcohol related death rate in Gippsland is high, see **Table 35**, especially in Bass Coast, East Gippsland, Latrobe and Wellington.

Table 35. Alcohol related death rate per 10,000 people, by local government area in Gippsland and comparison to Victoria.

BASS COAST	SOUTH GIPPSLAND	BAW BAW	LATROBE	EAST GIPPSLAND	WELLINGTON	VICTORIA
2.6	1.7	1.4	2.3	2.4	2.3	1.3

Source: Turning Point (2021a)
High compared to Victorian LGAs, top 25%

- In Gippsland, there were an average of 23 Gippsland drug overdose deaths per year 2011-20, with an apparent increasing trend and about a third in Latrobe (CCOV 2021).

Population groups more likely to misuse alcohol and other drugs:

- There is a strong association between illicit drug use and mental health issues. According to the 2019 National Drug Strategy Household Survey (NDSHS) (AIHW 2021j):
    - 26% of people who had recently used an illicit drug (in the past 12 months) experienced high or very high levels of psychological distress (up from 22% in 2016)
    - 26% of people who recently used drugs had been diagnosed with or treated for a mental health condition in the previous 12 months

- A comparison of people with a mental health condition to people without a mental health condition:
    - 1.7 times as likely to have recently used any illicit drug (26% compared with 15.2%)
    - 1.8 times as likely to have used cannabis (19.4% compared with 10.7%)
    - about 2.2 times as likely to have used meth/amphetamine (2.6% compared with 1.2%)
    - 1.4 times as likely to have used ecstasy (4.1% compared with 3.0%) or cocaine (6.2% compared with 4.3%)
    - 2.1 times as likely to use pharmaceuticals for non-medical purposes (7.6% compared with 3.6%)
- Aboriginal and Torres Strait Islander people;
    - Mental health and substance use disorders are leading contributors to burden of disease, causing 19% of total disease burden (AIHW, 2020d)
    - Several reasons including cultural deprivation, disconnection from cultural values, and traditions, trauma, poverty, discrimination and lack of adequate services result in more harm from alcohol, tobacco and drug use (AIHW, 2017)
    - Almost four times as likely to die from an unintentional drug induced death in 2019 (Pennington Institute 2021)
    - Fewer Indigenous Australians aged 14 and over were smoking or drinking at risky levels in 2019 when compared to data collected in 2010
- Young people were identified as a priority population in the National Drug Strategy 2017-2026;
    - more vulnerable to the direct and indirect impacts of substances which can affect their physical, psychological health, wellbeing and development
    - several negative social and economic outcomes associated with substance use including unemployment, low education attainment, poverty, homelessness and family breakdown
    - risky drinking has decreased substantially among young people aged 14–24 (from 47% to 30% between 2001 and 2021)
    - a reduction in the recent illicit use of drugs (including non-medical use of pharmaceuticals) among young people aged 14–24 (from 32% to 24%)
    - smoking has decreased, but 4.1% of young people aged 14-24 used e-cigarettes (electronic cigarettes) in 2019
- 14% of LGBTIQ+ people reported struggling to manage their drug use or where it negatively impacted their everyday life (Hill et al. 2020)
- Several other factors are associated with alcohol and other drug misuse, including discrimination, unemployment, family breakdown, homelessness, poverty and social isolation (National Drug Strategy 2017-2026).

Prevalence of alcohol use has been estimated:

- A high proportion of Gippsland people consume alcohol at risky levels. See **Table 36**.
- A growing proportion of women are not drinking alcohol while they are pregnant (65% in 2019 compared with 40% in 2007), (AIHW 2021k).

Table 36. Estimated alcohol consumption by local government area in Gippsland and comparison to Victoria.

INDICATOR	BASS COAST	SOUTH GIPPSLAND	BAW BAW	LATROBE	EAST GIPPSLAND	WELLINGTON	GIPPSLAND	VICTORIA
Consumed alcohol at levels likely to increase lifetime risk of harm (> 2 standard drinks per day - adults) (age-standardised)	73.4%	66.6%	59.2%	63.5%	67.3%	64.8%	64.6% Inner 66.3% Outer	59.5%
Consumed alcohol at levels with increased risk of injury on a single occasion (>4 standard drinks single occasion at least monthly - adults) (age-standardised)	54.5%	46.8%	45.1%	47.8%	55.7%	53.4%	48.2% Inner 54.8% Outer	43.0%

Source: DH (2017a)

High compared to Victorian LGAs, top 25%

Service system

Refer to **Appendix I** for a detailed service map of alcohol and other drug services in Gippsland, updated with the help of the Gippsland Alcohol and Other Drug Service Provider Alliance (GADSPA), October 2021.

Gippsland PHN Commissioned Alcohol and Other Drug (AOD) services include; a service providing education and support for families and carers of substance users in the Gippsland region, a youth AOD outreach service and a program offering local Aboriginal and Non-Aboriginal young people support through a withdrawal episode under professional supervision.

Availability of pharmacotherapy prescribing in Gippsland is through 61 GPs with at least one permit to prescribe (in 2020, up from 56 in 2017); a small number of nurse practitioners are also able to prescribe. 48 pharmacies are approved to dispense pharmacotherapy (of a total 70 community pharmacies), covering all Gippsland LGAs (Regional Pharmacotherapy Network Coordinator, Latrobe Community Health Service, Personal communication, November 2021).

Withdrawal beds are available at the hospitals in Bairnsdale, Sale and Leongatha.

Service use

The crime rate for drug offences is high in parts of Gippsland including Latrobe (1,576 offences per 100,000), East Gippsland (884), Baw Baw (788) and Wellington (707), compared to 597 in Victoria. These rates are all higher than in 2017-18 (CSA 2021a).

Ambulance attendance rates related to alcohol and other drugs is high in many parts of Gippsland (**Table 37**). The highest rates are for alcohol intoxication and Latrobe, Bass Coast, East Gippsland and Wellington had the highest rates.

Table 37. Ambulance attendances related to alcohol and drugs, 2019-20, rates per 100,000 population.

DRUG CATEGORY	BASS COAST	SOUTH GIPPSLAND	BAW BAW	LATROBE	EAST GIPPSLAND	WELLINGTON	VICTORIA
Alcohol intoxication	606	301	292	674	596	581	463
Illicit drugs – any	151	74	189	465	207	257	247
Pharmaceutical drugs - any	231	114	221	367	192	261	186

Source: Turning Point (2021a)

High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

General practice

- 1.3% of all active patients in general practice had an active diagnosis related to alcohol and other drugs in 2020-21. See **Table 38**. East Gippsland had the highest proportion at 1.6%, followed by Wellington and Latrobe at 1.3%.
    - 58% were males
    - People aged 40-49 years were most likely to have an active AOD diagnosis (2.5%) See **Table 39**.

Table 38. Prevalence of active patients with an active AOD related diagnosis in 2020-21 by LGA.

LGA	Number of patients	Proportion of all active patients
Bass Coast (S)	381	0.9%
Baw Baw (S)	896	1.0%
East Gippsland (S)	908	1.6%
Latrobe (C)	1,248	1.3%
South Gippsland (S)	435	0.9%
Wellington (S)	1,157	1.3%
Gippsland	3,877	1.3%

Source: Gippsland PHN (2021e)

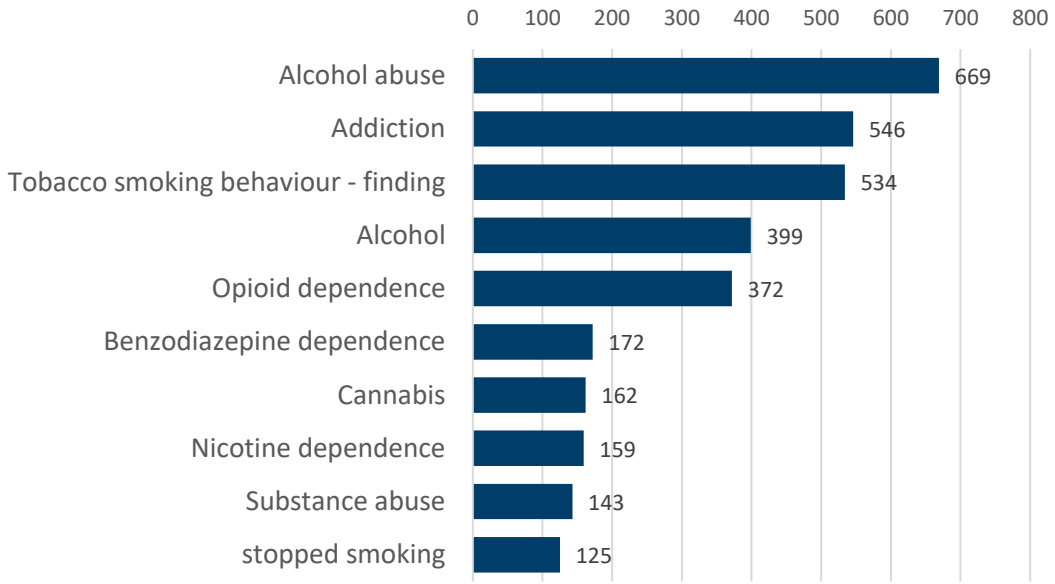
Table 39. Prevalence of active patients with an active AOD related diagnosis in 2020-21, by age group.

Age group	Number of patients	Proportion of all patients
0-9	<20	-
10-19	40	0.1%
20-29	332	1.0%
30-39	697	1.9%
40-49	782	2.5%
50-59	846	2.1%
60-69	697	1.5%
70-79	370	1.0%
80+	109	0.6%
Overall	3,877	1.3%

Source: Gippsland PHN (2021e)

The most common AOD related diagnosis recorded among general practice patients was alcohol abuse, followed by addiction and tobacco smoking. See **Figure 20**.

Figure 20. Top 10 active AOD related diagnoses among Gippsland patients, 2020-21



Source: Gippsland PHN (2021e)

- 9.2% of patients had been prescribed an opioid in 2020-21; varying from 11.9% of patients in East Gippsland to 6.1% of patients in South Gippsland
- The number of opioid scripts dropped slightly across Gippsland between 2017-18 and 2019-20
- Pharmacotherapy was prescribed for a total of 1,819 patients in 2019-20, an increase from 1,715 in 2017-18; 44% resided in East Gippsland.

Hospital activity

- Gippsland had a similar rate of hospital admissions due to use of alcohol and other drug use (10.3 admissions per 10,000 people) as Victoria (9.9) in 2020-21. The highest rate was in East Gippsland (18.0) and Wellington (13.0) (DH 2021b).
- The rate in East Gippsland has remained highest in Gippsland since 2017-18 (13.5 admissions per 10,000 people) but an increase was noted in 2019-20 and 2020-21.
- In 2020-21, there were 93 admissions due to dependence syndrome, 78 withdrawal and 57 acute intoxication.
- There were 340 emergency department presentations with simple intoxication of alcohol in 2019-20.

Alcohol and drug treatment services

Reports from the National Minimum Dataset for Gippsland for 2019-20 activity show (AIHW 2021l):

- There were 24 agencies in Gippsland reporting data to the national data set in 2019-20.
- Gippsland had the fifth highest number of clients receiving a service per population of Australia's PHNs and the third highest rate of treatment episodes.
- 82% of clients received a service for their own drug use (93% nationally)
- The most common drug types (principal drug of concern) compared to national averages:
    - 25% alcohol – steady (33%)
    - 24% amphetamines – steady (28%)
    - 14% cannabis – decreased (21%)
    - 3% heroin (5%)
    - 30% not stated (4%)
- Treatment type in Gippsland
    - 36% counselling (43%)
    - 31% assessment only (20%)
    - 16% support and case management (13%)
    - 9% withdrawal management (7%)
    - 2% rehabilitation (5%)
    - 1% information and education (8%)
    - Pharmacotherapy not available for Gippsland (2%)
- Referral source for Gippsland clients were:
    - 20% self-referral (35%)
    - 21% health service referral (31%)
    - 11% corrections (9%)
    - 1% diversions (10%)
    - 47% other (15%)
- Treatment delivery setting
    - 63% non-residential setting (69%)
    - 5% residential treatment facility (9%)
    - 5% home (2%)
    - 10% outreach setting (13%)

Gippsland PHN commissioned services

Gippsland PHN commissioned services are required to report periodically, enabling Gippsland PHN to assess the performance and outcomes of the commissioned service and inform future commissioning decisions.

Referrals to AOD services were from:

- Hospital
- Health and welfare services
- Self-referral
- General Practice
- Families/carers
- Police
- Mental health agencies

In 2019-20, a total of 213 clients used a Gippsland PHN commissioned AOD service, with a total of 1,649 sessions or an average of 7.7 sessions per client (GPHN 2021k).

- 26% of all clients were male with variation across services;
    - 15% of clients in the family and carer program were male
    - 69% of youth outreach clients were male
    - 31% of withdrawal program clients were male
- 6% of clients were Indigenous
- The age of clients varied across services;
    - 80% of clients in the family and carer program were 50 years or older
    - 53% of youth outreach services were 20-29 years old (22% were 15-19 years and 3% were 14 years or younger)
    - 73% of withdrawal program clients were aged 20-29 years (27% were 15-19 years)
- Most services were provided to people in Latrobe, Baw Baw, Wellington, and Bass Coast, noting that services are not region-wide.

During 2019-20, some services noted an upward trend in self-referrals which may be due to the increase in outreach activity and service promotion, the program being well established in the community or its co-location with other mental health services reducing the barriers to service accessibility. Programs were promoted using social media, advertisements on the local radio and in newspapers. Workers also promoted programs to area mental health services, engaged in community events such as mental health week, attended youth and mental health network meetings and conducted school-based education sessions on mental health, AOD, sexual health and how to access services.

Specialist services

Use of the **Direct Line telephone service** for alcohol and other drug support is variable across Gippsland, see **Table 40**.

- Latrobe had a high rate of calls for all drug categories, including pharmaceutical drugs

- Callers in Latrobe and Wellington were most commonly seeking support related to illicit drug use
- Callers from other LGAs were most commonly seeking support related to alcohol misuse

Table 40. Use of the Direct Line telephone service, rate per 10,000 population, 2018.

DRUG CATEGORY	BASS COAST	SOUTH GIPPSLAND	BAW BAW	LATROBE	EAST GIPPSLAND	WELLINGTON	VICTORIA
Alcohol	27.2	12.9	13.1	18.1	19.4	14.8	17.3
Illicit drugs (any)	15.0	6.8	11.9	19.0	15.0	17.5	15.3
Pharmaceutical drugs (any)	3.4	3.0	2.3	7.5	4.7	4.8	6.6

Source: Turning Point (2021a)

High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

National data about **Pharmacotherapy** show that (AIHW 2021m):

- 67% were male and about 10% were indigenous
- Heroin was the most common drug of concern
- The rate of population receiving pharmacotherapy treatment was highest in the 35 to 50 year age group. The rate in older age groups has increased in recent years, while there has been a decrease in the proportion of people under 39 using the service.

Pharmacotherapy service delivery in Gippsland (based on personal communication with the Regional Pharmacotherapy Network Coordinator, Latrobe Community Health Service, preliminary figures, November 2021):

- A total of 682 clients in October 2021, an increase from 626 in June 202 and 632 in 2017).
- 36% of permits were for people in Latrobe (this has increased from 25% in 2017), 17% East Gippsland, 16% Wellington, 13% Bass Coast, 12% in Baw Baw and 6% in South Gippsland.
- The introduction of long acting injectable buprenorphine (LAIB) was made available in April 2020 and in October 2021, this was the prescribed medication for 10% of clients in Gippsland.

Professional stakeholder perspective

National data (AIHW 2021j) shows that:

- An increase in total alcohol spending when compared with the same weekly period in the previous years of between 4% and 24% (May 2020 to February 2021). This increase was driven by spending on alcohol goods (such as bottle shops).

- The results from several self-reported surveys have produced mixed findings with regard to the impact of COVID-19 on the consumption of alcohol and other drugs with some people reporting an increase in use while others report a decrease.
- Wastewater analyses show increased consumption of alcohol, cannabis and heroin in regional areas between August 2019 and 2020.
- Existing drug users reported increased use of cannabis and e-cigarettes while use of MDMA and methamphetamines had decreased.
- Access to treatment has been affected and data suggests a significant unmet need for drug and alcohol counselling during the COVID-19 pandemic.
- COVID-19 restrictions also impacted prescribers and people accessing opioid pharmacotherapy treatment
    - maintaining effective social distancing measures, particularly where people are required to visit their dosing site daily
    - regulatory changes to support treatment delivery.

Consultations with professional stakeholders during 2020-21 (GPHN 2021f), noted:

- Alcohol and other drug issues was a top rated priority area among workshop attendees.
- There are gaps in referral options to AOD services generally and in particular for rehabilitation locally (community and residential).
- Themes from Gippsland PHN commissioned services consultations in 2021:
    - All currently commissioned services are meeting important needs but are not able to meet demand.
    - Gippsland PHN commissioned services were temporarily disrupted by the Covid-19 pandemic. Mitigation strategies involved following a pandemic plan, screening clients for centre visits and outreach and diversion of clients to online AOD support.
    - What is working well:
        - Assertive outreach support for young people and co-location with headspace
        - Co-location with other mental health and AOD services provided a strategy to manage waiting lists due to a high demand for services by referring clients to another service if an appointment was not immediately available.
        - AOD services communicated the value of collaboration and shared care with area mental health teams, health and welfare services, housing and employment services and the judicial system. This ensured that the complex needs of vulnerable clients were being met.
        - Support to families and carers of people requiring substance abuse support. This includes advocating on behalf of the client and offering support for both the client and the family / carer.
    - What needs improvement:
        - Services highlighted the need for appropriate and safe housing for young people as AOD services received referrals to work with young people who were homeless or at risk of becoming homeless.
        - Dual diagnosis support is a gap everywhere and requires a more flexible funding approach to allow services to take responsibility for both mental health and AOD.
        - Additional support for the older population is needed, including residential aged care.
        - Continued services gaps for Aboriginal and Torres Strait Islander people.
- Input from AOD service providers across Gippsland:
    - Increased demand for pharmacotherapy with demand close to doubling in some areas.
    - COVID has presented many challenges with the way services can be delivered and telehealth is not ideal with the AOD cohort. A lot of clients have dropped off when no face to face contact is possible.

    - The geographical locations of detox and rehab beds can make it very difficult for clients in parts of Gippsland to access. A 'dayhab style' program where clients can attend but stay in their home is needed.
    - More training for dual diagnosis and the utilisation of Nurse Practitioners would benefit all AOD services in Gippsland.
    - More detox beds needed.
    - Regional planning required to enable a more integrated system with no duplication of services.
    - Workforce gaps include addiction medicine, psychology for AOD and an increased peer workforce

- A regional workforce survey in 2021 (GPHN 2021h) included suggestions to include secondments between aligned services, for example AOD with forensic system, justice, mental health and headspace. This would improve integration of services for clients and provide an important learning experience, especially for young graduates.
- Availability of pharmacotherapy in Gippsland:
    - Introduction of long-acting injectable buprenorphine (LAIB) which was made available in April 2020 but not used widely for a few months.
    - Using a combination of face to face and telehealth with support from local community health services, patients should be able to access pharmacotherapy prescribing in all major towns throughout Gippsland.
    - Nurse practitioners are important in complementing general practitioners who can be difficult to access.
    - It is difficult for nurse practitioners to operate as sole practitioners as the Medicare rebates are low.

      "More publicly funded nurse practitioner positions … would be enormously helpful for the NP's to be appropriately remunerated for the essential work they do."

    - Changes implemented due to COVID to allow reduced face to face interaction including access to telehealth, increased number of allowable take away doses, provisions for third party collection and increased script length. Unknown if there has been an impact on overdose deaths.
    - Workforce shortages and staff burnout in pharmacy related to extra pressures with COVID vaccinations.

Community, consumer and carer perspective

Community engagement by Gippsland PHN and partner organisations has identified the following themes (GPHN, 2021f):

- Drug and alcohol is a key health issue among young people across Gippsland

  "Drugs – it's one of the major things that affects health and wellbeing"

- Concern among parents about the safety of young people in the community, including a fear that alcohol and drug issues are normalised.

  "…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."

- There is a lot of strain on family and carers who often report difficulty obtaining information about services and supports for people misusing alcohol land other drugs.

  "There are so many different services, but I don't know which one is the right one. My young person isn't keen to engage and when he does try, the person he has spoken to doesn't seem to get it and he gives up without getting much further than assessment."

- Alcohol and drug use is closely tied to mental health

  "Drug and alcohol use can often be people trying to treat their mental health issues… they are just trying to get through their day"

- Consumer and carer consultations with dual diagnosis service users (Murphy 2018) identified a need to:
  - Reliable and local information about available services.
  - Primary care providers need to be better equipped to manage mental health and AOD diagnoses, especially GPs.

    "*Some GP's are excellent, but if a person with a psychiatric illness goes to a GP who has predetermined ideas about mental health and who just doesn't get it, they're going to cause more harm…"*

  - Coordination of services needs improvement to ensure individuals receive the care they need when ready to address their issues, regardless of where they present.

    "There's been a culture in these services, they don't want to share and then, … they have to tell their story, again."

Figure 21. Adam's journey – Alcohol and other drugs and Mental health and wellbeing, including suicide prevention.

Source: GPHN (2021d)

6. Cancer

"*For my health I would like to be connected to all health professionals, skin cancer, general practitioner, hospital, ambulance and any others which are available as a centred approach to each person.*" [Survey respondent]

"More specialists in Gippsland." [Survey respondent]

Health status

- Nationally, cancer is the leading cause for burden of disease (as DALY), accounting for 18% of total burden. A high proportion of the disease burden from cancer is fatal.
- An estimate of adults ever diagnosed with cancer (DH 2017a) found the highest rates in Bass Coast (12.2%), Wellington (10.2%), South Gippsland (10.0%) and Baw Baw (9.8%); Latrobe and East Gippsland (7.4%), compared to Victoria 8.1%.
- Age-standardised cancer incidence rates for all cancers for Gippsland are similar to national rates (485 new cancers per 100,000 people compared to 496 for Australia) but were lower in Baw Baw and Wellington. See **Table 41** and **Figure 22**.
- Cancer incidence rates for lung cancer are high in Gippsland compared to Australia.
- Cancer incidence rates for prostate cancer are low in Gippsland compared to Australia.

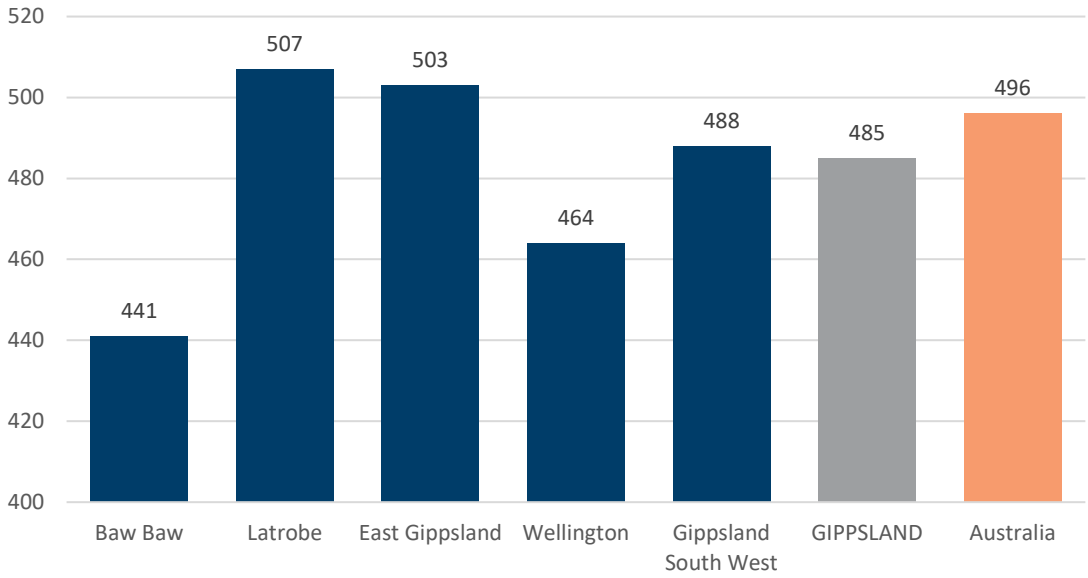
Table 41. Cancer incidence by LGA, age-standardised rate per 100,000, 2010-14.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	GIPPSLAND	Australia
All cancers	441	507	503	464	488	485	496
Lung cancer	33	58	53	51	43	48	43
Breast cancer	106	117	119	123	134	121	122
Cervical cancer - females	NA	11.5	NA	NA	NA	7.8	7.1
Colorectal (bowel) cancer	56	58	70	62	59	61	59
Melanoma of the skin	44	42	53	36	47	45	50
Prostate - males	138	144	124	123	150	138	162

Source: AIHW (2019c)

High compared to Australian SA3s, top 25%
Low compared to Australian SA3s, bottom 25%

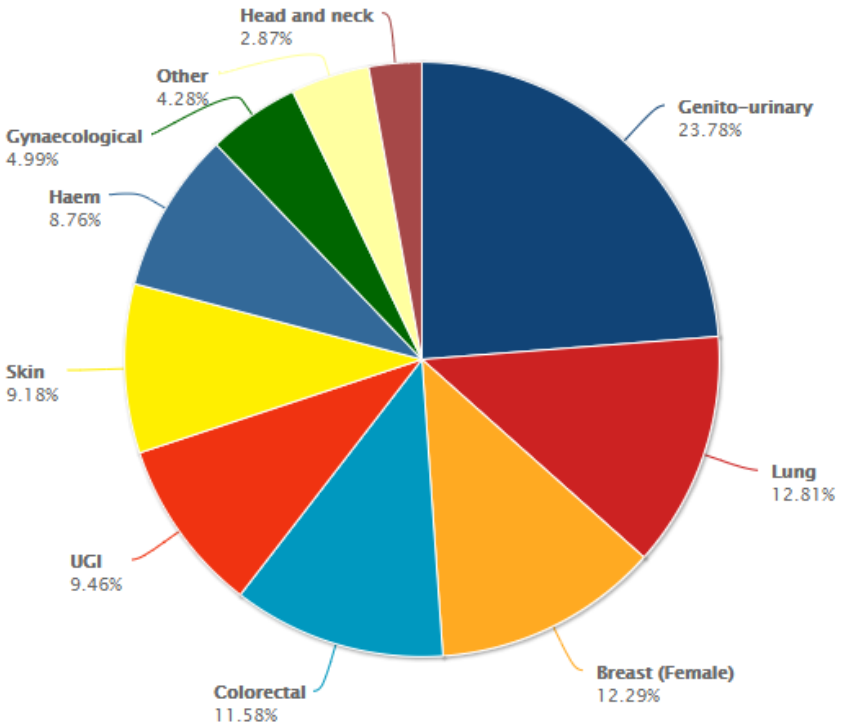
Figure 22. Age-standardised cancer incidence rates for all cancers, per 100,000 people, 2010-14.



Source: AIHW (2019c)

- Genito-urinary cancers were the most common cancer in Gippsland. This includes prostate cancer, kidney cancer, bladder cancer, testicular cancer and cancers of the penis. See **Figure *23***. (CCV 2020).
- Lung and breast cancers had the 2nd and 3rd highest cases in Gippsland, followed by colorectal and Upper Gastrointestinal tract (UGI) cancers. (CCV, 2020)

Figure 23. Prevalence of new cases for each of the top 10 tumour streams for all persons in Gippsland, 2019.



Source: CCV (2020)

Gippsland had the highest avoidable deaths for all cancers of all Australian PHNs and was significantly higher in Latrobe and Wellington. See **Gippsland main health issues**. Gippsland had the highest avoidable deaths for breast cancer of all Australian PHNs and was significantly higher in all LGAs except East Gippsland.

Cancers rate among the top causes of death in Gippsland (AIHW 2021b).

- Lung cancer deaths was the 2nd cause of death among males in five of six Gippsland LGAs (4th in South Gippsland); (Australia 2nd). For females, lung cancer was the 4th cause of death in East Gippsland and South Gippsland while it was the 5th in Latrobe and Wellington (Australia 4th).

- Prostate cancer was the 3rd cause of death for males in South Gippsland and Wellington, 4th in Baw Baw and East Gippsland, 5th in Bass Coast and 6th in Latrobe (Australia 6th).
- Breast cancer was the 4th cause of death for females in Bass Coast, 5th in Baw Baw and South Gippsland, 6th in Latrobe, 7th in Wellington and 8th in East Gippsland (Australia 6th).
- Colorectal cancer was the 6th cause of death for males in Bass Coast and Wellington, 7th in East Gippsland and Latrobe, 8th in South Gippsland and 11th in Baw Baw (Australia 7th); colorectal cancer was 6th for females in East Gippsland and Wellington, 8th in Bass Coast, 9th in Latrobe and South Gippsland and 13th in Baw Baw (Australia 7th).

Cancer mortality rates due to all cancers are high in Latrobe, East Gippsland and Wellington compared to Australia. See **Table 42** and **Figure 24**.

- Breast cancer mortality rates are high in Gippsland compared to Australia, especially in Wellington, Bass Coast and South Gippsland.
- Colorectal cancer mortality rates are high in East Gippsland compared to Australia.
- Lung cancer mortality rates are high across Gippsland compared to Australia, except in Baw Baw.
- Melanoma mortality rates are high in Baw Baw and Latrobe compared to Australia.
- Prostate cancer mortality rates are high in Gippsland compared to Australia, especially in East Gippsland, Wellington and Latrobe.

Table 42. Cancer mortality by SA3, age standardised rate per 100,000 people, 2011-15.

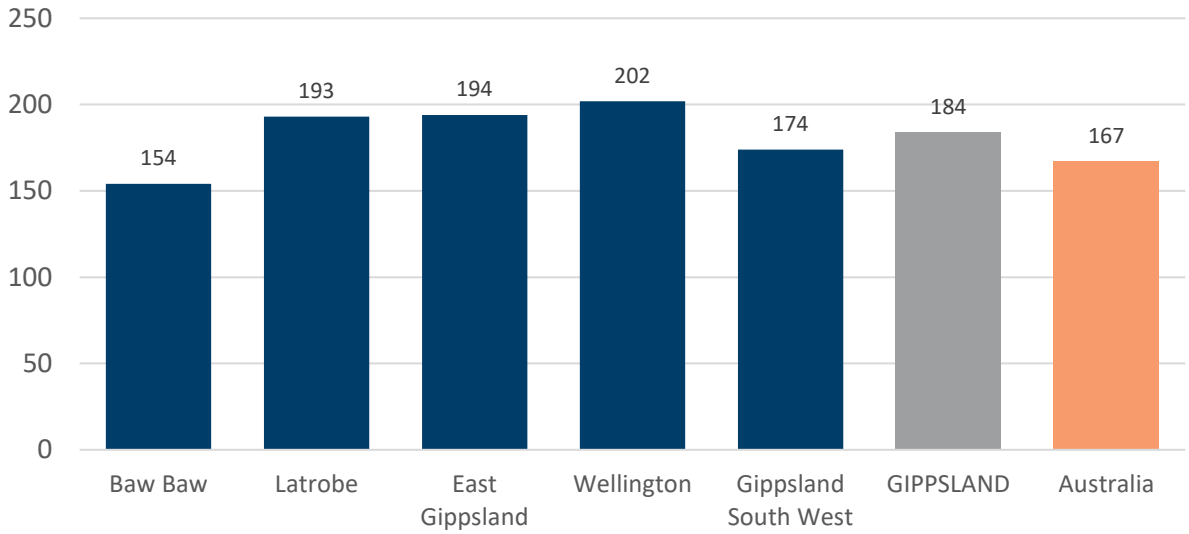
Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	GIPPSLAND	Australia
All cancers	154	193	194	202	174	184	167
Breast cancer	23	18	23	26	25	23	21
Colorectal cancer	11	14	19	16	11	14	16
Lung cancer	25	43	38	38	38	37	32
Melanoma of the skin	9.3	8.6	6.1	NA	4.4	7.0	5.9
Prostate cancer - males	27	35	38	33	26	32	27

Source: AIHW (2019c)

High compared to Australian SA3s, top 25%

Low compared to Australian SA3s, bottom 25%

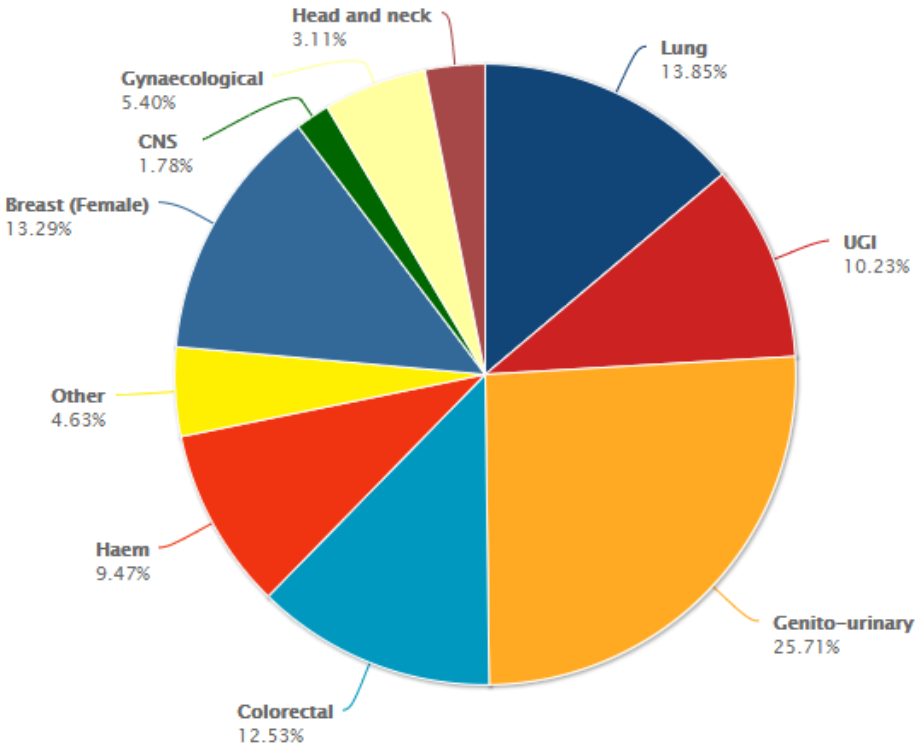
Figure 24. Age-standardised cancer mortality rates for all cancers combined, per 100,000 people, 2011-15.



Source: AIHW (2019c)

- Genito-urinary cancer accounted for the highest proportion of deaths in Gippsland, followed by lung, breast and colorectal cancers, see **Figure 25**. (CCV, 2020).

Figure 25. Deaths by top 10 cancer tumour stream for all persons in Gippsland, 2019.



Source: CCV (2020)

Population groups:

- Aboriginal and Torres Strait Islander people were 1.1 times as likely to be diagnosed with cancer as non-Indigenous Australians. (AIHW 2018c)
    - In 2011-2015, Indigenous Australians were 1.4 times as likely to die from cancer as non-Indigenous Australians.
    - The age-standardised incidence rate for all cancers combined was 564.5 for Indigenous persons in Victoria compared to 471.0 for non-Indigenous persons.
- People living in the most disadvantaged areas of Australia had the highest age-standardised incidence rates of cancers including cervical cancer, cancer of unknown primary site, colorectal cancer, uterine cancer and head and neck cancer. They also had the highest age-standardised mortality rates of cancers including lung cancer, cancer of unknown primary site, colorectal cancer and prostate cancer. (AIHW 2019d)

- The proportion of women aged 50–74 years who had ever a mammogram was significantly lower in the LGBTIQ+ group (77%) compared with the heterosexual, non-LGBTIQ+ group (89%). (VAHI 2020).

Refer to the **Chronic disease** section for data on risk factors also relevant for cancer.

Service system

See **Gippsland health services** for an overview of main providers.

The Gippsland Cancer Care Centre provides radiotherapy, chemotherapy and specialist consulting and support services through and hub and spoke model. There are an additional five locations that provide chemotherapy, one in each LGA.

The Gippsland Regional Integrated Cancer Service (GRICS) works to positively impact cancer outcomes for patients in Gippsland by fostering strong working relationships with partner organisations and stakeholders and undertaking projects that will ensure best practice cancer service delivery within the region.

There are five permanent BreastScreen Victoria locations with additional sites visited by a mobile screening service.

Service use

General practice data

- GP data for Gippsland show the 3,627 patients with a new cancer diagnosis in 2019-20, down slightly from 2018-19; 1,918 were for males and 1,701 for females (**Table 43**).
- New cancer diagnoses increased with age and peaked at the 70-79 age group.

Table 43. Gippsland patients with a new cancer diagnosis, by age group and year.

	2017/2018	2018/2019	2019/2020
0-9	<20	<20	<20
10-19	<20	<20	<20
20-29	25	25	21
30-39	81	94	74
40-49	170	153	190
50-59	392	427	446
60-69	876	925	934
70-79	1,123	1,289	1,172
80+	871	895	773
Gippsland	3,549	3,816	3,627

Source: GPHN (2021e)

- 5.3% of Gippsland patients in general practice had an active cancer diagnosis in 2020-21 (**Table 44**);
- 5.7% of males and 5.1% of females
- Prevalence increased with age and peaked at 18.2% in patients 80 years and older
- South Gippsland (6.5%) and Bass Coast (6.2%) recorded the highest proportions of active patients with an active cancer diagnosis; the lowest was in Latrobe (4.4%).

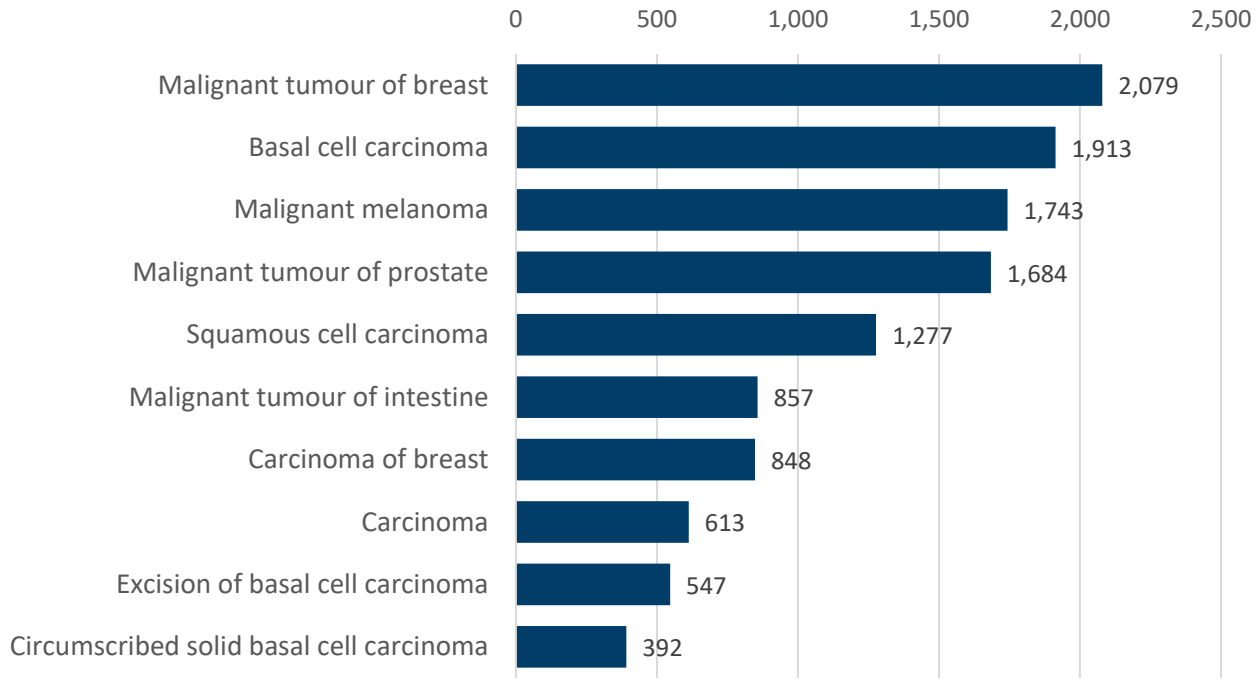
Table 44. Prevalence of active patients with an active cancer diagnosis in 2020/21, by age group

Age group	Number of active patients with cancer diagnosis	Proportion of all active patients
0-9	0	0.0%
10-19	29	0.1%
20-29	82	0.2%
30-39	299	0.8%
40-49	773	2.4%
50-59	1,908	4.8%
60-69	4,124	8.8%
70-79	5,313	13.9%
80+	3,482	18.2%
All ages	16,022	5.3%

Source: GPHN (2021e)

The most common active cancer diagnoses in 2020-21 were malignant tumour of the breast (13.0% of all cancer diagnoses), basal cell carcinoma (11.9%) and malignant melanoma (10.9%), see **Figure 26**.

Figure 26. Top 10 active cancer diagnoses, 2020-21.



Source: GPHN (2021e)

Cancer screening

Bowel cancer screening rates across Gippsland continue to be higher than the rates for Australia, especially for females, see **Table 45**:

- Coverage rates are lower for males, younger age groups (50-55 years) and there is variation by LGA.
- The proportion of positive bowel cancer screening results for Gippsland were a little higher than for Australia with 9.9% of males (Australia 8.8%) and 7.5% of females (7.1%) returning a positive result in 2016-17.
- Breast cancer screening rates show that more of Gippsland women aged 50-74 were screened, compared to Victorian women. Variation by age group is noted with screening rates lowest for the 50-54-year age group.
- Breast cancer screening was not more likely to detect breast cancer among women in Gippsland than Australia.

- Cervical cancer screening rates in Gippsland were slightly lower to Australia (46.3%) in 2018-19, with regional variation. Variation by age group is noted with screening rates generally lower for younger age groups.
- Cervical cancer screening was significantly more likely to detect a high-grade abnormality among women in East Gippsland (13.4 per 1,000 screened women); Victoria (11.0).
- Cervical cancer screening detected similar rates of low-grade abnormalities among women in Gippsland (39.3 per 1,000 screened women) and Victoria (37.6).

Table 45. Cancer screening and outcomes in Gippsland by LGA, 2018-19.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	Australia
Bowel cancer screening participation, female	52.6%	52.4%	50.9%	49.3%	55.4%	50.3%	51.7%	43.2%
Bowel cancer screening participation, male	47.5%	47.8%	46.8%	44.3%	50.9%	44.5%	46.8%	39.5%
Bowel cancer screening positive screening result, female	7.9%	6.7%	6.6%	8.3%	7.8%	7.1%	7.5%	7.1%
Bowel cancer screening positive screening result, male	10.5%	8.3%	10.1%	9.8%	10.0%	10.0%	9.9%	8.8%
Breast cancer screening, women aged 50-74 years	55.7%		55.8%	57.9%	57.5%	55.8%	56.7%	54.8%
Breast screening outcomes: cancer, females 50-69 years; age-standardised rate per 10,000 screened women*	30.4	20.8	36.9	28.2	41.4	29.8	32.5	33.4
Cervical cancer screening, women aged 25-74 years	42.7%		47.1%	41.3%	44.5%	42.6%	43.5%	46.3%
Cervical cancer screening outcomes, high grade abnormality, females 50-69 years; age-standardised rate per 1,000 screened women*	11.2	11.9	8.9	11.9	13.4	9.1	11.0	11.0
Cervical cancer screening outcomes, low grade abnormality, females 50-69 years; age-standardised rate per 1,000 screened women*	41.6	39.5	44.5	38.2	38.3	34.0	39.3	37.6

Source: AIHW (2021n) * PHIDU (2021), comparisons to Victoria

High compared to Australian LGAs, top 25%
Low compared to Australian LGAs, bottom 25%

Hospital admissions

Endoscopy rates in Gippsland LGAs are low for both colonoscopy and gastroscopy hospitalisations compared to Victoria and Australia, see **Table 46**.

Table 46. Endoscopy rates in Gippsland by LGA, age-standardised rate per 100,000 people, 2016-17.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	Victoria	Australia
Colonoscopy hospitalisations	878	2,682	2,508	2,921	1,416	3,371	2,881
Gastroscopy hospitalisations	625	1,637	1,392	1,714	877	2,259	1,931

Source: ACSQHC (2021)

Low compared to Australian SA3s, bottom 25%

Professional stakeholder perspective

Gippsland PHN's Latrobe Cancer Screening Collaborative developed a change-management program which drew upon primary care quality improvement to support practice-led change to improve patient cancer screening utilising a 'Collaborative' methodology (GPHN 2020b). Four Latrobe general practices trialled, tested and implemented various innovative quality improvement activities based on evidence-based change principles to improve their patient cervical and bowel cancer screening participation rates. Data cleansing activities, collection and analysis were a significant part of the project outcomes. By the end of the project, as a collaborative the average cervical cancer screening participating rates increased from 42.3% (June 2019) to 49.7% (February 2020) and from 32.7% (June 2019) to 36.2% (February 2020) for bowel cancer screening. Practices successfully used the collaborative approach to share and develop solutions to address cancer screening. The approach was supported by learning workshops, data collection projects and structured engagement and communications. Feedback from general practice staff included:

> *"Increase in the number of cervical screen nurses… have been able to increase the number of days that a cervical screening nurse is now available for the patients."*
>
> *"The reason this PDSA cycle worked so well was that it encapsulated the entire practice staff and patient cohort….. The key learning from this PDSA was staff empowerment. I recruited everyone in the clinic into this program."*
>
> *"Some staff did not participate as well with the Model For Improvement and were very resistant to doing anything extra than what they wanted to do"*
>
> *"Getting involvement of doctors was disappointing for me…"*

- There is concern about lack of awareness and screening for bowel cancer and prostate cancer (GPHN, 2021d); also, cervical screening in terms of education and training to improve access.

Community, consumer and carer perspective

Gippsland PHN community consultations pre COVID-19 identified the following themes which are still relevant (GPHN 2016):

- Cancer screening / services was rated as an important health issue in the community, especially among older people.
- Barriers to early diagnosis and management included cost of diagnostic services, travel and cost to see specialists and treatment locations.

  "I need to have an endoscopy done to look at things and I cannot afford it"

  "Travel to Melbourne and Traralgon for specialist treatment. Understand why this is so but it's a hassle ..."

More recently, focus groups to understand barriers and enablers to cancer screening have occurred in Latrobe (Azar 2021). Fourteen focus groups were held with 80 participants. Key themes were that the concept of cancer screening was not well understood, a low priority for preventive health behaviours, issues relating to local general practitioners and screening was unpleasant, embarrassing and/or inconvenient. A key determinant of participation in cancer screening was exposure to prompts to action, and it was evident that participants often required multiple prompts before they acted.

A community survey addressing cancer screening and smoking cessation campaigns in Latrobe City was used to increase understanding of how campaigns influence participation (Federation University 2021a). Cancer screening advertisements improved awareness of the risks of cervical, breast and bowel cancers, the benefits of getting tested, and what screening involves. Awareness was lowest for Gippsland PHN's 'Screen for Me' campaign, with 27% of respondents being aware of it. However, 26% of respondents credit it with having influenced their attitude towards cancer screening and 37% indicated that it increased their likelihood of getting screened for cancer. The most effective methods for encouraging people to take the cervical screening test, were the cervical screening letter and the advice of a GP, with approximately 75% of respondents attributing their decision to take the cervical screening test to both methods. In contrast, 34% of respondents attributed their decision to take the cervical screening test to cervical screening advertisements. For breast screening, 76% of respondents attributed their screening to the advice of their GP, and 44% to breast screen advertisements. 80% of respondents reported taking the at-home bowel screen test, with just under half (49%) citing bowel screening advertisements as the reason.

Aboriginal Breast Screening Shawl project was trialled in Latrobe to improve the breast screening experiences of local Aboriginal women (GPHN 2020c). Cultural shawls were designed by the community and offered to Aboriginal women to wear during a group breast screening booking at the Traralgon West BreastScreen clinic. Positive feedback was received from the women that screened, with all clients agreeing that both the staff and the group booking made them feel more comfortable about their breast screen, and six women agreeing that the shawl made them feel culturally safe and comfortable.

During community engagements in Latrobe, people specifically mentioned that they were looking for improved access to doctors, prostate cancer support nurses and haematology nurses (LHA 2019).

A Gippsland PHN survey in 2021 (GPHN, 2021d) included mentions of cancer; people suggested that improved skills in skin cancer checks in primary care is needed and easier access to specialists would be helpful.

7. Mental health and wellbeing, including suicide prevention

"I want holistic care, no wrong door…too many services have exclusion criteria…" [Workshop participant]

"If you can help someone's mental health and their wellbeing, a lot of other stuff falls into place" [Workshop participant]

"Appointment wait times to see specialists and allied health specialists – demand exceeding supply for recommended specialists – health status deteriorates during the months of waiting…" [Workshop participant]

Health status

- Over 30% of adults across Gippsland have ever been diagnosed with anxiety or depression, higher than in Victoria (27.4%). See **Table 47**.
- Between 10% and 22% of adults are estimated to have current high or very high psychological distress (Victoria 15.4%).
- Up to 25% of people rate their satisfaction with life as low or medium (Victoria 20.5%).

Table 47. Mental health related indicators among adults in Gippsland, age standardised rates, 2017.

INDICATORS	BASS COAST	SOUTH GIPPSLAND	BAW BAW	LATROBE	EAST GIPPSLAND	WELLINGTON	GIPPSLAND	VICTORIA
Ever diagnosed with anxiety or depression	39.1%	35.5%	35.4%	36.0%	33.8%	26.0%	36.0% Inner 30.0% Outer	27.4%
Persons with high or very high psychological distress (K10 scale)	20.1%	21.5%	14.2%	17.5%	11.6%	9.8%	17.5% Inner 10.8% Outer	15.4%
Persons with low or medium satisfaction with life	23.3%	19.6%	19.4%	25.2%	17.9%	14.9%	22.4% Inner 16.1% Outer	20.5%

Source: DH (2017a)

High compared to Victorian LGAs, top 25%

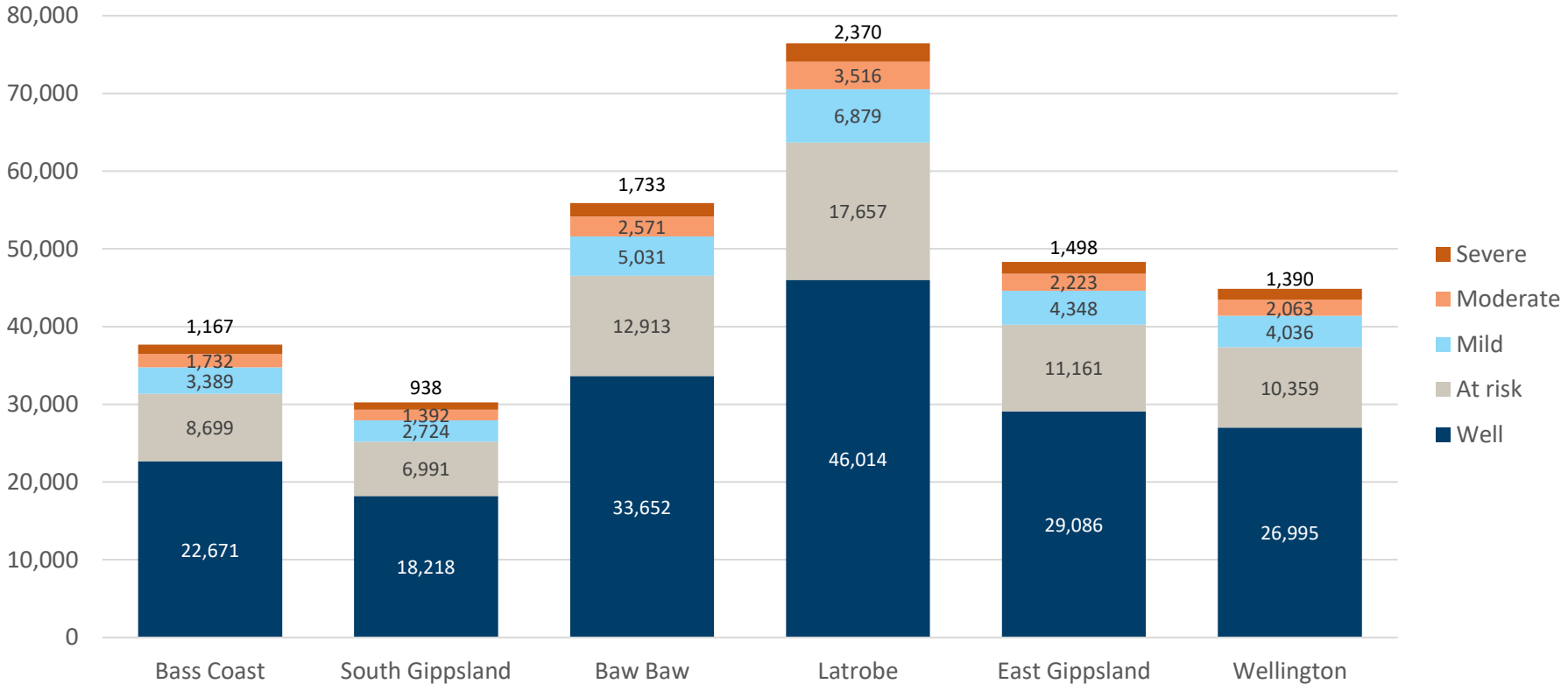
Low compared to Victorian LGAs, bottom 25%

According to national mental health prevalence estimates (NMHC 2017), 39.9% of the population are either experiencing mental illness or are at risk of mental illness while 60.2% are well:

- 23.2% at risk
- 9.0% mild
- 4.6% moderate
- 3.1% severe

Applying these estimates to the 2021 Gippsland population shows that over 9,000 people would have severe mental illness, about 13,500 people moderate mental illness and about 26,500 people mild mental illness at any one point in time. In addition, about 68,000 are at risk of mental illness. See **Figure 27**.

Figure 27. Gippsland population estimates by mental health stepped care model category, 2021.



Source: Estimates calculated by Gippsland PHN based on NMHC (2017) (prevalence) and DELWP (2019) (population).

- In Australia, mental and substance use disorders is the fourth highest cause of burden of disease (as DALY), estimated to cause 13% of total disease burden (AIHW 2021a).
- Mental and substance use disorders is the second leading cause of non-fatal burden of disease, contributing to 23% of non-fatal burden. (AIHW 2021a).

- Among children aged 5–14 years, mental disorders contribute significantly to burden of disease; anxiety disorders (10.6%), depressive disorders (7.1%) and conduct disorders (6.0%).
- 'Suicide and self-inflicted injuries' is the leading cause of burden among people aged 15–44 years old. Anxiety disorders and depressive disorders continue to contribute significantly to burden of disease for these age groups.
- Among Indigenous Australians, the years of healthy life lost per 1,000 people due to mental and substance use disorders was 2.4 times the rate for non-Indigenous Australians (57.8 compared with 23.6) (AIHW 2020d).
- It is estimated that 14% of 4-17-year-olds experienced a mental disorder in the past 12 months. Modelled estimates by SA3 indicate East Gippsland had the highest prevalence at 17% and Latrobe had the highest modelled prevalence estimate for 4-11-year-olds (16%). (Telethon Kids Institute 2021)
- Prevalence of mental illness (AIHW 2020f):
    - 46% of adults experience a mental illness in their lifetime; 48% of males and 43% of females
    - 16-24 year olds are most likely to have current mental illness at 26%
    - 20% of adults have a mental illness in any one year
- Population groups more likely to have a high prevalence of mental illness:
    - 43% of people with a profound or severe disability, compared to 17% of people with no disability. (AIHW 2020c)
    - Young people with a disability are concerned about mental health, suicide, bullying and emotional abuse (Mission Australia 2019). They are four times more likely to have mental health problems than other children and adolescents; 50 to 70% of people with autism experience mental illness (CYDA 2020).
    - 36.5% of clients of specialist homelessness services had a current mental health issue in 2019-20. This has increased since 2011-12. (AIHW 2021o). In 2019-20, 7,746 people in Gippsland received assistance from homelessness services; more than 2,500 are likely to have a mental health issue based on national estimates.
    - 24.4% of LGBTIQ+ adults had high or very high levels of psychological distress compared with 14.5% of heterosexual, non-LGBTIQ+ Victorians (VAHI 2020).
    - 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.
    - 26% of people who use illicit drugs had been diagnosed with a mental illness (AIHW 2020g).
- 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. (NMHC 2017).
- Risk factors for mental ill health include a broad range of **15. Factors affecting health (or social determinants of** health). Experiences in childhood and as a young adult are important for developing minds. See indicators in **Children and young people** (0-25 years), including high rates of bullying; up to 28% of year 7-9 students compared to 17.5% in Victoria.

Service system

The mental health service system includes Commonwealth funded services (including MBS, PBS and programs and initiatives funded through PHNs) and State funded services (including hospitals and community mental health services) but also relies on consumer contributions and private health funds. The Council of Australian

Governments (COAG) agreed to the Fifth National Mental Health and Suicide Prevention Plan, which established a national approach for collaborative government effort from 2017 to 2022. There are also other shared arrangements, including the National Disability Insurance Scheme.

As part of the Fifth National Mental Health and Suicide Prevention Plan, the Commonwealth, State and Territory Governments have agreed that Local Health Networks (LHNs) and Primary Health Networks (PHNs) will develop and publicly release joint Regional Mental Health and Suicide Prevention Plans by 2022.

The Gippsland Mental Health and Suicide Prevention Final Plan is a collaboration between Gippsland PHN and Latrobe Regional Hospital. The Plan is a comprehensive service development plan, informed by evidence-based service planning tools, including the National Mental Health Service Planning Framework, detailed service and workforce mapping, and regional stakeholder engagement and consultation. It is also being finalised in the context of recommendations of the Royal Commission into Victoria's Mental Health System.

The **'**Plan on a Page' (**Figure 28**) clarifies the Plan's vision, mission, values and commitments. An example of proposed areas of focus, outcomes and measures of the regional commitments include the following focus areas:

- Regional benchmarking / data sharing of health and wellbeing performance indicators
- The governance and accountability of mental health and suicide prevention deliverables are regionally managed
- Community voice is represented and shared across providers
- Regional risk assessment tools and risk categorisation systems are developed in accordance with the Stepped Care model.
- All relevant organisations participate in the operationalisation of the Gippsland Mental Health and Suicide Prevention Workforce Strategy.
- Services are consultative and inclusive of staff, consumer and community views
- Regional treatment guidelines and protocols are informed by people with a lived experience and used to support a pathway aligned with the Stepped Care continuum

In 2020, the Gippsland Mental Health Alliance (GMHA) endorsed the Gippsland Mental Health and Workforce Strategy, developed in 2019 by Gippsland PHN and Latrobe Regional Hospital. Implementation of the strategy commenced with the convening of a GMHA working group on workforce and the design and pilot of a workforce survey as a recurring component of the Gippsland PHN's Needs Assessment activity to inform future workforce and service planning.

Detail of these commitments at a local level will be included in the final Plan, due for submission to Commonwealth in June 2022.

Figure 28. Gippsland Mental Health and Suicide Prevention Plan on a Page, 2020.

A detailed analysis of mental health services in Gippsland is in progress and will inform the final Regional Plan. An overview of Gippsland PHN commissioned services is included as **Table 48**; additional services that are available across the region:

- Child mental health online portal, low intensity (Calm Kids Central)
- Mental health coaching, low intensity (New Access)
- Mental health in residential aged care, mild – moderate
- An Indigenous Dual Diagnosis service through ACCOs

Table 48. Overview of Gippsland PHN funded mental health services by LGA, 2021.

Service	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington
Wellbeing program					Mild-moderate	Mild-moderate
Psychological therapies	Mild-moderate		Mild-moderate		Mild-moderate	
Headspace centre (mild-moderate, 12-25 years)						
HeadtoHelp centre						
Mental health practitioner (nurse, social work)	Mild-severe	Mild-severe			Mild-moderate	Mild-moderate
Mental health nurse in practice		Severe	Mild-severe	Mild-severe	Mild-severe	Mild-severe
Psychosocial supports						

Service not funded
Limited to visiting practitioners and/or part of catchment only
Full time local practitioners covering most of catchment

Suicide prevention services commissioned by Gippsland PHN:

- Post-suicide attempt psychosocial supports (The Way Back)
- Suicide bereavement counselling
- Place-based suicide prevention projects in partnership with Victorian DoH are underway in Latrobe and Bass Coast, using the Lifespan Model.

An analysis of the mental health service system across funders to date has noted that:

- The Latrobe Regional Hospital (LRH) Area Mental Health Service is the main provider of acute mental health services, including the Child and Youth Mental Health Service, mental health triage and a dual diagnosis service. Inpatient care is available at Traralgon only.
- Indigenous people have limited options for specialised mental health support with two providers and ongoing presence in two LGAs only.
- Specialised services for children and people aged 65 years or older are very limited.
- Public psychiatry is only available through the Area Mental Health Service.
- Secondary consultations are only available through the Area Mental Health Service and via telehealth.
- Dual diagnosis services are only available through limited providers.
- Programs including a peer support workforce are limited.
- Group programs suitable for moderate and severe illness are very limited.
- High reliance on phone and other digital services for some cohorts (eating disorders, perinatal support, LGBTIQ+ people), and/or geographies (far East Gippsland).

Service use

The Victorian Population Health Survey found that in 2019, significantly more people in Gippsland (26.8%) sought professional help for a mental health problem in the previous year compared to Victoria (18.7%) (DH 2019a); females were significantly more likely to seek professional help for a mental health problem in Gippsland (36.2%) compared to Victorian females (23.8%).

Data by LGA from 2017, estimated the proportion of the adult population reporting that they sought professional help for their mental health varied between 12% in Wellington to 20% in Baw Baw, compared to 17.6% across Victoria. See **Table 49**. It is apparent that a lower proportion of adults in East Gippsland and Wellington sought professional help for their mental health.

Table 49. Estimated proportion of adults across Gippsland's LGAs who sought professional help for their mental health, 2017 (age-standardised rates).

Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Victoria
17.7%	17.6%	19.9%	18.7%	15.1%	11.6%	17.6%

Source: DH (2017a)

High compared to Victorian LGAs, top 25%

Low compared to Victorian LGAs, bottom 25%

Medicare subsidised services

Medicare subsidised services related to mental health care reveal differences by LGA, see **Table 50**:

- 10.3% of Baw Baw, Bass Coast and South Gippsland residents used a Medicare subsidised GP service related to mental health, compared to 9.3% across Australia; the lowest rate was in East Gippsland (8.3%).
- East Gippsland and Wellington also had among the lowest rates for allied health, clinical psychology and psychiatrist use for mental health.

Table 50. Medicare subsidised mental health care, per cent of people who used a service, by Gippsland LGA, 2020-21.

Service	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	Gippsland	Australia
GP attendance	10.3%	9.8%	8.3%	10.0%	10.3%	9.8%	9.3%
Allied health attendance - mental health care	5.2%	4.8%	4.4%	4.6%	5.8%	5.0%	5.4%
Clinical psychologist attendance	2.3%	1.0%	1.1%	1.0%	2.1%	1.5%	2.2%
Other psychologist attendance	2.5%	2.8%	2.6%	2.7%	2.8%	2.7%	3.0%
Specialist attendance - psychiatry	2.0%	1.8%	1.1%	1.1%	1.5%	1.5%	1.7%

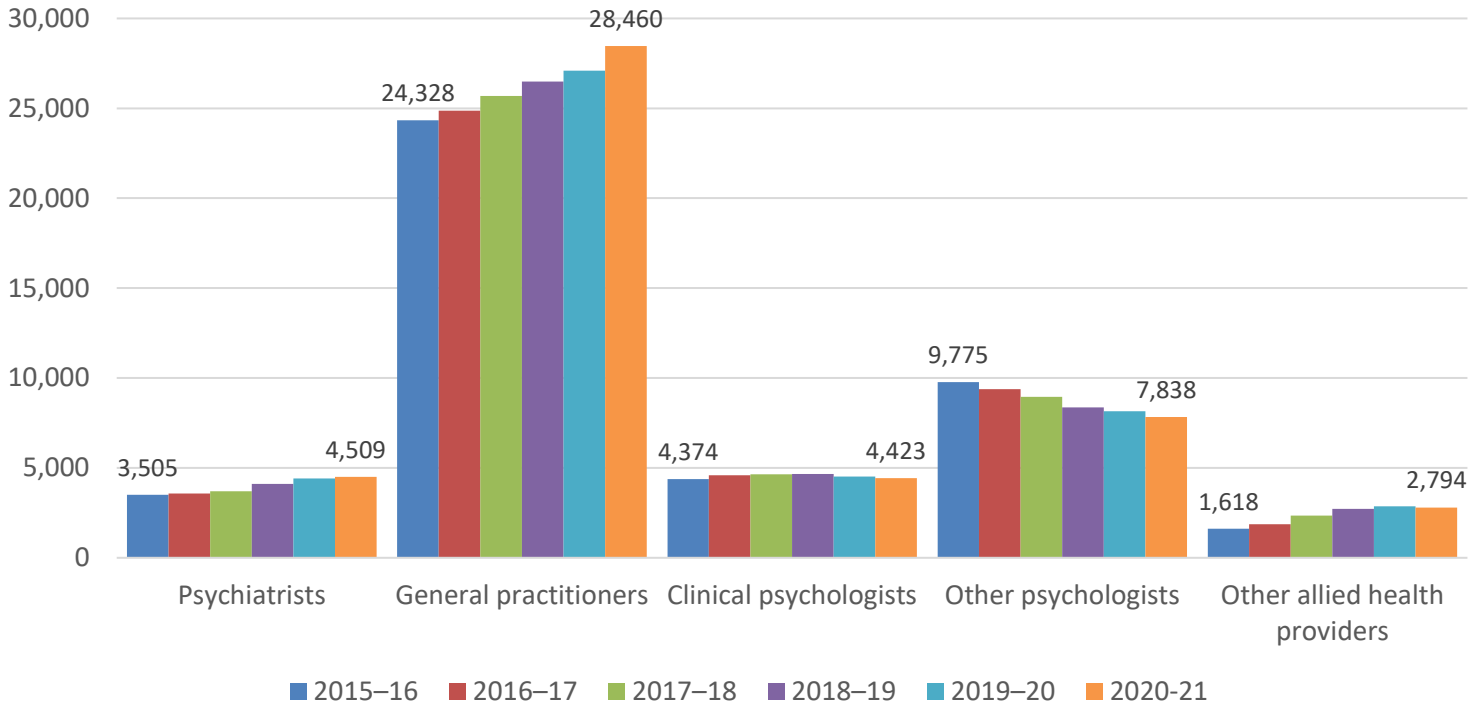
Source: AIHW (2021p)

High compared to Australian SA3s, top 25%
Low compared to Australian SA3s, bottom 25%

Trends over time for the use of Medicare funded services for mental health (**Figure 29**) show that:

- general practitioners provided mental health care for 28,460 people in Gippsland in 2020-21, up from 24,328 people in 2015-16
- less people are receiving Medicare subsidised services from a psychologist in 2020-21 compared to 2015-16
- while the number of people receiving a Medicare subsidised service during 2020-21 remained relatively steady, the number of services by psychiatrists was down by 34% compared to 2019-20.

Figure 29. Medicare subsidised mental health care, number of people who used a service in Gippsland, 2015-16 to 2020-21.



Source: AIHW (2021p) and AIHW (2021f)

Mental health related prescriptions

- The rate of mental health related prescribing was high across Gippsland with the highest rate in Latrobe (**Table 51**).

Table 51. Gippsland population with mental health related prescriptions, 2019-20.

INDICATORS	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	Gippsland	Victoria	Australia
Per cent of population with mental health-related prescriptions (subsidised and under co-payment)	19.4%	21.6%	21.9%	20.3%	20.5%	20.8%	16.4%	17.2%
Mental health-related prescriptions per 1,000 population (subsidised and under co-payment)	1,861	2,184	2,085	2,022	1,998	2,056	1,531	1,597

Source: AIHW (2021o)
High compared to Australian SA3s, top 25%
Low compared to Australian SA3s, bottom 25%

General practice

- 17% of all Gippsland patients had an active mental health diagnosis in 2020-21, see **Table 52**. This varied from 14% in Bass Coast to 20% in East Gippsland
- 20% of females had a mental health diagnosis, compared to 14% of males
- The proportion of patients with an active mental health diagnosis varied by age group; highest among 40-49 year olds (24%) while 14% of people 80 years or older had a diagnosis (**Table 53**).
- There were 13,027 patients with a new mental health diagnosis in 2019-20, up from 12,300 in 2017-18; 35% of diagnoses were for people between 20 and 39 years.

Table 52. Prevalence of active patients with an active mental health related diagnosis in 2020-21 by LGA

	Number of patients	Proportion of all active patients
Bass Coast (S)	5,813	14.3%
Baw Baw (S)	12,949	14.9%
East Gippsland (S)	11,063	20.0%
Latrobe (C)	17,646	18.7%
South Gippsland (S)	7,757	16.7%
Wellington (S)	15,954	18.5%
Gippsland	51,879	17.2%

Source: Gippsland PHN (2021e)

Table 53. Prevalence of active patients with an active mental health related diagnosis in 2020-21, by age group

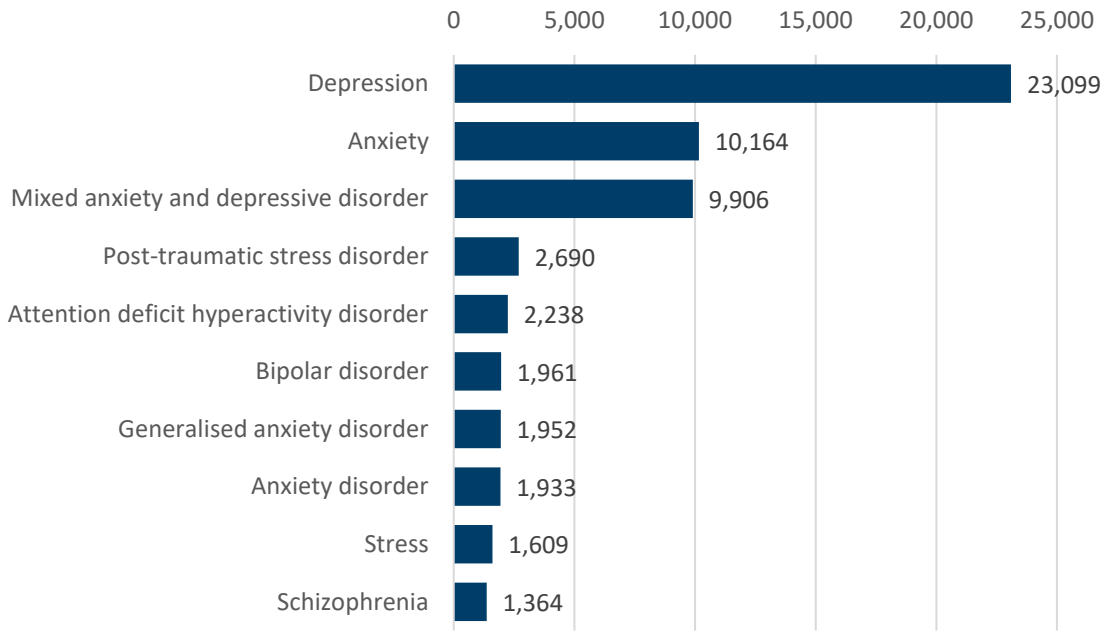
	Number of patients	Proportion of all active patients
0-9	556	1.9%
10-19	3,260	12.2%
20-29	6,384	19.2%
30-39	7,734	21.5%
40-49	7,690	24.2%
50-59	8,878	22.3%
60-69	8,488	18.2%
70-79	6,139	16.1%
80+	2,746	14.4%
Gippsland	51,879	17.2%

Source: Gippsland PHN (2021e)

- The most common mental health diagnoses in general practice were depression and anxiety (**Figure 30**):
    - 10.9% of patients had a diagnosis of depression (including mixed with anxiety)
    - 7.9% anxiety (including mixed with depression)
    - 0.9% post-traumatic stress disorder
    - 0.7% ADHD
    - 0.7% bipolar disorder
    - 0.5% schizophrenia
- A total of 364 patients with an active diagnosis of any eating disorder in 2020-21; 102 had anorexia nervosa and 70 bulimia.
- There were 14,975 referrals for psychology across Gippsland in 2020; 12,483 of these were for a patient with an active mental health diagnosis. 22% were for patients in East Gippsland, 21% for Latrobe, 18% Baw Baw, 17% Wellington, 14% Bass Coast and 8% South Gippsland.
- 10.5% of patients with a mental health diagnosis had a GP mental health plan in 2019-20, down from 12.5% in 2017-18 and 12.3% in 2018-19
- An average of 105 patients had a new diagnosis of suicidal ideation or attempt (2017-18 to 2020-21); numbers were steady.
- Proportion of patients with a mental health diagnosis prescribed selected groups of medications:
    - 54.1% antidepressants

- 15.4% opioids
- 11.5% antipsychotics
- 10.3% anxiolytics
- 7.7% hypnotics and sedatives
- 1.9% psychostimulants

Figure 30. Top 10 active mental health related diagnoses among general practice patients in Gippsland, 2020-21



Source: Gippsland PHN (2021e)

Gippsland PHN funded primary mental health services

- In 2019-20, there were 2,516 clients accessing Gippsland PHN funded Primary Mental Health care services with 2,831 episodes of care and 13,883 service contacts.
- Of all service contacts;
    - 36.2% were health care card holders

- 2.7% were NDIS participants
- 54.4% had a GP mental health treatment plan flag
- 8.8% were employed full time; 9.3% were employed part time and 53.5% were not in the work force
- 67% were referred by a GP, 14% were self-referred; other referrers included psychologist and social worker
- The main principal diagnoses of contacts was mood disorders, see **Table 54**. The most frequently diagnosed additional diagnosis was psychotic disorder (**Table 55**).
- The source of cash income was paid employment for 17% of contacts (**Table 56**).
- 34.5% of contacts were structured psychological interventions; 18.8% were clinical care coordination and 16.7% clinical nursing services, see **Figure 31**.

Table 54. Per cent of service contacts by principal diagnosis in Gippsland, 2019-20.

Principal diagnosis	Service contacts (%)
Affective (mood) disorders	31.2
No formal mental disorder but subsyndromal problems	22.4
Anxiety disorders	20.9
Missing or unknown	16.4
Other mental disorders (4.7%)	5.4
Psychotic disorders	2.4
Substance use disorders	0.6
Disorders with onset usually occurring in childhood and adolescence not listed elsewhere	0.6

Source: GPHN (2021k)

Table 55. Per cent of service contacts by additional diagnosis in Gippsland, 2019-20.

Additional Diagnosis: Grouped	Service contacts (%)
No additional diagnosis	27.9
Missing or unknown	20.2
Psychotic disorders	20.0
Disorders with onset usually occurring in childhood and adolescence not listed elsewhere	19.9
No formal mental disorder but subsyndromal problems	5.5
Other mental disorders	3.1
Anxiety disorders	2.0
Substance use disorders	0.8
Affective (mood) disorders	0.6

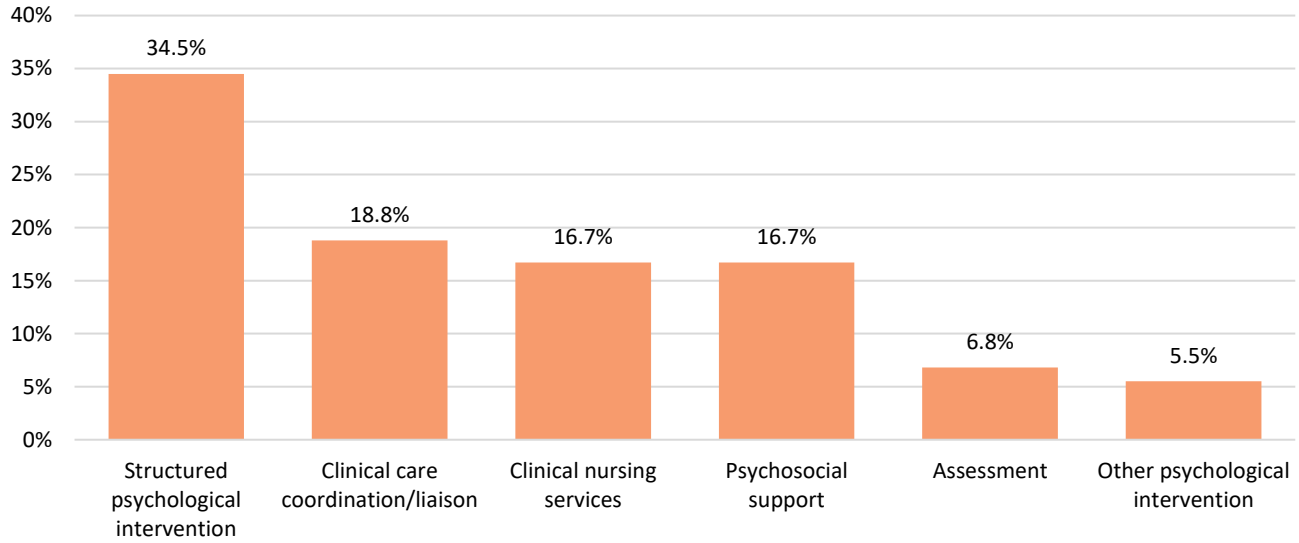
Source: GPHN (2021k)

Table 56. Service contacts by source of cash income for Gippsland, 2019-20.

Source of Cash Income	Service Contacts	
	Number	Per cent
N/A - client aged less than 16 years	1,616	11.7%
Disability support pension	1,254	9.1%
Other pension or benefit (not superannuation)	2,804	20.3%
Paid employment	2,319	16.8%
Compensation payments	111	0.8%
Other (e.g. Superannuation, investments etc.)	261	1.9%
Nil income	425	3.1%
Not known	1,068	7.7%
Not stated/inadequately described	3,974	28.7%

Source: GPHN (2021k)

Figure 31. Per cent of service contacts by service contact type for Gippsland, 2019-20.



Source: GPHN (2021k)

- In 2020-21, 4,659 clients accessing Gippsland PHN funded Primary Mental Health services with 4,764 episodes of care and 29,158 service contacts. The significant increase was in part due to the investment in HeadtoHelp in response to the pandemic.
- Demographic details over time are shown in **Table 57**. Some variation over time is apparent, including an increased proportion of female clients.

Table 57. Client demographics, Gippsland PHN funded primary mental health services, 2018-21.

Client characteristic	2018-19	2019-20	2020-21
Age 25-64 years	53.7%	58.7%	57.3%
Gender identification as female	57.9%	62.6%	65.2%
Main language spoken at home was English	99.7%	98.9%	99.2%
Aboriginal and/or Torres Strait Islander identification	3.5%	2.2%	2.0%
Country of birth was Australia	96.4%	92.6%	93.3%

headspace services

See **Children and young people** (0-25 years) for details.

Other Gippsland PHN funded services

- Membership of the Calm Kid Central online program is free for Gippsland families. The program is delivered by child psychologists and helps primary school aged children (and families, health and education professionals) to manage mental, emotional, social or life challenges. An example of the success of the program was a parent webinar on "Calm and Confident Kids" conducted in May 2021, with 56 parents attending (with no drop outs during the seminar) and 12 membership sign ups after the webinar. This seminar was designed to help parents/caregivers of primary aged children know how to support children aged 4-12 with a tendency towards worry or anxiety - or who are dealing with difficult life situations. In this seminar parents/caregivers learn practical strategies including:
    - What causes of anxiety and stress in children
    - What to say and not say when children are worried, stressed or anxious
    - What parenting behaviours help anxious children - and which accidentally make them worse
    - How to help children take steps to act more confidently
    - How to "de-escalate" situations when children are extremely anxious or experiencing panic
    - How to help children talk more confidently to themselves rather than rely on parent reassurance.

- 58.7% of student presentations to a Doctors in Secondary Schools clinic across nine secondary schools in Gippsland were related to mental health issues (GPHN 2021l).

Hospital

- Rates of hospital admission for intentional self-harm were similar in Gippsland compared to Australia in 2019-20 **Table 58**); these rates were lower than in 2018-19 for both males and females, except East Gippsland and Gippsland South-West.
- Mental health related hospital admissions that included at least one overnight stay were similar in Gippsland as across Australia, but with high rates in Latrobe and a low rate in East Gippsland.
- The average length of stay was 12.1 days in Gippsland compared to 15.1 days in Australia; East Gippsland had the longest admissions at 15.7 days. See **Table 59**.

Table 58. Hospital admissions for intentional self-harm for Gippsland residents, rate per 100,00 people in 2019-20, by gender.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	Gippsland	Australia
Hospitalisation rates, females	77	175	151	157	89	130	141
Hospitalisation rates, males	42	102	68	106	68	78	84

Source: AIHW (2021q)

Low compared to Australian SA3s, bottom 25%

Table 59. Mental health hospital admissions that included at least one overnight stay for Gippsland residents, 2017-18.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	Gippsland	Australia
Rate per 10,000 people (age-standardised)	92	132	84	109	109	109	108
Average number of days per separation	12.8	12.0	15.7	10.1	11.1	12.1	15.1

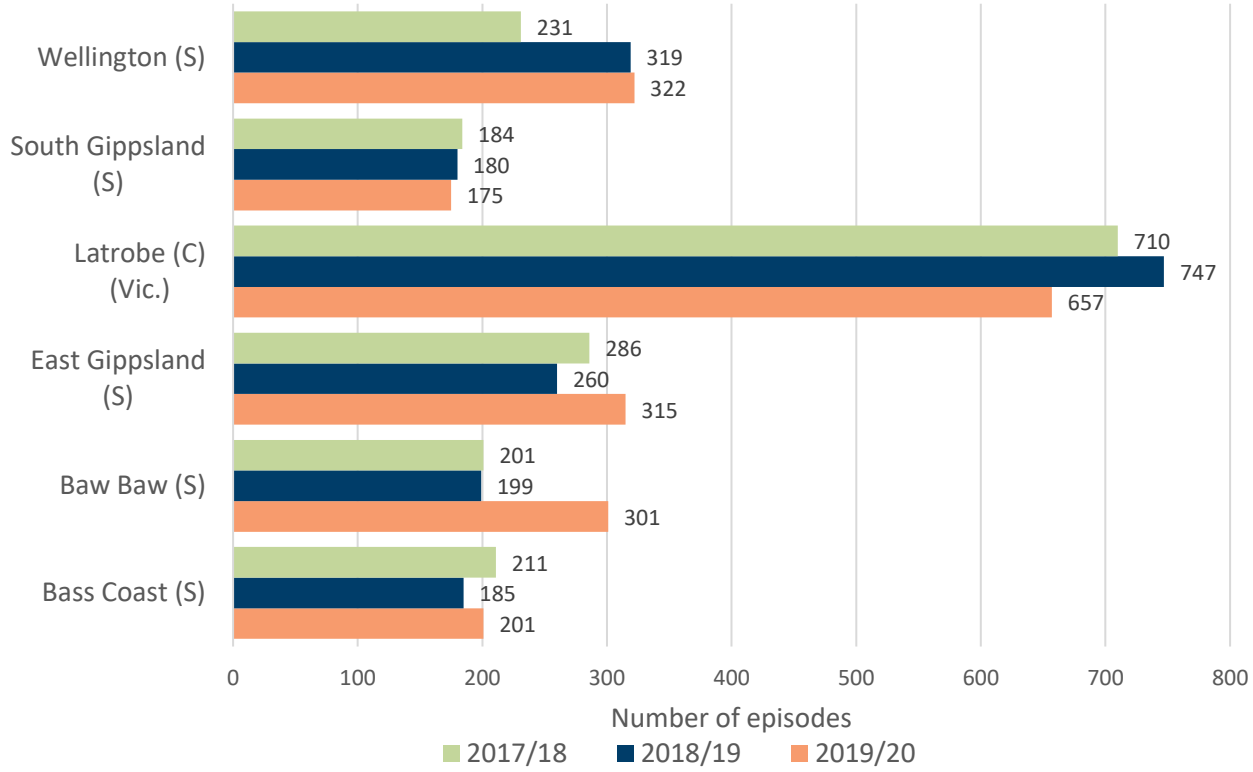
Source: AIHW (2021o)

High compared to Australian SA3s, top 25%

Low compared to Australian SA3s, bottom 25%

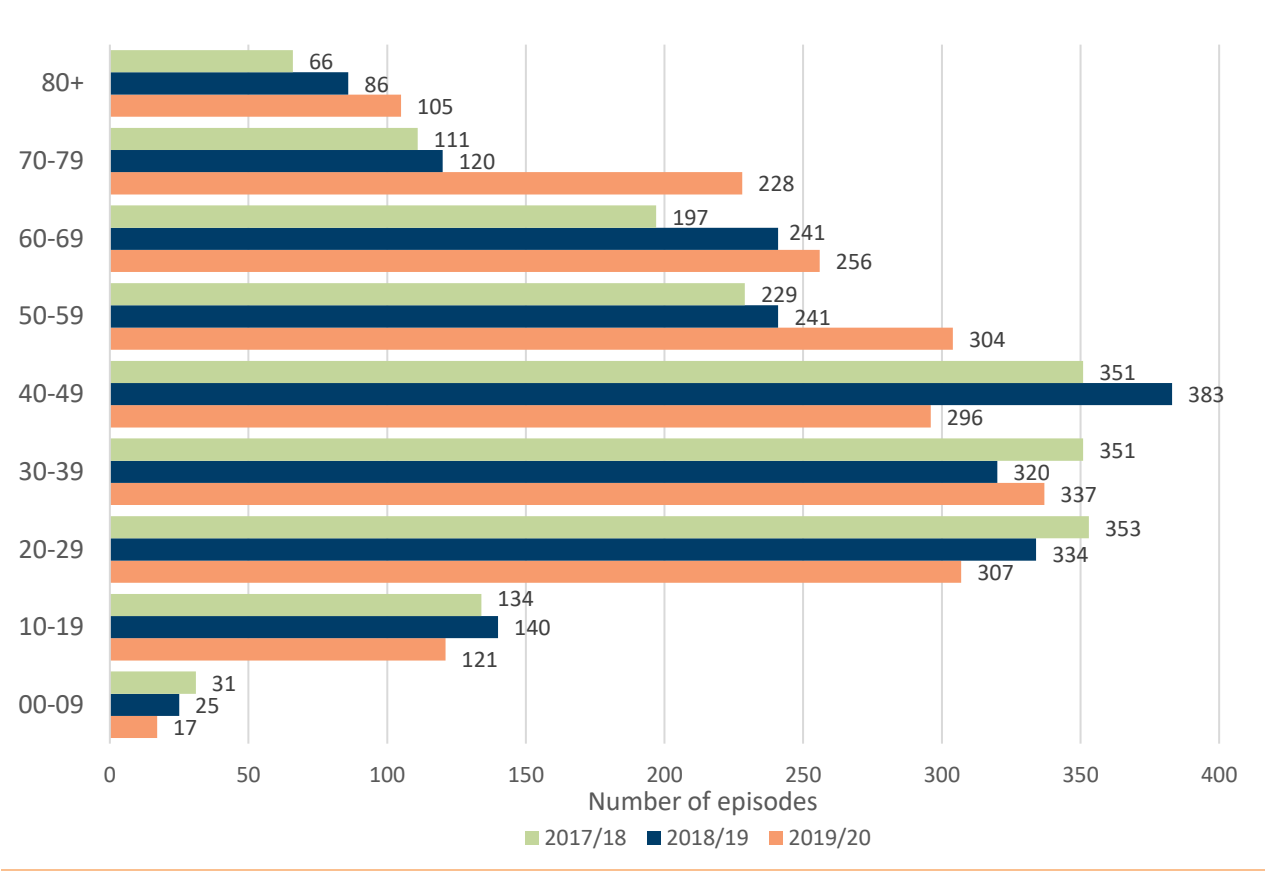
- An analysis of the number of mental health admissions for Gippsland residents to a Victorian hospital show the distribution by LGA (**Figure 32**) and age group (**Figure 33**). A shift to more people aged 50 years or older being admitted can be noted, especially people aged 70-79 years.
- The rate of mental health related emergency department presentations is high in Gippsland compared to Victoria; the highest rate was in East Gippsland. See **Table 60**.

Figure 32. Mental health hospital admissions for residents of Gippsland local government areas, by year.



Source: DH (2021b)

Figure 33. Mental health hospital admissions by age group by year for Gippsland residents.



Source: DH (2021b)

Table 60. Mental health related emergency department presentations for Gippsland residents, 2019-20.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	Gippsland	Victoria	Australia
Number of emergency department presentations that were mental health-related	483	1,035	856	598	617	3,589	NA	NA
Emergency department presentations - mental health-related (rate per 10,000)	90	137	181	135	93	125	98	122

Source: DH (2021c)

High compared to Australian SA3s, top 25%

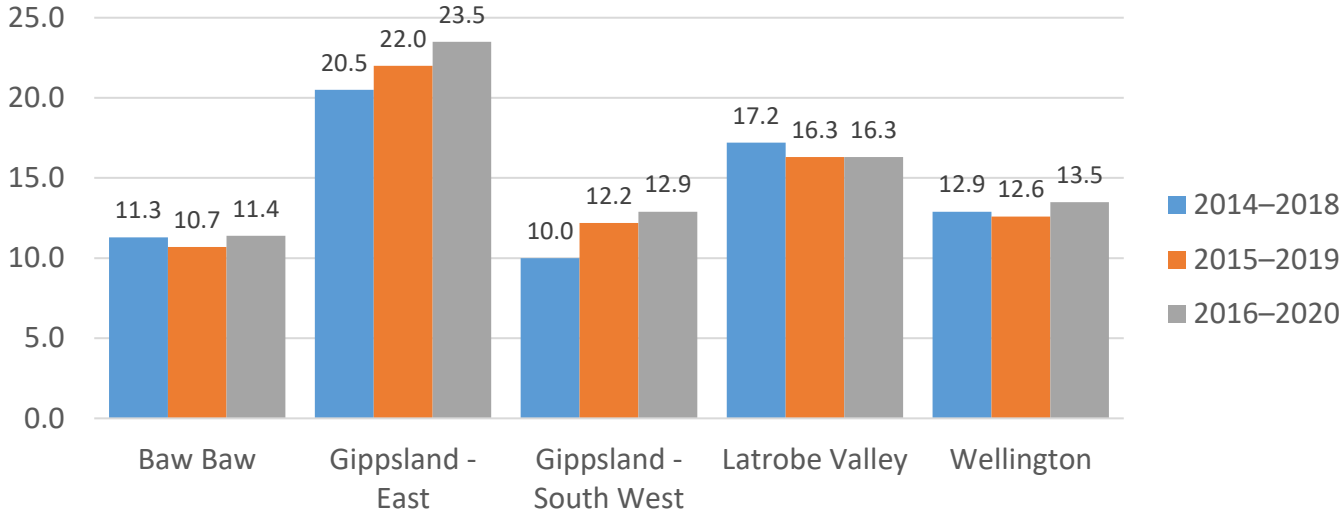
Community based mental health services

- Approximately 32% of Mental Health Community Support Service (MHCSS) clients resided in Latrobe, 17% in East Gippsland, 16% in Wellington, 14% in Baw Baw, 12% in Bass Coast and 10% in South Gippsland. (LCHS 2015).

Suicide prevention

- Suicide accounts for 1.5% of all deaths in Gippsland and 2.4% of male deaths (AIHW 2021b).
- Suicide is the leading cause of death among people aged between 15 and 44 years in Australia and accounts for the highest number of years of potential life lost among leading causes of death in the general Australian population (ABS 2019b).
- About 9% of people with a mental illness report suicidality compared to 1% of people with no mental illness (AIHW 2020f).
- Some 72% of people who exhibited suicidality had a mental disorder in the past year (AIHW 2020f).
- The suicide rate for Gippsland was 15.4 deaths per 100,000 people (age standardised) in 2016-20, an increase from 14.5 in 2014-18 and high compared to Victoria (10.5). East Gippsland has the highest rate (**Figure 34**).

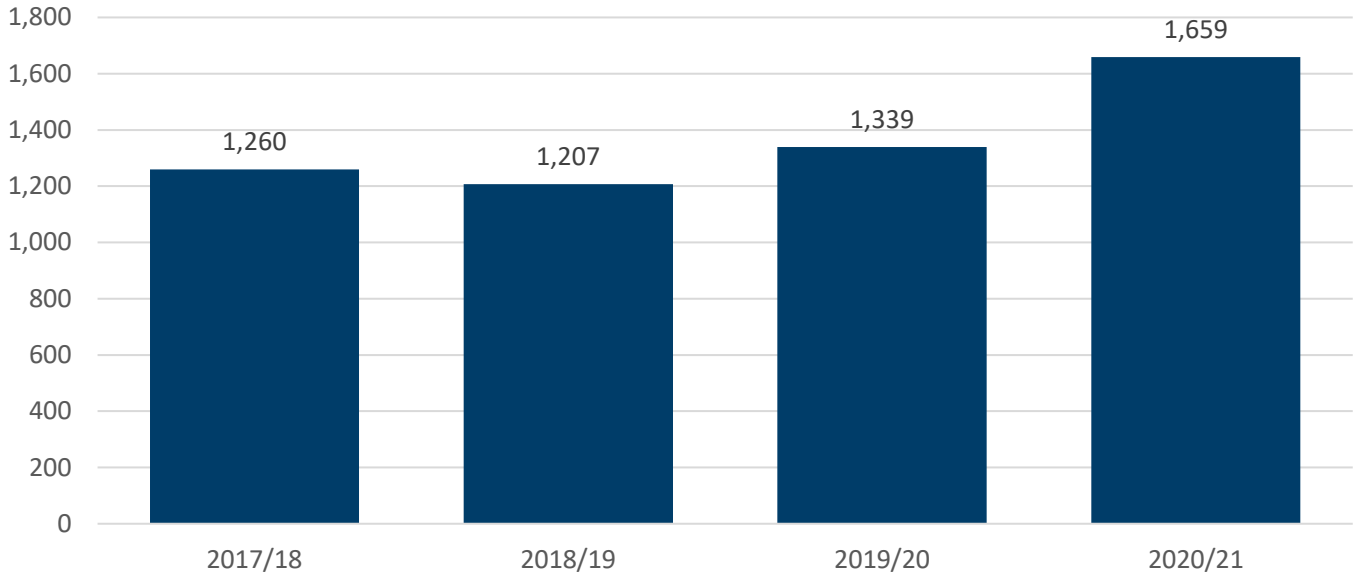
Figure 34. Age-standardised suicide rate, by year of registration of death, Gippsland Statistical Areas 3, 2014–2018, 2015–2019 and 2016–2020.



Source: AIHW (2021q)

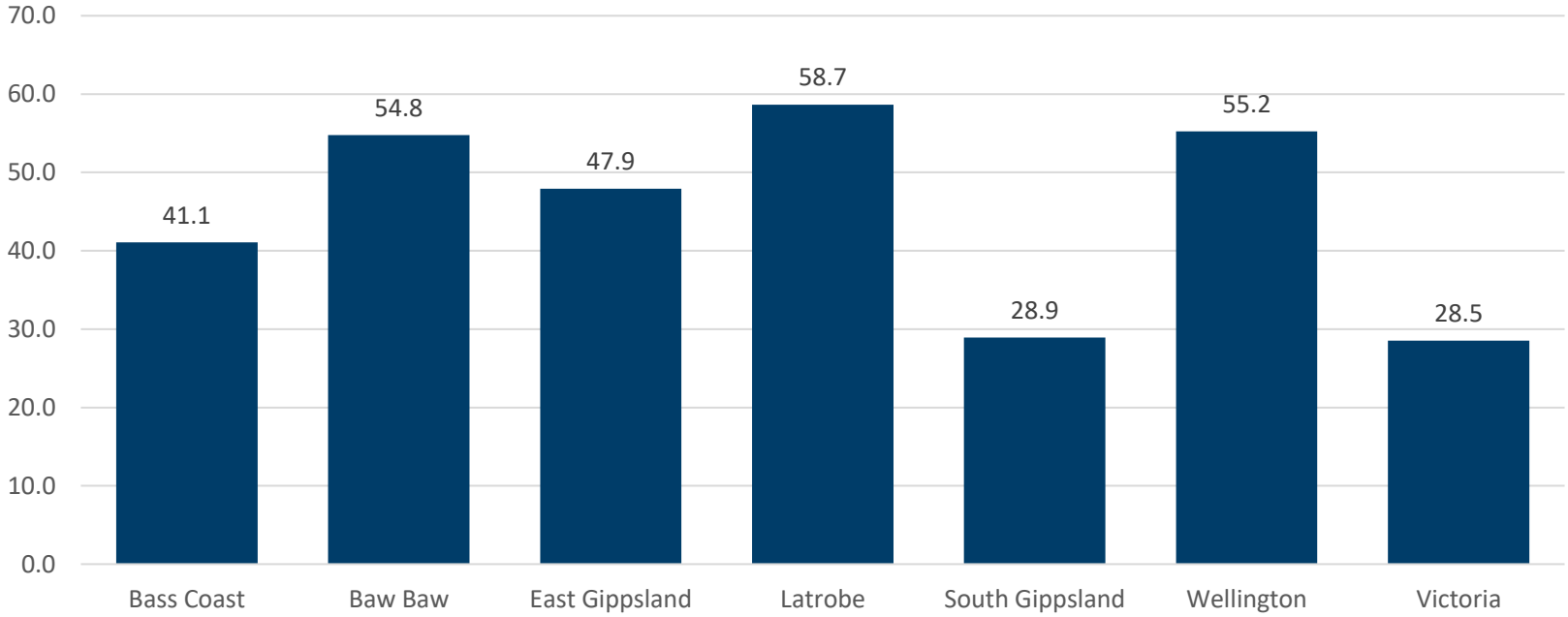
- There were 1,659 emergency department presentations for suicide attempts and suicidal ideation in 2020-21, up from 1,339 in 2019-20. See **Figure 35**.
- The rate of ED presentations were high compared to Victoria in all LGAs except South Gippsland, especially in Latrobe, Wellington and Baw Baw. See **Figure 36**.

Figure 35. Emergency department presentations for suicide attempts and suicidal ideation for Gippsland residents.



Source: DH (2021c)

Figure 36. Rate of emergency department presentations for suicide attempts and suicidal ideation for Gippsland residents by LGA per 10,000 people, compared to Victoria, average annual rate for 2017-18 to 2020-21.



Source: DH (2021c) and DELWP (2019)

- The suicide rate for males in Gippsland is high (23.4 per 100,000 males) compared with Australia (19.4); especially in East Gippsland (34.8), see **Table 61**. Rates have increased slightly since the previous reporting period (2014-18).
- Across Australia, the suicide death rate for Aboriginal people is about twice that for non-Aboriginal people (AIHW 2021r). Gippsland numbers are small, and no trend is clear.
- Aboriginal suicide prevention requires specific strategies led by Aboriginal communities, including programs that build connection to culture. (CBPATSISP 2021)
- Ex-serving males are around 24% more likely to die by suicide than Australian males (AIHW 2021r); while ex-serving females are around twice as likely to die by suicide.

Table 61. Suicide death rate for males in Gippsland by LGA, average annual crude rate (per 100,000), 2015-19.

Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland	Victoria
17.9	17.7	15.3	29.3	34.8	18.9	23.4	19.4

Source: AIHW (2021b)
High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

Factors associated with a higher burden of disease of suicide and self-inflicted injuries (AIHW 2021t):

- Child abuse and neglect contributed to 33% of the total burden of suicide and self-harm in females and 24% for males
- Most disadvantaged areas twice as high as in the least disadvantaged areas
- Alcohol use was responsible for 17% of the burden among males aged 15 years and over
- Intimate partner violence contributed 20% of the burden among females aged 15 years and over

Aboriginal and Torres Strait Islander mental health

- 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 (AIHW 2021c).
- The rate of hospital separations for mental and behavioural disorders was 4.9 times higher for Aboriginal people compared to non-Aboriginal people in Gippsland in 2019-20 (**Table 62**).

Table 62. Rate of mental and behavioural disorder hospital separations (standardised rate per 100,000) by Aboriginality.

Year	Aboriginal	Non-Aboriginal	Rate ratio
2015-16	2,370	730	3.2
2016-17	3,107	733	4.2
2017-18	3,143	758	4.1
2018-19	4,214	712	5.9
2019-20	3,563	731	4.9

Source: DH (2021a)

- Key gaps in mental health services for Aboriginal and Torres Strait Islander people were identified as part of the work to inform the Gippsland Mental Health and Suicide Prevention Plan:
    - No specific specialist suicide prevention referral pathways for Aboriginal and Torres Strait Islander people currently exists
    - Specific mental health promotion campaigns which consider the unique needs of communities with high-risk populations such as Aboriginal and Torres Strait Islander people do not exist
    - Limited knowledge of what local expertise exists in region in relation to mental health of Aboriginal and Torres Strait Islander people
    - No formalised or region wide postvention process in relation to suicide clusters in Aboriginal community exists

- A key barrier to access mental health services was long waiting lists to access affordable services. (GPHN 2016)

    "…end up stuck on waiting lists, often more than 6 months, but what choice do you have when private health care is so expensive."

Professional stakeholder perspective

Workforce

The low numbers of allied health and specialist workforce compared to State average (see **11. Health** workforce for details) impacts the ability to provide services in Gippsland in a major way according to professional stakeholder feedback to Gippsland PHN (GPHN 2021f):

- Difficulties in recruiting and retaining skilled and qualified mental health staff is an issue across Gippsland, but especially in the more remote areas.
- GPs have highlighted difficulties in accessing timely and appropriate referrals to public psychiatrists and paediatricians; there are very few local options and they often involve a long wait and can be associated with high gaps fees.
- Mental health referral options for psychology, perinatal mental health, young people and eating disorders are also very limited.
- Cost of psychologists can be a major barrier even with a mental health plan.
- GPs and other clinicians have also raised concerns about the difficulty in accessing acute mental health services across Gippsland, but especially in areas away from the regional centre.
- Workforce shortages are particularly noted in child mental health across the catchment, particularly significant in geographically isolated areas.
- There are few specialised mental health positions in Gippsland, leading to a greater importance of the availability of secondary consultations.
- More support for peer workers as part of the service system would be helpful.

A regional workforce survey in 2021 included some key findings relevant to mental health (GPHN 2021h), see also **11. Health** workforce:

- Greatest competency in the mental health sector was reported for depression, anxiety, and suicide prevention. No competency at all was most frequently reported for mental health problems in children, psychotic disorders, and personality disorders.
- The top four categories for preferred professional development topics in the mental health sector were: people with a trauma history; personality disorders; mental health problems in children; and suicide postvention (care after suicide).
- Mental health was among the top competencies for preferred professional development in the primary care and allied health sector and in the aged care sector.

Other topics

Professional stakeholder feedback has noted the following themes (GPHN, 2021f), see also **Children and young people** (0-25 years) for specific feedback.

Community need

- Mental health and wellbeing, including suicide prevention was consistently the highest rated priority area among workshop attendees.
- An increase in eating disorders among young people has been noted by providers.
- An increase in domestic violence has also been reported related to the pandemic.
- A need to advocate for vulnerable clients trying to access support via Disability Support Pension or National Disability Insurance Scheme from the Department of Social Services (Centrelink). There is a need for a social worker to liaise with mental health clinicians in managing financial support.
- Stigma around mental health and alcohol and other drug misuse is still strong in parts of the Gippsland community.
- High proportion of presentations are level 4 with delayed help seeking and low health literacy.

Service needs

- Uneven service provision and distribution across the Gippsland region with many services located in regional centres and limited access in other areas. This is especially true for complex clients; existing services designed for mild to moderate support report lack of referral options leading to managing high acuity clients.
- There is a lack of service coordination and integration across providers, leading to unnecessary assessments and difficulty transitioning between providers.
- Lack of clarity in service provision scope by providers leading to inappropriate referrals and service utilisation across the mental health system.
- Mental health and AOD supports should be integrated; currently very limited services for dual diagnosis. This group has a greater need for support to coordinate care.
- A lack of awareness among healthcare professionals about available service options limits people's ability to access the right service. This is made more difficult by short term funding for specific initiatives, leading to reluctance to refer as it "*might be another dead end*" for the person in need of a service.
- Service providers report gaps in services for people with specific conditions which are often not well understood, even by mental health professionals. This includes hoarding and squalor behaviours, eating disorders and moderate to severe personality disorders. Benefits from professionals participating in further education and training have been noted:

  "…*hearing directly from people who have experienced* [eating disorders] *firsthand was invaluable".*

- There is a lack of local access to evidence-based treatment options including psychological therapies such as Dialectical Behaviour Therapy, group therapy.
- Additional challenges to the service system such as bushfires and the COVID-19 pandemic has led to additional initiatives, but workforce limitations have made these difficult to implement. They can also make the system even more challenging to navigate.
- Service providers report a positive community response to the new dual diagnosis service for Indigenous clients.
- Access to acute mental health support in smaller, remote communities was identified as a need by stakeholders.
- HeadtoHelp model with drop in option to see fully trained staff is promising.

"We need mental health support for the missing middle… HeadtoHelp is meeting that need, what are we going to do if it closes?" [Workshop participant]

- The 'no wrong door' concept still needs to be implemented, including ensuring that all staff across the service with client contact have had training.
- Providing support for patients on wait lists is a priority; concern that low intensity presentations will escalate during the wait and lead to crisis.
- A flexible outreach service option is needed to accommodate the needs of vulnerable people across providers – it shouldn't require a referral to another service.
- Population groups which continue to have reduced service access: lower socioeconomic, older population (including RACF), school-aged children, socially isolated, young people, children of family violence and disabilities. Other sub-regional populations of concern for service access include: people out of hospital, people out of prison, Sudanese community and other recent arrivals (refugee/migrant).

Service suggestions

- To see improvements in mental health and wellbeing, we need to address the social determinants of health (see **15.** Factors affecting health (or social determinants of health), with a focus on early childhood identification and intervention, employment opportunities and supports and homelessness and housing. (AHHA 2021c)
- Consumer voice should be central when designing services to ensure they meet needs. Consumers also need to be involved in developing outcomes to measure to ensure they capture what really matters, including clinical outcomes and experience of the service.

  "We need to measure how people's lives are better after engaging with our program"

- Co-locating services in locations such as community houses, schools and medical centres to improve access and integration.
- Greater collaboration across providers, including training, and including all professions; a holistic one stop shop.
- Central intake can create barriers for local communities and vulnerable individuals; it needs to be complemented by 'no wrong door' option.
- High demand for mental health nurses who provide holistic care using an integrated service model.

Community, consumer and carer perspective

Gippsland PHN engagement has identified the following main themes related to mental health and suicide prevention in Gippsland:

- Mental health is consistently rated as a top health issue in the community across Gippsland and that was again the case during 2021 (GPHN 2021d). This reflects the understanding that mental wellbeing is foundational to health.

  "If you can help someone's mental health and their wellbeing, a lot of other stuff falls into place" [Workshop participant]

- Many community members were concerned about access and availability of a professional who understand the conditions.

  "…insufficient mental health practitioners/psychologists etc in general, let alone those who bulk bill."

  'I need to see a psychiatrist every month and a psychologist and a very good GP who understand not just general mental health but complex mental health.'

- Mental health and wellbeing is included as a priority in many LGAs updated Municipal Public Health and Wellbeing Plans, reflecting growing awareness and community support for the importance of mental wellbeing and the link to a resilient, well connected community. This includes in Bass Coast (Bass Coast Shire

Council, Healthy Communities Plan 2021-25, personal communication), Baw Baw (Baw Baw Shire Council, Municipal Public Health and Wellbeing Plan 2021-2025, personal communication) and Wellington (Wellington Shire Council, Healthy Wellington, MPHWBP 2021-25, personal communication), noting that not all were finalised at the time of writing.

- Community and professional stakeholder engagement to inform the model for a mental health café (Latrobe Health Assembly 2021) has noted the need for:
    - A safe, calm and welcoming space for people experiencing mental health challenges, open on weekdays, evenings and on weekends
    - A non-clinical space staffed by people with lived experience, including social activities, coffee, food
    - Help with service navigation and ability to "*talk to someone who cares*"

    "This café is a great community response to better supporting people with mental illness and will fill a gap"

- Specific challenges in East Gippsland include the widespread impact of the 2019-20 bushfires which followed years of drought and underlying disadvantage including challenges related to distance.
- The importance of prevention and early intervention has been highlighted.

    "Many mental health issues could be prevented by well-funded school programs and early access."

- Specific population groups such as farmers, LGBTIQ+ people and people who are socially isolated are at increased risk.

    "… we live remote on a farm. Financial worries impact otherwise we have a very good GP in nearest town."

- Mental health is more commonly reported as a challenge by people with financial worries in the community. The cost of accessing mental health services is a key barrier and more remote locations are more likely to be affected by long waiting times and access issues due to transport issues and fewer local options.
- There are still many roadblocks in the mental health system and these affect both the person with a mental health issue as well as their family, carers and friends.

    "The journey has been huge, frightening and exhausting for all."

- There is a lack of after-hours / crisis services. This can mean a presentation to ED can be needed as a starting point to access required mental health services and this environment is not resourced to deal appropriately with acute mental health and AOD presentations.
- There is recognition of a lack of staff who are perceived as being overworked and needing more support. More funding for local services and supports is needed.
- Physical conditions are often present alongside mental health issues.

    "Try to stay physically and mentally healthy, I struggle with both."

- There are insufficient services suitable for people with a dual diagnosis in Gippsland. Most general health practitioners do not sufficiently understand the complexity of dual diagnosis, and there is a lack of skilled workers, (Murphy 2018). There are often significant underlying factors related to mental health and AOD issues, especially for people with a dual diagnosis:
    - Homelessness
    - Lack of community spaces and social activities
    - Poverty

- Shame and stigma
- Family violence
- Family breakdown
- Lack of affordable housing

- Need to address stigma and discrimination, including among the health professionals.
- Privacy and confidentiality are a concern and it can be especially difficult to manage in small communities.
- Primary care providers need to be better equipped to manage mental health and AOD diagnoses, especially GPs.

  "A lot of the doctors don't know where to send people to…"

  "…take more medication, sleep it off, you'll be better in morning."

- Consumers and carers of mental health and AOD services in Gippsland report a range of experiences, with overall sense that needs were not effectively being met.

Suicide specific themes included:

- Key service gaps related to suicide prevention have been identified:
  - A need for regional planning to ensure State and Federal initiatives suit the region
  - Lack of consistency and confidence in suicide risk assessment, screening, medication use and referral pathways
  - Communications and integration between hospitals and primary care can be challenging
  - Varied process for forwarding discharge summaries
  - Significant workforce challenges, including a need for medical, allied health and peer workforce
  - Evaluation and understanding of impact of current services is limited
  - Consideration of population groups with specialised needs and/or high risk (including LGBTQI+, men, Aboriginal, trauma impacted) is required
  - Need for consistent and available education, training and support for GPs working with people experiencing suicidal symptoms
  - Lack of specific, routine or consistent inclusion of stories from people with lived experience to help guide improvements in practice
  - Suicide prevention training for frontline staff (gatekeepers)
- Lack of inpatient capacity and follow up after suicide attempts

COVID-19 has led to several documented health impacts including:

- There has been worsening mental health, parental alcohol and drug misuse, overcrowding, food insecurity, and a decline in access to services. Stress on parents, often mothers, and children due to home-based learning, household stress, restricted movement, social isolation, changed routines, and decreased access to services.
- Mental health can be difficult to address using telehealth (GPHN, 2021d).

  "Video conferencing specialist/ mental health sessions is very frustrating from home"

Figure 37. Bec's journey – Mental health and wellbeing, including suicide prevention.

Bec's journey

Bec is 29 years old, she relocated interstate to a rural property with her partner and daughter and is six months pregnant. She was diagnosed with bipolar disorder and is managing this with medication and regular appointments with her psychiatrist who works interstate. The move has taken a toll on her mental health and she wants to find out about local supports available.

Bec feels frustrated as her local GP clinic has a six week wait for new patients.

The GP generates a mental health plan with her current psychiatrist while she transitions to local care.

Bec faces another wait for a psychologist while her medication is reviewed by her psychiatrist.

She feels anxious about the pregnancy and speaks to her GP about feeling isolated.

She also discloses that the move has caused financial stress on her family with the baby on the way.

Her GP connects her to a service that offers donated baby items and runs a parent support group.

Bec is also referred to the perinatal emotional health program for further mental health support.

What didn't help?

- Long wait times as GPs were unable to take on new patients.
- Shortage of mental health professionals in the region including psychiatrists and psychologists.
- Feeling isolated from her support system.

What helped?

- Care coordination between her GP and pre-existing mental health support team while she transitions to local care.
- Accessing social and mental health support services in an integrated way through her GP.

Key messages

- Finding local health services and community supports is an integral part of adjusting to life in a rural community.
- Accessing social and financial supports is just as important as accessing physical and mental health related supports.

Source: GPHN (2021d)

8. Chronic disease

"There is a lack of GPs, we need basic GP services in …, let alone continuity of care" [Workshop participant]

"Early intervention rather than later and addressing the too hard basket rather than ignoring people as is sometimes the case unfortunately" [Workshop participant]

Health status

Many people have more than one chronic condition and many chronic conditions share common risk factors (AIHW 2021u):

- 47% of people in Australia have one or more chronic condition
- 20% have two or more of ten selected chronic conditions
    - More common among older people; 51% of people aged 65 years or older, compared to 12% for 18-44 year olds
    - More common among females (23% compared to 18% for males)
    - Many live in areas with low socio-economic status (45% compared to 34%)
    - 35% experience high or very high psychological distress (compared with 4.3% for people with no chronic conditions)
    - 50% have restrictions to everyday activities (compared to 7.9%)
    - The 3 most strongly associated combinations of 2 chronic conditions were asthma with COPD, diabetes with chronic kidney disease and selected cardiovascular diseases with chronic kidney disease

The AIHW commonly report on ten chronic conditions; arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease mental health conditions (note that this includes dementia) and osteoporosis. These ten chronic conditions accounted for:

- 51% of hospitalisations in 2017–18 (principal or additional diagnosis)
- 89% of deaths in 2017 (underlying or associated cause of death)
- 61% of the total burden of disease

For the purpose of the Gippsland PHN Health Needs Assessment, **Mental health** and wellbeing, including suicide prevention **and wellbeing, including suicide prevention**, **Dementia** and **Cancer** have been identified as priority areas in their own right and most information about these conditions are reported under those headings.

Chronic disease groups causing most burden of disease (AIHW 2021a):

- Musculoskeletal conditions caused the second most burden (after cancer), and accounted for 13% (most commonly back pain and problems 4.5%, followed by rheumatoid arthritis and osteoarthritis)
- Cardiovascular disease was the third, accounting for 13% (down from 15% in 2015); (most commonly coronary heart disease 6.3%, followed by stroke)
- COPD accounted for 3.5% of disease burden

- A high proportion of people with chronic conditions also have a disability, more than 50% including emphysema, stroke, arthritis, back problems and coronary heart disease. (AIHW 2020c)

Several risk factors for chronic disease are more common in Gippsland compared to Victoria as whole, see **Table 63**:
- Over 60% of adults consume alcohol at levels likely to cause increased risk of lifetime harm across Gippsland with over 70% in Bass Coast, compared to Victoria 59.5%.
- Over 20% of adults are current smokers in Bass Coast, Baw Baw and Latrobe, compared to 16.7% in Victoria.
- Around 30% of adults have been diagnosed with high blood pressure in Bass Coast, Baw Baw, Latrobe and Wellington, compared to 24.5% in Victoria
- Around 22% of adults in Gippsland are obese compared to 19.3% in Victoria.
- Around 40% of people met physical activity guidelines compared to 51.1% for Victoria (DH 2019a); males were significantly less likely to meet the physical activity guidelines in Gippsland (36.0%) compared to Victorian (53.0%).

Over 30% of adults in Gippsland report more than one chronic disease, compared to 25.5% in Victoria. Prevalence of common chronic diseases among adults in Gippsland are estimated, see **Table 64**:
- 6.5% have heart disease (8.9% in Bass Coast) compared to 6.7% in Victoria
- 2.3% have COPD (2.6% in Latrobe) compared to 2.1% in Victoria
- 5.9% have type 2 diabetes (7.8% in Latrobe) compared to 5.5% in Victoria
- It is recognised that multimorbidity increases the complexity of patient care (AIHW 2021u), making coordination of care and communication between different providers especially important.

7.7% of adults in Gippsland are registered with the National Diabetes Services Scheme (NDSS) with type 2 diabetes (AIHW 2021v), the third highest for any PHN. In addition, data shows that in Gippsland;
- Diabetes prevalence is 20.5% for people 75 years or older compared to 2.1% of people aged 18-55 years.
- 9.9% of adults in Moe/Newborough/Morwell have diabetes type 2; high rates were also reported for Churchill (8.9%), Sale (8.5%), Wonthaggi/Inverloch (8.3%) and Longford/Loch Sport/Yarram (8.3%).

Modelled prevalence of chronic kidney disease among adults in Gippsland was 10.1% (2011-12), (AIHW 2021v).

Table 63. Estimated prevalence of selected risk factors among adults in Gippsland, age-standardised rates by LGA, 2017.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Consumed alcohol at levels likely to increase lifetime risk of harm (> 2 standard drinks per day)	73.4%	66.6%	59.2%	63.5%	67.3%	64.8%	64.6% Inner 66.3% Outer	59.5%
Consumed alcohol at levels with increased risk of injury on a single occasion (>4 standard drinks single occasion at least monthly)	54.5%	46.8%	45.1%	47.8%	55.7%	53.4%	48.2% Inner 54.8% Outer	43.0%
Current smokers	23.9%	19.9%	23.4%	21.6%	15.3%	18.0%	22.2% Inner 16.9% Outer	16.7%
Daily smokers	18.2%	14.4%	18.3%	18.7%	13.7%	11.3%	18.0% Inner 12.4% Outer	14.7%
Dietary guidelines for fruit met	42.9%	41.1%	52.1%	37.1%	44.8%	42.5%	42.3% Inner 43.2% Outer	43.2%
Dietary guidelines for vegetables met	7.8%	4.8%	6.8%	4.3%	6.7%	4.1%	5.7% Inner 5.4% Outer	5.4%
Drink sugar-sweetened drink every day	8.4%	16.6%	10.3%	13.9%	9.8%	14.2%	12.6% Inner 11.8% Outer	10.1%
Physical activity guidelines NOT met; 'insufficient time and sessions'	44.7%	38.6%	44.7%	38.1%	48.9%	32.5%	41.0% Inner 39.9% Outer	44.1%
High blood pressure diagnosed by doctor - adults (age-standardised)	31.3%	24.1%	29.3%	29.3%	23.9%	28.8%		25.4%
Persons who are obese (BMI 30.0 or greater - adults) (age-standardised)	20.3%	24.6%	23.6%	20.4%	20.9%	24.1%	21.7% Inner 22.7% Outer	19.3%

Source: DH (2017a)

High compared to Victorian LGAs, top 25% of values
Low compared to Victorian LGAs, bottom 25% of values

Table 64. Estimated prevalence of selected chronic diseases in the Gippsland population, age-standardised rates by LGA, 2017.

Disease	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Chronic Obstructive Pulmonary Disease (modelled estimates) (PHIDU 2021e)	1.7%	1.8%	2.5%	2.6%	2.2%	2.6%	2.3%	2.1%
Ever diagnosed with asthma (adults)	18.8%	21.0%	20.0%	21.1%	17.1%	18.8%	Inner 20.4% Outer17.8 %	20.0%
Ever diagnosed with diabetes type 2 (adults)	5.8%	5.0%	5.7%	6.8%	4.6%	7.5%	5.9%	5.5%
Ever diagnosed with heart disease (adults)	8.9%	5.4%	5.3%	6.8%	5.6%	6.8%	Inner 6.5% Outer 6.1%	6.7%
Persons ever diagnosed with osteoporosis (adults)	5.5%	5.9%	5.8%	6.0%	8.2%	5.0%	Inner 5.8% Outer 6.7%	5.7%
Persons reporting arthritis (adults)	25.7%	21.9%	24.4%	28.5%	30.4%	21.8%	Inner 25.2% Outer 25.1%	20.5%
Persons reporting two or more chronic diseases (adults)	34.6%	31.7%	27.1%	33.5%	29.6%	24.9%	Inner 31.4% Outer 27.4%	25.5%

Source: DH (2017a)

High compared to Victorian LGAs, top 25% of values
Low compared to Victorian LGAs, bottom 25% of values

- Mortality rates in Gippsland due to chronic disease are high compared to Australia (see **Table 65**) and rates in Latrobe are especially high.
- Gippsland also has high rates of avoidable deaths (compared to Victoria) due to chronic diseases:
  - Circulatory system diseases 39.4 deaths per 100,000 people (age-standardised), compared to Victoria (32.5)
  - Chronic Obstructive Pulmonary Disease 12.7 (8.5)
  - Diabetes 5.3 (4.9)

Table 65. Mortality due to selected chronic diseases in the Gippsland population, rate per 100,000 people (age-standardised), by LGA, 2015-19.

Cause of death	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	Australia
Chronic Obstructive Pulmonary Disease	23.1	23.6	20.2	40.7	29.3	30.2	29.0	24.0
Coronary heart disease	64.1	62.1	59.9	79.9	60.5	78.3	68.2	59.8
Diabetes	14.3	18.4	15.1	20.3	12.4	18.9	16.5	15.7

Source: AIHW (2021b)

High compared to Australian LGAs, top 25% of values

Low compared to Australian LGAs, bottom 25% of values

Populations more likely to be affected by chronic disease include:

- Aboriginal and Torres Strait Islander people. See **Aboriginal and Torres Strait Islander health and wellbeing**
- People affected by **15.** Factors affecting health (or social determinants of health)

National data also shows that people with a low socio-economic status are more likely to have chronic disease or risk factors (Victoria University 2021)):

- Rates of physical inactivity are higher in low socioeconomic areas
- Risky drinking, defined as two or more standard drinks per day on average, occurs at a higher rate in the most advantaged communities. However, people in lower socioeconomic communities experience higher rates of harm from alcohol consumption.
- People in the most disadvantaged communities are 2.8 times more likely to smoke than people in communities with higher socioeconomic status
- Obesity rates are rising in most socioeconomic groups. People in the most disadvantaged communities are 57% more likely to be obese than the most advantaged areas.
- People in most disadvantaged communities are more than twice as likely to live with diabetes than the most advantaged. Hospitalisations and deaths related to diabetes are, respectively, 2 and 2.3 times as high in the lowest socioeconomic communities compared to the highest.

Service system

Most care for chronic conditions is provided in the primary health care setting by general practitioners (GPs) and allied health practitioners. See **Gippsland health services**.

Gippsland PHN has delivered a number of education and training events including COPD training for practice nurses, diabetes management training, chronic disease management.

Service use

Selected indicators of chronic disease service user found in **Table 66**. It can be noted that:

- Prescribing of asthma medications is high
- Tests related to cardiovascular disease and diabetes are not as common among the Gippsland population compared to Victoria
- Diabetes education and diabetes cycle of care rates per population vary across Gippsland

Table 66. Chronic disease indicators, by Gippsland LGA.

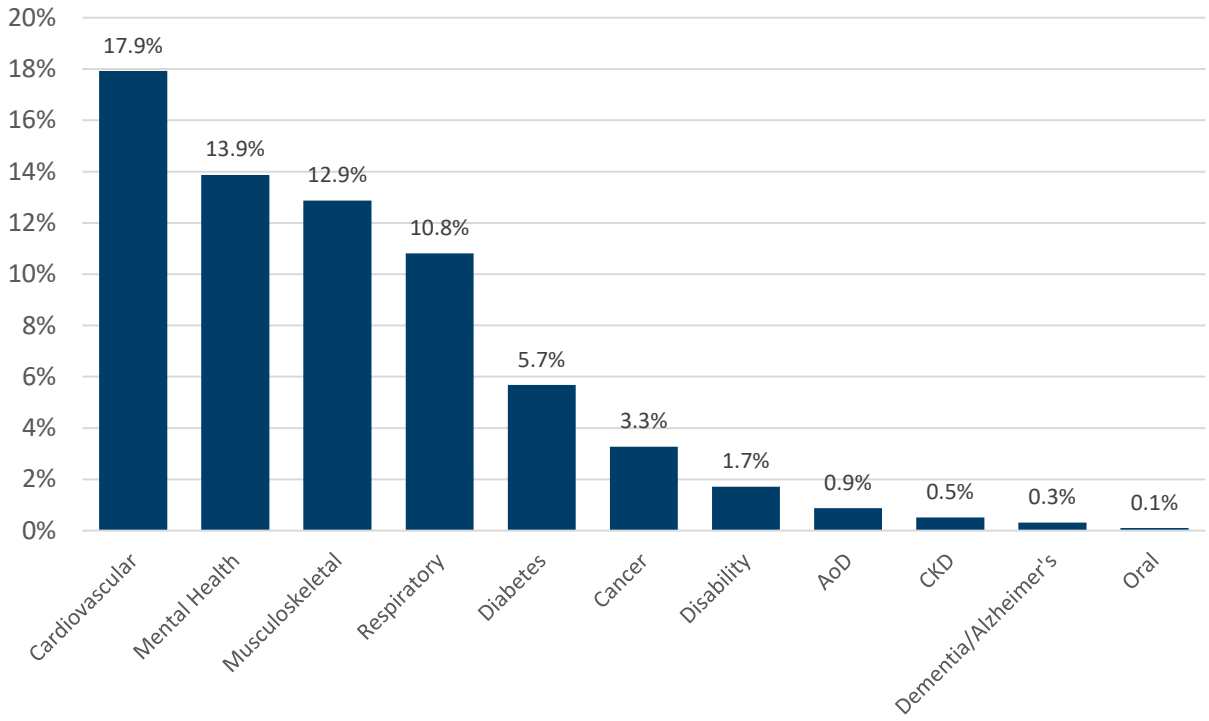
Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	Victoria	Year	Reference
Asthma medicines, aged 3 to 19 years, age-standardised rate per 100,000 people	24,962		26,952	37,331	23,613	30,678	23,810	23,810	2013-14	ACSQHC (2021)
Asthma medicines, aged 20-44 years, age-standardised rate per 100,000 people	25,701		28,720	33,845	32,164	29,592	19,496	19,496	2013-14	
Standard echocardiography, age-sex standardised rate per 100,000 people	4,027		4,364	4,107	3,538	3,845	NA	4,316	2016-17	
Stress echocardiography, 18 years and over, age-sex standardised rate per 100,000 people	1,251		1,156	362	1,146	362	NA	1,465	2016-17	
Cardiac stress test and imaging, age-sex standardised rate per 100,000 people	3,599		3,966	3,073	3,009	2,925	NA	4,575	2016-17	
Blood sugar or diabetes check in past two years - adults (age-standardised)	51.1%	43.6%	48.7%	53.2%	44.2%	51.8%	50.0% Inner 48.6% Outer	50.7%	2017	DH (2017a)
Diabetes education - per cent of people	0.3%		0.3%	1.1%	0.2%	1.4%	0.7%	0.3%	2018-19	AIHW (2021f)
Diabetes mellitus cycle of care - per cent of people	1.1%		1.7%	1.5%	0.8%	1.2%	1.3%	1.1%	2018-19	
Incidence of insulin treated type 2 diabetes - annual age-standardised rate (per 100,000 people with diabetes type 2)	4,142		5,807	4,018	4,472	3,750	4,361	4,700	2014-18	AIHW (2020h)
Incidence of insulin treated type 1 diabetes - age-standardised rate (per 100,000)	10.0		12.4	10.1	12.8	14.7	14.0	8.6	2014-18	

High compared to other areas, top 25% of values
Low compared to other areas, bottom 25% of values

General practice

General practice data shows the most common chronic conditions among general practice patients are cardiovascular disease, mental health and musculoskeletal conditions, see **Figure 38**. An analysis by age group shows that mental health and respiratory conditions are common across age groups, while cardiovascular disease and musculoskeletal conditions gradually increase with age and become dominant from 60 years.

Figure 38. Prevalence of active patients with an active chronic disease diagnosis by category – 2020-21



Source: GPHN (2021e)

Across Gippsland, 43.1% of all active patients had one or more chronic disease diagnosis, see **Table 67**. Data by LGA indicate that 51.3% of East Gippsland patents have a chronic disease diagnosis, while 35.6% of Baw Baw patients have a chronic disease diagnosis. 43% of both males and female had any chronic disease diagnosis. For 0-9 year olds, 8% had a chronic disease diagnosis, rising to 74% of general practice patients aged 80 years or older.

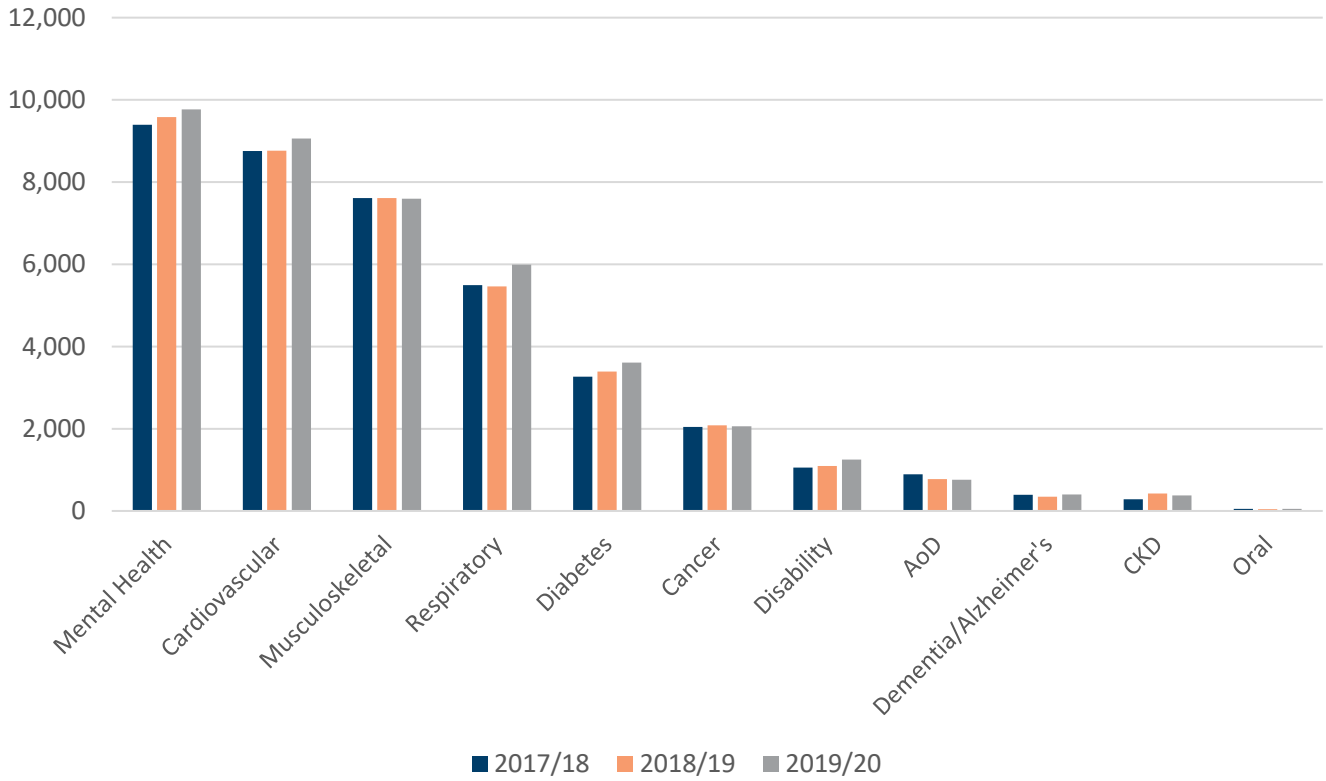
Table 67. Prevalence of active patients with an active chronic disease diagnosis in 2020-21 by LGA.

	Number of patients	Proportion of all active patients
Bass Coast (S)	16,544	40.7%
Baw Baw (S)	30,946	35.6%
East Gippsland (S)	28,366	51.3%
Latrobe (C)	41,607	44.2%
South Gippsland (S)	21,379	46.0%
Wellington (S)	38,730	44.8%
Gippsland	129,785	43.1%

Source: GPHN (2021e)

The number of new chronic disease diagnoses by condition over three years are shown in **Figure 39**.

Figure 39. Number of patients with a new chronic disease diagnosis by chronic disease category, by year.



Source: GPHN (2021e)

Patient management in general practice is important to prevent chronic conditions and to manage them well. The Practice Incentives Program Quality Improvement (PIP QI) commenced 1 August 2019. As part of the program, practices share data to inform a minimum data set, including several measures relevant to chronic disease. Data from 63 practices in Gippsland contribute to the data set (71% of practices) and 2020-21 results show, see **Table 68**:

- In Gippsland, smoking status was recorded for 73.0% of patients, compared to 51.9% with alcohol consumption recorded and 21.7% with height and weight recorded.

- A higher proportion of Gippsland patients had an influenza vaccination status recorded compared to Australia; 71.7% of people over 65 years and for people with diabetes (68.5%) or COPD (75.5%).
- 80.6% of Gippsland patients with a diabetes type 2 diagnosis also had a HbA1c results recorded in the past 12 months, compared to an average of 73.4% for Australia.
- 42% of Gippsland patients had all necessary risk factors for cardio-vascular disease (CVD) risk recorded; this is lower than Australia at 48.5%.

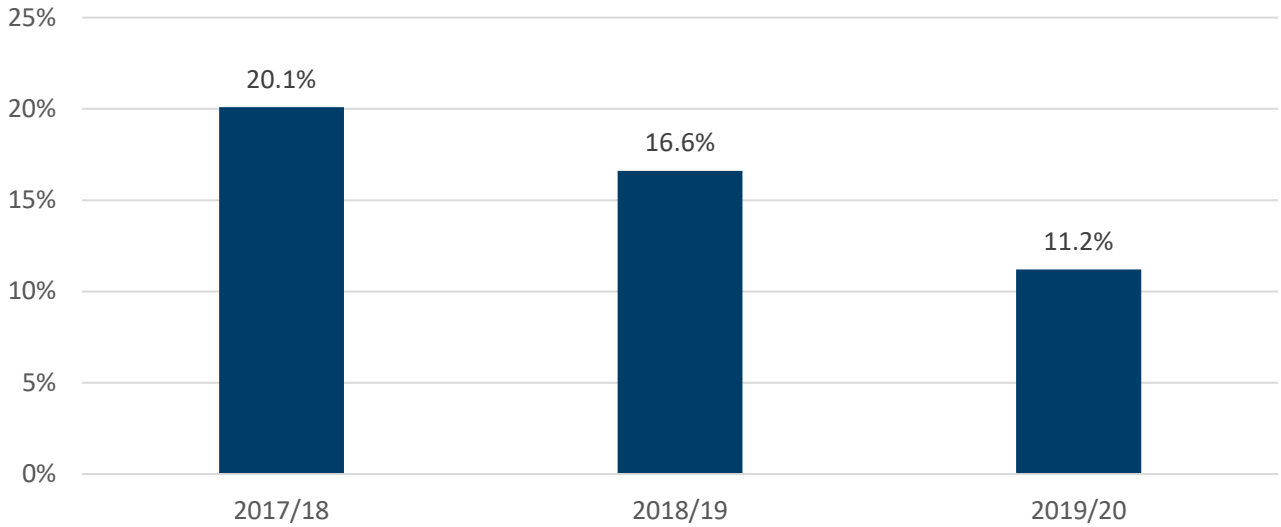
Table 68. Selected Practice Incentives Program Quality Improvement (PIP QI) measures for regular clients to general practice, Gippsland compared to Australia, 2020-21.

PIP QI indicator	Gippsland	Australia
With a smoking status recorded, 15 years age and over	73.0%	66.1%
Current smoker	17.0%	14.7%
Clients with height and weight recorded, 15 years age and over	21.7%	23.6%
BMI Obese	47.8%	39.8%
Alcohol consumption status recorded, 15 years age and over	51.9%	56.2%
Clients aged 65 years and over with an influenza immunisation status recorded	71.7%	64.2%
Clients with diabetes with an influenza immunisation status recorded	68.5%	58.2%
Clients with COPD with an influenza immunisation status recorded	75.5%	66.8%
Clients with diabetes type 2 diagnosis and a HbA1c result within the previous 12 months	80.6%	73.4%
With diabetes and blood pressure recorded within the previous 6 months	64.7%	58.7%
A record of the necessary risk factors for CVD risk assessment, 45-74 years age	41.9%	48.5%
Female clients with an up-to-date cervical screening test record, 25-74 years age	42.2%	37.4%

Source: AIHW (2021v)

- An analysis of POLAR GP data, noted a decrease in diabetic patients completing a cycle of care between 2017-18 and 2019-20, see **Figure 40**.

Figure 40. Proportion of Diabetes Cycle of Care completion for diabetic patients, by year (MBS items: 2517, 2521, 2525).



Source: Gippsland PHN (2021e)

- 9.3% of patients who had their alcohol consumption recorded had an increased risk of alcohol related disease; this was most common in the 60-69 year age group (13.1%).
- 16.8% of patients who had their smoking status recorded were current smokers, see **Table 69**; Latrobe had the highest proportion at 19.3%. Smoking was most common in the 40-49 year age group (26.4%).

Table 69. Proportion of active patients (with a recorded smoking status) who were current smokers by LGA, 2020-21.

	Number of patients	Proportion of active patients
Bass Coast (S)	4,843	16.4%
Baw Baw (S)	9,965	15.6%
East Gippsland (S)	7,153	16.1%
Latrobe (C)	12,827	19.3%
South Gippsland (S)	4,939	14.5%
Wellington (S)	10,256	16.7%
Gippsland	37,213	16.8%

Source: Gippsland PHN (2021e)

Hospital activity

Potentially preventable hospitalisations (PPHs) for chronic conditions in Gippsland are high compared to Victoria / Australia with 1,513 PPHs per 100,000 people compared to 1,306 / 1,233. See **Gippsland main health issues**. The chronic conditions leading to most PPHs in Gippsland, age-standardised rates per 100,000 people, (compared to Victoria):

- Iron deficiency anaemia 399 (358), especially high in Latrobe (582) and Wellington (419)
- Diabetes complications 324 (204), especially high in Baw Baw (816) and Latrobe (274)
- COPD 284 (229), especially high in Latrobe (356)
- Congestive heart failure 202 (213), highest in Latrobe (234) and lowest in Baw Baw (168)
- Asthma 135 (138), highest in Latrobe (176)
- Angina 108 (90)

The average length of stay was highest for congestive heart failure at 5.8 days, followed by asthma 5.8 days, COPD 4.8 days, diabetes complications 4.6 days, angina 2.0 days and iron deficiency anaemia 1.2 days.

In an analysis of admitted activity in Gippsland (see **Access to care that meets people's needs**), it was noted that:

- East Gippsland and Latrobe had high rates of haemodialysis, pointing to high levels of chronic kidney (renal) failure in these LGAs

Chronic conditions that lead to an ED presentation for Gippsland residents in 2019-20 included (see **Access to care that meets people's needs**):

- Chest pain 4.4% of presentations
- Muscle or joint pain 1.8%
- Back pain 1.8%
- Heart failure 1.6%
- Stroke 0.8%
- Hypertension 0.5%
- Anaemia 0.3%
- Diabetes complication (0.2%)

Professional stakeholder perspective

Based on Gippsland PHN consultations with clinicians and other professional stakeholders, including Clinical Councils (GPHN 2021f):

- Chronic disease was identified as key issue with COPD, cardiovascular diseases and diabetes the most frequently identified health conditions
- Service gaps related to chronic respiratory disease were identified and include the need for respiratory specialists (medical and nursing) across the catchment
- Service gaps related to diabetes include diabetes education, care coordination and lack of endocrinologists
- A survey of allied health stakeholders in Gippsland identified diabetes as a key issue among their clients

The Hazelwood mine fire inquiry resulted in recommendations to address respiratory health in the Latrobe Valley through the creation of the Latrobe Health Innovation Zone.

Consultations with stakeholders during 2020-21 (GPHN 2021f), the following main themes are noted:

- Chronic disease and in particular cardiovascular disease, COPD and diabetes remain significant issues in general practice
- Obesity is common in the community and impacts referral pathways

The increased burden of disease due to chronic conditions requires action at the regional level (AHHA 2021d):

- Recognise the growth in the population with chronic health needs at a regional level to allow planning
- Increased focus on prevention initiatives suited to the local population and co-designed with regard to vulnerable populations
- Shared responsibility and funding across all levels of government, industry and community to allow alternative models to be implemented
- Team based models where professionals work together to improve outcomes that matter to patients

Prevention activities in Gippsland are guided by local Municipal Public Health and Wellbeing Plans and the Victorian Public Health and Wellbeing Plan 2019–2023. MPHWPs for 2021-25 all incorporate priority areas that have the potential to contribute to a reduced burden of disease due to chronic disease in the long term,

including; Healthy lifestyles (Bass Coast Shire Council, Healthy Communities Plan 2021-25, personal communication), Active living and Healthy eating (Baw Baw Shire Council, Municipal Public Health and Wellbeing Plan 2021-2025, personal communication) and Active living (Wellington Shire Council, Healthy Wellington, MPHWBP 2021-25, personal communication), noting that not all were finalised at the time of writing.

Community, consumer and carer perspective

Based on Gippsland PHN consultations with community, consumers and carers, including the Community Advisory Committee (GPHN 2018):

- Lung health was an important health issue, with older people and Indigenous people rating it as a top health issue. People in the Latrobe Valley raised pollution and coal mines, including the mine fire.

  "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"

- Heart health was identified as one of the most important health issues, especially by older people. Cardiologists were mentioned as a service gap.

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

- Diabetes was mentioned but no sub-group rated it as a top health issue. Service gaps were noted but diabetes educators / nurses were mentioned as a valuable resource to manage the condition.

  "Having a chronic illness, Type 1 diabetes, I will often put off seeking medical treatment that is not urgent just because it's too hard to access."

- Community members reported instances where chronic disease was not well managed by professionals and a willingness to self-manage through a healthier lifestyle.

  "… I was told to attend my GP in the morning but was refused due to there being no appointments available."

  "After having chest pains … changed my diet … and have never felt better."

A Gippsland PHN survey (GPHN 2021d) had 225 respondents who had a long term health condition that limited their daily activities a lot or moderately (16.2% of respondents). Main themes in response to the question about what would improve their health were:

- Improved access to a regular GP in their local area
- Affordable care including allied health, pain management and specialists, all communicating well with their GP

  "Having access to allied health services and specialists and not have to travel so far or wait so long for appointments."

  "Access to services, considerations of other life factors that impact health i.e.: mental health concerns, relationship breakups etc."

- Good quality emergency care locally
- Access to specialists between appointments

  "Cost and availability in my local area. I am working poor!"

9. Dementia

"I don't have a regular GP that I am comfortable with at this point. The last GP I saw … she was like nah we're all like that."

"… for people to be aware of some of the early signs of dementia."

"…we need more home care packages. …it would be more effective money wise to keep people at home…with the right support to the carers."

[Dementia project participants – GPHN 2020d]

Health status

Dementia (AIHW 2020i) is a group of conditions characterised by the gradual impairment of brain function, the most common is Alzheimer's disease affecting about 70% of people with dementia. One person can have more than one type of dementia.

- Dementia was the fourth leading cause of disease and injury burden in Australia in 2015 and was responsible for 3.8% of the total burden of disease (AIHW 2020d):
    - 5.0% of burden among females
    - 2.7% among males
    - 7.7% among people aged 65 years or older
- Dementia is the second leading cause of death of Australians and the leading cause of death of women (ABS 2019b).
- 68% of residential aged care residents have moderate to severe cognitive impairment.
- Younger onset dementia (under 65 years of age) is increasing.
- It is estimated that over 6% of the population are involved in the care of someone with dementia.
- Data from a 2020 survey showed that 63% of people living with dementia and 73% of family, friends or carers of people living with dementia believe discrimination against people living with dementia is common or very common (Dementia Australia 2020).

Dementia data for Gippsland (see **Table 70**) show that:

- In 2021, there are an estimated 7,488 people in Gippsland with dementia and this expected to increase to 13,783 by 2058.
- There were an average of 171 deaths per year attributed to dementia between 2015 and 2019.
- There were 35.3 deaths per 100,000 people across Gippsland, compared to 41.5 across Australia; these are age-standardised rates.
- Dementia is the second cause of death among females in Gippsland and the sixth cause of death among males.

Table 70. Dementia prevalence and deaths in Gippsland by LGA.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	Australia	Reference
Dementia prevalence estimate 2021	1,149	805	1,257	1,713	1,499	1,065	7,488	NA	Dementia Australia (2021a)
Dementia prevalence estimate 2058	2,801	1,228	3,774	2,662	1,683	1,635	13,783	NA	
Average annual deaths - dementia	29	16	24	47	34	21	171	68,480	AIHW (2021b)
Dementia death rate per 100,000 people (age-standardised)	39.5	30.1	31.1	40.2	34.9	32.2	35.3	41.5	

Low compared to areas Australian LGAs, bottom 25% of values

Service system

A Gippsland PHN study was conducted during 2020 to improve our understanding of what it is like to live with dementia and what the key community needs are, including access to services and supports, (GPHN 2020d).

A community facing summary of service and support options for people worried about their own or someone else's memory or thinking was designed. See **Figure 41**.

Figure 41. Service and support options for community members in Gippsland related to dementia, 2021.

Additional services include:

- CDAMS (Cognitive Dementia and Memory Service), a specialist multidisciplinary diagnostic, referral and educational service for people experiencing memory loss or changes to their thinking (cognition), and for those who care about them.
- Allied health professionals such as physiotherapists, occupational therapist, social workers and counsellors also provide important services for people with dementia.
- Residential aged care homes care – see **People 65 years or older**.

Local governments have an important role in providing a healthy community for people diagnosed with dementia, including support to live at home. Several of the six local government areas in Gippsland have a Positive Ageing Strategy and all deliver support services.

Service use

General practice

- 0.5% of all general practice patients had an active dementia diagnosis, increasing by age to 3.1% of patients 75 years or older, see **Table 71**.
- Wellington and Latrobe recorded the highest number of patients with a dementia diagnosis, while Bass Coast had the highest proportion, see **Table 72**.
- A dementia diagnosis was slightly more common among females (0.5%) compared to males (0.4%).
- The number of people that recorded a new dementia related diagnosis increased from 424 in 2017-18 to 456 in 2019-20; 80% were for people aged 75 years or older, see **Table 73**.
- The most common dementia diagnosis identified in general practice was Alzheimer's disease, see **Table 74**.

Table 71. Prevalence of active patients with an active dementia related diagnosis in 2020-21, by age group.

Age group	Number of patients	Proportion of all active patients
<65 years	62	0.0%
65-74 years	206	0.4%
≥75 years	1,095	3.1%
All ages	**1,363**	**0.5%**

Source: GPHN (2021e)

Table 72. Prevalence of active patients with an active dementia related diagnosis in 2020-21 by LGA.

LGA	Number of patients	Proportion of all active patients
Bass Coast	282	0.7%
Baw Baw	293	0.3%
East Gippsland	309	0.6%
Latrobe	337	0.4%
South Gippsland	230	0.5%
Wellington	347	0.4%
Gippsland	**1,363**	**0.5%**

Source: GPHN (2021e)

Table 73. Gippsland patients with a new dementia related diagnosis, by age group and year.

	2017/2018	2018/2019	2019/2020
<65 years	<20	20	33
65-74 years	62	54	68
≥75 years	344	315	356
Overall	424	390	456

Source: GPHN (2021e)

Table 74. Gippsland patients with a dementia related diagnosis, by dementia diagnosis type, 2017-18 to 2019-20.

Dementia related diagnosis	Number of patients
Dementia	780
Alzheimer's disease	398
Senile dementia of the Lewy body type	47
Vascular dementia	40
Multi-infarct dementia	38
Frontotemporal dementia	23

Source: GPHN (2021e)

Professional stakeholder perspective

A dementia study (GPHN, 2020d) found that the health needs of many people living with dementia and their family and carers are not currently met. In some cases, people with dementia and their carers did not access available services. In other cases, the health system did not address their individual needs. Key themes from professionals working with dementia services and supports highlighted that there is still a lack of understanding that dementia is a terminal disease in the community, and that many professionals do not know of available services and supports, see **Table 75**.

> *"To know of local services. Which geriatricians visit locally."*
>
> *"There never seems to be sufficient time to be able to learn the history and life story of each person which is what would lead to improved care."*
>
> *"Increased understanding by family of as well as those caring for the patient* [would make the most difference to improve care]".

Table 75. Key themes for professionals working with dementia services and supports in Gippsland, 2020.

A lack of understanding of dementia in the community	*…this is a terminal illness.*
A lack of understanding of dementia among health professionals	*…health professionals … of all backgrounds … still do have a lack of knowledge…* *A diagnosis can help to find supportive services at home*
Service gaps include access to geriatricians and respite care	*… having specialist support available to GPs…*
Waiting times prevent people from staying in their own home	*… help early, enables them to stay in their home longer.*
Model of care makes person centred care difficult	*… I'm just tired of going to work and doing your utmost best… if you don't write a note or tick a box, or do something, you can get disciplined for it.*

Source: GPHN (2020d)

Additional Gippsland PHN professional stakeholder input has included the following themes (GPHN 2021f):

- An increased demand for services suitable for dementia patients, both in residential aged care and support in the community setting
- Service gaps have been identified related to dementia assessment services, allied health services and dementia beds in Residential Aged Care Facilities
- Younger onset dementia is increasing and there continues to be a need for appropriate accommodation as an alternative to aged care.

Community, consumer and carer perspective

A dementia study (GPHN, 2020d) found that the health needs of many people living with dementia and their family and carers are not currently met. We also heard about very dedicated and capable workers who do their very best.

> "… *people have been fantastic."* [Carer]

A summary of the themes identified by people living with dementia or worries about their memory or thinking and by carers and family members of people living with dementia are summarised in **Table 76** and **Table 77**.

> *"Diagnosis helped to find supportive services at home"* [Carer]

Themes about how things can be improved are detailed in **Table 78**. Local services that people have found most helpful include Dementia Access and Support Worker, CDAMS (Cognitive Dementia and Memory Service), day respite, dementia counsellors (phone and in person) and social worker assisting with discharge planning.

Table 76. Key themes for people living with dementia or worries about their memory or thinking in Gippsland, 2020.

Confusing, frustrating and embarrassing when you can't do simple things any more	*I'm stressed … having a lot of problems with words … things now just come out of nowhere*
Worries about the future and losing independence	*… if I was to lose my driver's license then that creates a bit of a problem.*
Hard to access needed care	*My Aged Care is so complex…*
Need someone who can provide personal support	*… [case manager] rings me every week …*
Need something meaningful to do and a supportive community	*…this is a magical town, it really is, and the people here are very supportive.*

Source: GPHN (2020d)

Table 77. Key themes for carers and family members of people living with dementia in Gippsland, 2020.

Getting a diagnosis varies a lot from person to person	*Some GPs reported as being …quite dismissive … more or less saying you know, she's old. For others; GP took us seriously from day 1.*
Support after diagnosis is needed to help carer and person living with dementia adapt	*…once X got the diagnosis, it was like – Now what?*
The carer role is essential but can be very demanding	*…with that constant 24/7 care … that meant I couldn't work I couldn't… leave the house…*
System navigation is challenging	*…I think to have a phone number to ring and just say look, are we on the right track…I felt quite isolated at times…*
Additional supports are needed to remain in own home	*…we need more home care packages. … to keep people at home...with the right support to the carers.*

Source: GPHN (2020d)

Table 78. Key themes about how things can improve from people living with dementia, carers, family and professionals in Gippsland, 2020.

Increased community awareness of dementia and available support	*What are the early signs of dementia? [Person with dementia]* *…people just don't seem to know about it [home support options].* [Carer]
Increased support to get a dementia diagnosis early	*… creating a clear pathway … what happens at diagnosis, what is the next step.* [Carer] *Sometimes … it's clear cut and obvious enough [that the diagnosis] can be done entirely at the primary care level... [Professional]*
Good communication skills among professionals are important	*…what works for me is when someone will listen to you, respects your parents… you know doctors can be very brusque, very dismissive, or very rude … [Carer]*
Increased support to navigate the system, especially immediately after diagnosis	*… tips on how to tell your family …X's children were in total denial that their father had dementia… [Carer]* *Dementia Access and Support Worker role is not well known among GPs and hospitals [Professional]*
Education for health professionals is helpful	*More health professionals … aware of dementia … to recognise the symptoms and who to refer to as well. [Professional]*
More support and increased recognition of carers	*I just felt like a completely different person after having respite. [Carer]*
Easier access to the right home support services when they are needed	*… servicing that better meets the needs of older people without the assumption that they have the internet...' [Carer]* *…we were so disappointed with the quality of the package …mum actually asked if she could go in to care in a nursing home. ... [Carer]*
Person-centred care is required in aged care homes	*…how we look after people with dementia needs a significant overhaul. It depends on staff training, depends on culture of the organisation. [Professional]* *…monitoring a person's wellbeing, picking up the little things that are important around their health. [Carer]*
Research needed	*I don't know if there is currently any treatment like this available to … stopping the progression. [Person living with dementia]*

Source: GPHN (2020d)

10. Reproductive and sexual health

"Free sexual health checks, more appointments, more specialists in Gippsland." [Workshop participant]

Health status

Mothers and babies

Indicators are presented in **Table 79**:

- 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).
- There is a lower rate of women accessing antenatal care in parts of Gippsland.
- A high proportion of mothers aged 15 to 19 years in Latrobe (15.3 live birth per 1,000) compared to Australia (7.7); these rates have reduced from 21.5 in Latrobe in 2015.
- 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%).
- A total of 2,871 registered births to Gippsland women in 2019.
- 16.7% of mothers smoked during the first 20 weeks of pregnancy compared to 9.1% across Australia (2019). This has improved from 20.0% in 2014-16. Highest smoking rates were seen in Latrobe (23.4% - down from 25.6%) and East Gippsland (16.1% - down from 21.7%).
- Aboriginal women and babies continue to have poorer health outcomes (VAHI 2021d):
    - 12% of babies were low birthweight compared to 8.5% of women born to non-Aboriginal women.
    - 54% of Aboriginal women in Gippsland did not access antenatal care, compared to 62% of Aboriginal women in Victoria.
    - 43% of Aboriginal women smoke during pregnancy, compared to 7.3% of non-Aboriginal women

Table 79. Sexual and reproductive health indicators by Gippsland LGA and compared to Australia.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	Australia	Reference
Women who gave birth and had at least one antenatal visit in the first trimester (2019)	68.9%		91.0%	68.5%	74.4%	74.2%	75.5%	76.6%	AIHW (2021b)
Women who gave birth and attended 5 or more antenatal visits (2019)	95.1		96.5%	97.2%	89.0%	93.5%	94.9%	94.7%	
Smoking during pregnancy (first 20 weeks) (2019)	11.0%		14.1%	23.4%	15.7%	16.1%	16.7%	9.1%	
Number of registered births (2019)	533		659	815	422	442	2,871		
Number of live births by mothers aged 15 to 19 years per 1,000 population (2019)	3.9		10.3	15.3	11..5	9.6	10.3	7.7	
Low birth weight babies (<2,500 grams at birth) (2019)	5.0%		7.0%	7.0%	6.6%	5.6%	6.3%	6.6%	
Registered births per 1,000 women (2019)	17.6	18.3	26.2	21.7	17.9	22.6		22.5*	WHV (2021)
Fertility rate, average number of children per woman (2017)	2.1	2.2	2.2	2.0	2.2	2.1		2.0*	

* Data for Victoria

High compared to other areas, top 25% of values

Low compared to other areas, bottom 25% of values

Abortion

- A survey of Australian women found that 26% of women who had ever been pregnant had experienced a termination of pregnancy (10.5% medical termination, 17.6% surgical termination), (Jean Hailes for Women's Health 2020).
    - LGBTIQ women were more likely to have a termination of pregnancy (40% compared to 25% of non LGBTIQ women).
    - Women living in rural and remote areas were less likely to have a termination (22% compared to 28% of urban areas); they were especially less likely to have a surgical termination.
- In Australia it is estimated that half of all pregnancies are unplanned, and that half of those pregnancies will be terminated. Between one quarter and one third of Australian women will experience abortion in their lifetime (Rissel et al 2003).
- South Australia is the only Australian State to report terminations of pregnancy. In 2017, 13.2 terminations of pregnancy per 1,000 women aged 15-44 years were reported. The rate has decreased steadily each year from commencement of reporting in 1998. (Government of South Australia 2019).
- An estimated 623 women in Gippsland would require an abortion each year using the South Australian estimate.

Sexually Transmitted Infections

- Chlamydia is the most common Sexually Transmitted Infection in Gippsland (DH 2021d);
    - 15.8 notifications per 10,000 population for females (18.5 in Victoria)
    - 10.9 notifications per 10,000 population for males (16.8 in Victoria)
    - Rates in Baw Baw were high at 28.1 for females and 17.3 for males
    - Young people are more likely to be infected with people aged 15 to 29 years accounting for around 80% of notifications
    - Modelling suggests that 77% of chlamydia cases remain undiagnosed (Bourchier et al 2020)
- Gonorrhea notifications are increasing with a total of 127 across Gippsland in 2019.
- Syphilis notifications are increasing with a total of 50 across Gippsland in 2019.
- Victorian syphilis notifications are increasing in women as well as in men who have sex with men (DH 2019b). For the first time since 2004, congenital syphilis is re-emerging; if left untreated, congenital syphilis can cause serious birth defects including fetal death.
- Rates of STIs among Aboriginal and Torres Strait Islander people in Victoria are around twice as high compared to non-Aboriginal people (DH 2021d)
- The greatest burden of STIs is among younger women, but STIs are increasing among older women (55-64 years) in Australia at a faster rate than among younger women. A study has found that GPs are less likely to offer testing to older women and that it is often left up to the patient to initiate the discussion. The rate of positive tests has been increasing. (Bourchier et al 2020)

Service system

Sexual and reproductive health provider options can be found through 1800MyOptions phone line and website (WHV n.d.). The service is supported by the Victorian Department of Health and provides information about contraception, pregnancy options and sexual health to both community and professionals. Not all service options in the database are included publicly; more options can be discussed by phoning 1 800 696 784.

- General practices and pharmacies provide an important first point of contact. See **Gippsland health services**.
- Gippsland HealthPathways include local public and private referral options to gynecologists and obstetricians practicing in Gippsland by LGA.
- A new sexual health and wellbeing Hub in Bairnsdale called Clinic 281, opened in 2021 and is operated by Gippsland Lakes Complete Health. It is a broad sexual health clinic for young people up to the age of 35 years and will include support with unplanned pregnancy, ensuring access for medical termination and a pathway to surgical termination support. The Hub has support from the Royal Women's Hospital Clinical Champions project, Gippsland Women's Health, Gippsland PHN and 1800MyOptions.
- The Melbourne Sexual Health Centre (MSHC) will partner with eligible general practices in Gippsland to provide expert sexual health training and support to all general practice staff and will provide clinical advice to enable the practice to provide STI treatment.
- The four headspace centers in Gippsland offer sexual and reproductive health services to young people.
- The Gippsland Sexual and Reproductive Health Strategy 2017-2021 is being implemented by the Gippsland Sexual and Reproductive Health Alliance (GWH 2021a). Priority areas for work have included increasing safe sex practices in young people, comprehensive and inclusive relationships and sexual health education in schools and improved access to affordable and confidential emergency contraception and abortion.

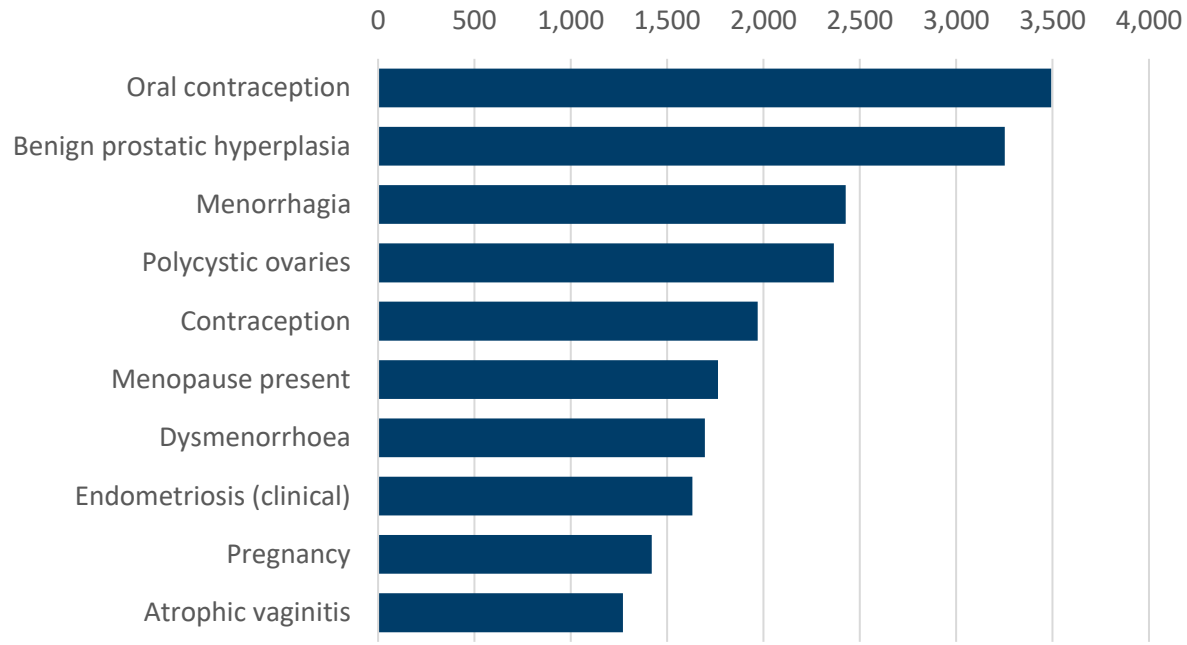
- Public access to condoms has been improved through a condom vending machine project; 34 vending machines have been installed across Gippsland in collaboration with local government and health services.
- Gippsland PHN are supporting general practices across Gippsland to provide free condoms, together with information about STI testing and consent.

Service use

General practice

- The most common active reproductive health diagnosis in 2020-21 was oral contraception (9.9% of all reproductive health diagnoses), followed by benign prostatic hyperplasia (enlarged prostate) (9.2%) and menorrhagia (heavy periods) (6.8%), see **Figure 42**.
- A new reproductive health related diagnosis was recorded for 8,647 patients in 2019-20; 82% were females.
- 16.5% of all female patients had a reproductive health related diagnosis, compared to 6.2% of males.
- New reproductive health related diagnoses were most common among patients aged 20-49 years.
- PIP QI data showed that 42.2% of Gippsland female clients, aged 25-74 years, had an up-to-date cervical screening test record, compared to 37.4% across Australia, (AIHW 2021v).

Figure 42. Top 10 active reproductive health related diagnoses, 2020-21.



Source: GPHN (2021e)

- Gippsland general practice data for 2020-21 shows the number of patients with an STI diagnosis;
    - Of 866 patients with a chlamydia diagnosis, 72% were under 30 years of age; 60% were under 30 years of age and 69% were female
    - There were 45 patients with a syphilis diagnosis (38 in 2019-20, 40 in 2018-19)
    - There were 91 patients with a gonorrhoea diagnosis
- Gippsland general practice data for 2020-21 also shows STI testing numbers;
    - 18,373 were patients tested for chlamydia (19,275 in 2019-20); 39% were under 30 years and 74% were females
        - Based on testing numbers in general practice, it is estimated that 17.8% of 20-29 year olds in Gippsland were tested
    - 9,413 patients tested for syphilis (9,255 in 2019-20)
    - 1,574 patients tested for gonorrhoea (1,699 in 2019-20)
- Across Gippsland, general practice data shows a total of 112 patients with a HIV diagnosis (2019-20); 40% were under 50 years of age and 90% were male

    - 6,576 patients had a HIV test; 85% were under 50 years of age, 27% were male and 3.2% were Aboriginal or Torres Strait Islander
- 106 patients across Gippsland were prescribed medications for medical abortion (Mifepriston and/or Misoprostol) in 2020-21 (up from 93 in 2019-20).

Hospital

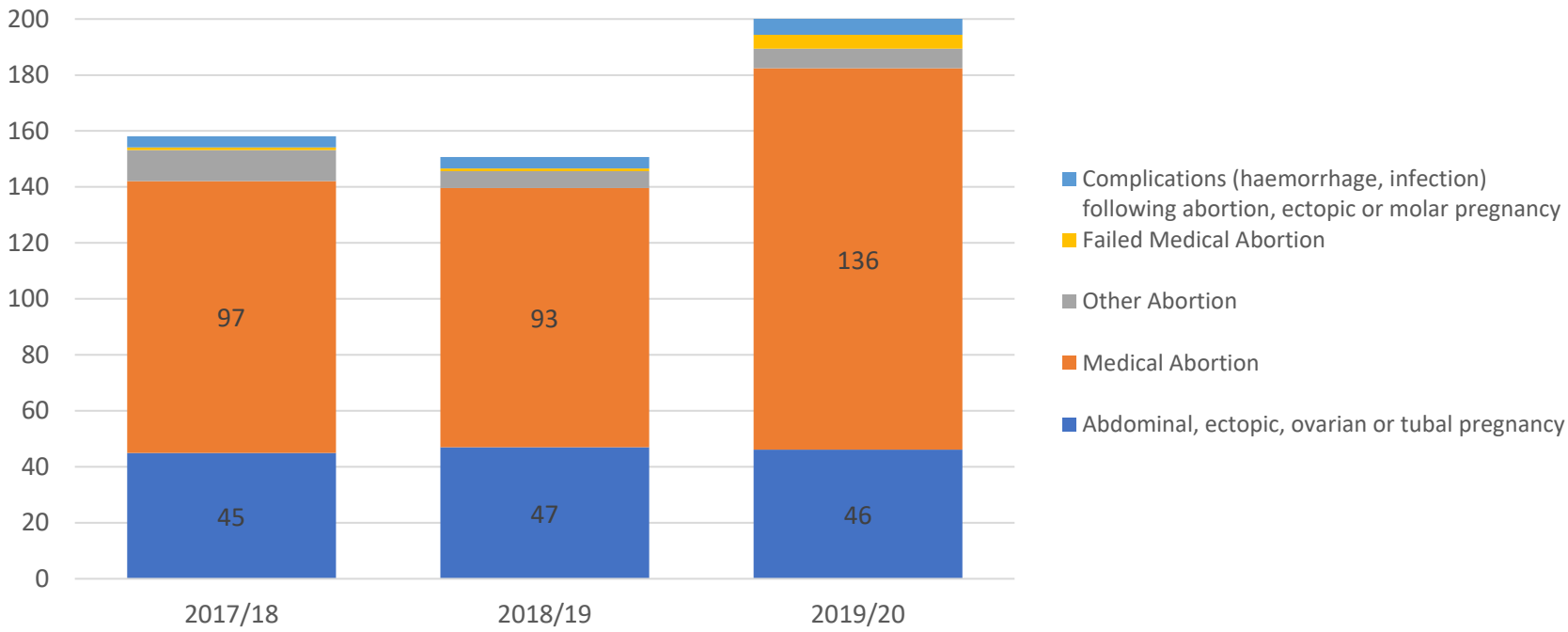
Termination of pregnancy (abortion) may be performed by:

- Surgical methods - dilation and curettage/evacuation (D&C/D&E) or suction curettage; or
- Medical methods – administration of pharmacological agent to induce abortion or labour.

The number of admissions for Gippsland residents to hospital over the last three years with abortion as the principal diagnosis is shown in **Figure 43**.

- The number of abdominal, tubal, ovarian and ectopic pregnancies remained steady over the three year period.
- The number of admissions for related to abortions increased by 44 (47%) in 2019-20 compared to 2018-19. The greatest increase was seen for residents of Baw Baw and Bass Coast.
- 46% of medical abortions recorded for women living in Gippsland occurred in hospitals/day surgery units outside Gippsland (2018-19).

Figure 43. Number of hospital admissions for Gippsland residents with abortion as the principal diagnosis.



Source: DH (2021b)

Professional stakeholder perspective

The Gippsland Sexual and Reproductive Health Alliance supports an annual forum for professionals working in the area. Attendees at the 2021 Forum included a diverse range of professionals and Forum topics provided up to date insights about emerging issues including:

- The impact of online dating, noting that sexual health information is often sourced privately online, especially by young people.
- Young people are exposed to pornographic images, online sexual behaviours and cyberbullying. This can lead to normalised perceptions of pornography as “sex education” and can predict condom use.

- Dating apps are estimated to be used by more than 10% of adults to look for a potential partner. App use more commonly led to sexual activity among men, young people and people who identify as gay, lesbian or bisexual, (Watchirs et al 2018).
- Dating app use is often interconnected with the use of other social media and users have described both the beneficial and detrimental impact on mental health, (Albury et al 2019.)
- Safe sex and sexual health information is limited for heterosexuals online.

Forum participants in 2021 were asked about the priorities for the next four years and the main themes included:

- Consent, respectful relationships and the law
- Building teacher knowledge of Respectful Relationships and sexual education
- Improving community awareness about gender-based violence
- Promote increase in cervical screening rates
- Intersectionality LGBTIQ+, youth and respectful relationships
- Appropriate and supportive practice around sexual and reproductive health by GPs and specialists
- Promotion of regular STI screening and its importance
- Importance of seeking help early if concerned about unwanted pregnancy
- Improve knowledge of how to access support services
- Supporting vulnerable young girls in residential care units

- A survey of pharmacies in Gippsland (GWH 2018a) found (68 pharmacies, response rate 71%);
    - 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 (GWH 2018b) found (75 clinics, response rate 48%);
    - Screening and treatment for Sexually Transmitted Diseases was 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
    - 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
- Gippsland PHN Clinical Councils and other professional stakeholders (GPHN 2021f) note:
    - concerns about access to appropriate sexual and reproductive health services in Gippsland, in particular for abortion and services suitable for young people
    - a lack of culturally safe maternity services for Indigenous people
- In a small Gippsland PHN survey (n=16), 50% of responding professionals (including GPs, nurses and pharmacists) reported low confidence in supporting a woman requesting an abortion. Barriers identified included lack of knowledge, referral options, stigma, judgement and religious belief of other practitioners.
- A Gippsland PHN study by a Monash University scholar looked at how chlamydia rates may be reduced in regional Victoria (GPHN 2021m). Barriers were identified:
    - Lack of knowledge about STIs is still as issue despite sex education in schools. Messages can be irrelevant to the audience with a focus on abstinence rather than safe sex, including how to navigate relationships, consent and condom use.
    - Judgement, stigma and lack of privacy in the local community can lead to low use of safe sex practices such as condom use and STI screen.
    - Public education campaigns may not suit the target populations; a need to target groups with low health literacy.
    - Enablers were identified:
        - Sexual education by confident educators using evidence based and age appropriate materials, including an emphasis on communication and relationships
        - Campaign aimed at young people to increase access to condoms and information about safe sex
        - Support from school principals, local government and health care providers
        - GPs proactive in offering annual STI screening of all sexually active patients
- Consultations with rural Victorian youth about their sexual and reproductive health needs resulted in six recommended steps to develop initiatives that focus on strengthening sexual and reproductive health outcomes for young people (YACVic 2019):
    - Support a peer led education campaign to reduce the stigma of sexual and reproductive health for young people
    - Advocate for a consistent state and national curriculum of sexual education for years 7 - 10 in all secondary schools
    - Specialised Sexual Health Educators facilitating sessions in schools
    - Youth services designed with and for young people using a human-centred design model with focus on end user testing and consultation
    - Introduce young people to health services sooner
    - Make contraceptive and sanitary products more easily available

Community, consumer and carer perspective

Gippsland PHN engagement with community noted the following themes (GPHN 2021d):

- Reproductive and sexual health was rated as more important among young people.

- Privacy concerns related to diagnostic service providers, pharmacies and general practice
- Concern about some professionals allowing their personal beliefs to influence clinical advice to patients and even obstructing access to timely referrals for abortion
- Reports about some general practitioners providing inaccurate information and displaying a lack of knowledge about sexual and reproductive pathways
- Service gaps were identified for abortion, access to specialist obstetricians and gynecologists, sexual assault and rape services and accessible sexual health clinics.

  "GP was uncomfortable discussing sexual health/family planning; it made me feel uncomfortable to discuss anything with her again."
- Comments made about what would improve sexual and reproductive health included:

  "There is respect for everyone's gender identity."

  "…more funding is needed for GCASA so women can receive x counselling"

  "Women's symptoms related to reproductive and sexual health are taken for face value and investigated properly in a timely manner…"

Figure 44. Yarah's journey – Reproductive and sexual health.

Yarah's journey

Yarah is 20 years old. She lives in a regional town with her partner and is a full-time university student. Recently, she becomes concerned that she may be pregnant. She searches for pregnancy options online through the 1800 My Options website. After browsing the information there, she decides to speak to her GP about accessing a medical termination.

At the GP clinic, she takes a pregnancy test which returns positive the next day.

She is informed that the clinic does not offer termination options and is referred to the hospital.

She experiences a six-day delay while the hospital confirms the pregnancy with a test and ultrasound.

Yarah is then referred to a gynaecologist who prescribes a medical termination.

She visits two local pharmacies as the medication was out of stock at the first one.

She accesses the medication within the time frame to avoid a surgical termination.

Yarah feels frustrated with the delays to access a medical termination.

What didn't help?

- Lack of timely access to pregnancy termination services through the GP clinic.
- Delays caused by long wait times for a pregnancy test and ultrasound.
- Medical termination pill out of stock at the local pharmacy.

What would help?

- Awareness of where to access reliable advice on contraception, screening and pregnancy options.
- The local GP and pharmacy offering medical termination options.
- Same day access to a medical termination through the GP clinic.

Key messages

- Young people often search online to find advice on reproductive and sexual health including contraception, pregnancy options and access to screening.
- Accessing abortion services locally and in a timely manner is important.

Source: GPHN (2021d)

11. Health workforce

"Access to allied health - we don't have it, or the wait list is 12 months" [Workshop participant]

"We can keep services going but we have no staff to service them. We also need to support the staff… so overwhelmed, they are stressed out…" [Workshop participant]

Regional context

Gippsland PHN recognise that a strong and sustainable primary health workforce is fundamental to improving health outcomes for Gippsland people. There are many stakeholders who have a role in supporting the health workforce in Gippsland to ensure it can meet the needs of the community. They include:

- The **Rural Health Workforce Agency Victoria** (RWAV) aims to improve access to health care for rural and regional communities. There are three priority areas:
    1. Access – improving access and continuity of access to essential primary health care services
    2. Quality of access – building health workforce capability
    3. Future planning – growing the sustainability of the health workforce

- **Eastern Victoria GP Training** is funded by the Commonwealth to deliver the Australian General Practice Training (AGPT) Program leading to fellowship of the Royal Australian College of General Practitioners (FRACGP) and fellowship Advanced Rural General Practice (FARGP) or fellowship of the Australian College of Rural and Remote Medicine (FACCRM).
- The **Victorian Rural Generalist Program** is offered to support trainees to navigate a training pathway all the way through to a Fellowship in the region of their choice.
- The **Gippsland Regional Training Hub** is a component of the Integrated Rural Training Pipeline for Medicine implemented through the Rural Health Multidisciplinary Training program. Both are Australian Government initiatives.
- Health services, general practice and others who employ or help educate the health workforce.
- Universities and other education and training providers.
- All levels of government and locally relevant organisations including the Latrobe Valley Authority, the Latrobe Health Advocate and non-government organisations.

There is a strong need for all stakeholders to work together as has been outlined (AHHA 2021e):

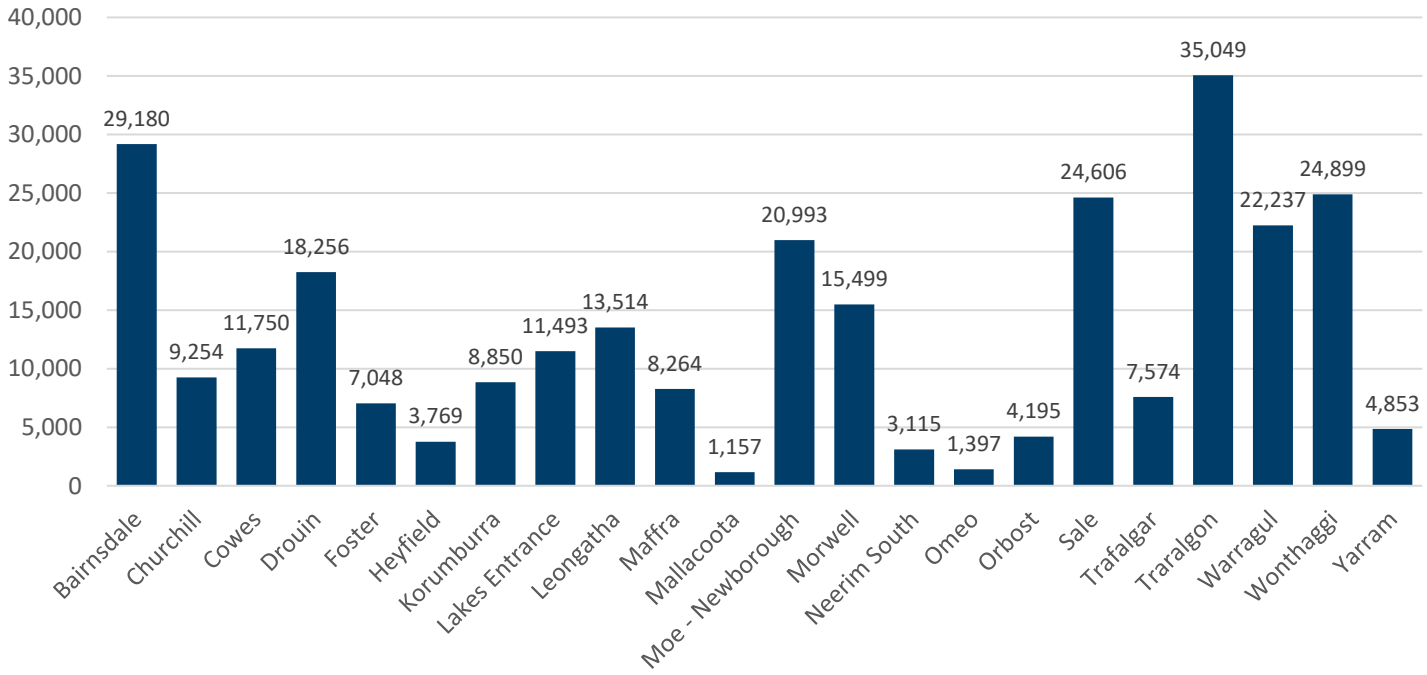
- use a cross-jurisdictional and cross-sector planning approach
- enable outcomes-focused and value-based changes in scopes of practice and models of care for both regulated and unregulated practitioners

- coordinate education, regulation and all service levels so they work for the local community
- embed long-term sustainability
- make sure equitable access and outcomes is the primary focus, including geographic locations and populations with specific needs
- build in technological solutions that meet people's needs

The HeaDS UPP tool (DoH 2021b) was used for much of the data reported in this section, including for population by GP catchment areas, the specific geography developed for the tool to assist workforce data analysis by small geography relevant to the local population.

Gippsland had an estimated population of 287,000 in 2019 with the distribution by GP catchment area in **Figure 45**.

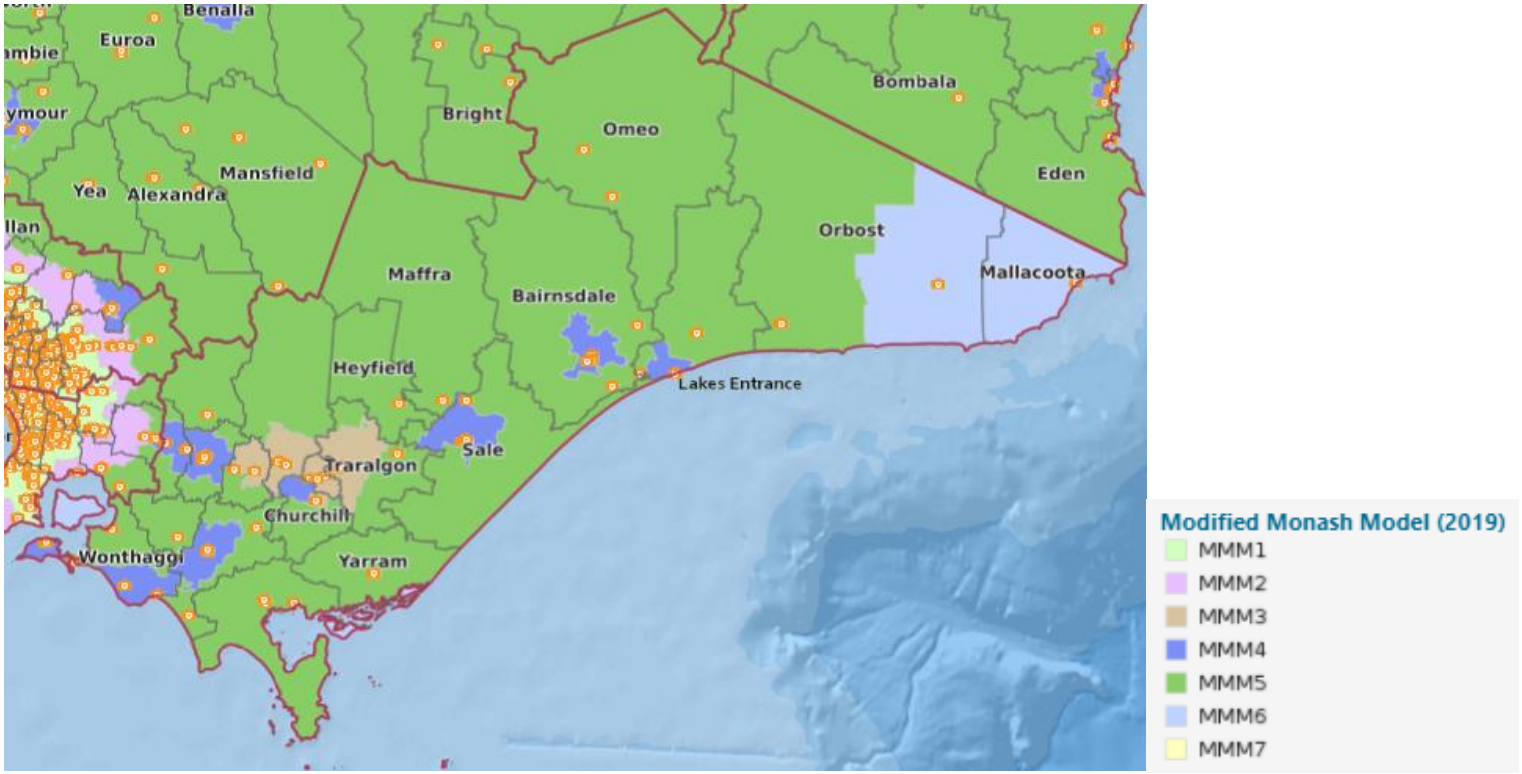
Figure 45. Estimated resident population by Gippsland GP catchment area, 2019



Source: DoH (2021b)

Geographical remoteness of Gippsland GP catchment areas, described using the Modified Monash Model (DoH 2021c), is shown in **Figure 46**. Highest levels of remoteness are found in Far East Gippsland which falls into MMM category 6, while the most populated areas around Gippsland's main towns are categorised as MMM3. The MMM classification is used to help distribute the health workforce better in rural and remote areas.

Figure 46. Modified Monash Model of geographical remoteness by GP catchment area in Gippsland with general practice locations shown, 2019.



Source: DoH (2021c)

Health workforce overview

The report *Modelling Gippsland's Future Health and Community Services Workforce* (Swinburne University 2019) estimated that the health care and social assistance sectors employ around 14,000 people in Gippsland (or 14.3% of the workforce in 2016), with an additional 2,000 people indirectly employed because of this industry. By 2036, the health care and social assistance sectors are expected to employ 19,000 people (or approximately 16% of the workforce).

For an overview of main health services, see **Gippsland health services**. In 2021, there were 89 general practice locations in Gippsland. Their distribution by LGA:

- Bass Coast – 8
- Baw Baw – 19
- East Gippsland – 19
- Latrobe – 25
- South Gippsland – 7
- Wellington – 11

Gippsland has a lower than expected Full Time Equivalent (FTE) of registered health workforce per population for all registered professions except chiropractors, GPs and paramedics when compared to Victoria, see **Table 80**. The deficit is especially notable for 'other medical practitioners' (includes specialists, hospital medical officers and junior doctors) and psychologists where the FTE per population in Gippsland is less than half of that available across Victoria.

Table 80. Registered professionals as Full Time Equivalents per 100,000 population by local government area in Gippsland and comparison to Victoria, 2019.

APHRA registered professional	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland	Victoria
Chiropractors	21	17	21	19	14	33	**21**	**19**
Dental Practitioners	65	38	61	54	51	56	**55**	**80**
Medical Practitioners - Total	231	190	311	393	229	247	**287**	**454**
General Practitioners	123	148	157	102	127	122	**126**	**125**
Other Medical Practitioners	108	43	155	291	102	125	**160**	**329**
Medical Radiation Practitioners	25	23	25	97	38	49	**50**	**59**
Nurses and Midwives	1,052	939	1,092	1,641	1,161	1,139	**1,238**	**1,364**
Occupational Therapists	77	37	64	69	48	51	**59**	**81**
Optometrists	10	10	18	22	26	22	**19**	**22**
Osteopaths	0	38	12	0	11	17	**11**	**21**
Paramedicine Practitioners	179	117	104	177	152	135	**147**	**90**
Pharmacists	83	82	59	106	85	70	**83**	**107**
Physiotherapists	84	62	106	96	57	55	**80**	**120**
Podiatrists	30	0	22	20	12	11	**17**	**25**
Psychologists	40	24	54	52	38	52	**46**	**113**

Source: AIHW (2021x) and calculations by Gippsland PHN ABS (2016) population figures

High compared to Victoria, >25% higher rate

Low compared to Victoria, >25% lower rate

Medical workforce

Distribution Priority Areas (DPA) are areas which have been assessed as having a shortage of GPs, based on the needs of the community (DoH 2021d). Areas classified as a DPA for GPs are able to recruit international medical graduates who specialise in general practice, and who have a requirement to work in an area classified DPA to obtain a Medicare Provider Number. Recruitment of doctors in a bonded scheme, which provide students with a place in medical school in return for a commitment to work in a DPA for a set period, also becomes possible.

In 2021, all GP catchment areas in Gippsland except Warragul and Drouin are classified as DPA for GPs. When DPA replaced the previous classification system in 2019, Latrobe was initially not classified as a DPA.

A total of 313 GP FTE serviced Gippsland residents in 2019-20, contributed to by 631 individual GPs (DoH 2021b). The distribution by GP catchment area can be found in **Table 81** and **Table 82**. It can be noted that;

- Gippsland had 1.1 GP FTE per 1,000 people, the same as Victoria.
    - GP catchment areas with the highest GP FTE per population were Warragul (1.7), Mallacoota (1.6), Morwell (1.4) and Leongatha (1.3).
    - GP catchment areas with the lowest GP FTE per population were Omeo (0.6) and Churchill (0.8). Several areas had 0.9 GP FTE per 1,000 people (Lakes Entrance, Orbost, Heyfield, Yarram, Cowes, Korumburra and Moe-Newborough).
- Changes in FTE by GP catchment areas since 2015-16 highlight a reduced medical workforce across Latrobe with 11.2 FTE less in 2019-20 compared to 2015-16. This also appears to have translated to fewer GP services per person for residents of Latrobe.
- The per cent of people in Gippsland who used GP services anywhere were lowest in Omeo (83.5%), Heyfield (89.5%), Bairnsdale (90.1%), Maffra (91.2%) and Traralgon (91.7%).
- Gippsland people had an average of 6.4 GP services per person, compared to 6.6 for Victoria.
    - GP catchment areas with the highest number of GP services per person were Wonthaggi (7.7), Cowes (7.5), Warragul (7.4), Foster (7.3) and Heyfield (7.3).
    - GP catchment areas with the lowest number of GP services per person were Bairnsdale (5.9), Churchill (5.9), Orbost (6.1) and Trafalgar (6.2).

The per cent of GP services by selected Reporting Groups show that:

- 1.9% of Gippsland services were provided after hours (8.9% in Victoria)
- 4.7% of Gippsland services were provided in aged care homes (3.2% in Victoria)
- 11.9% of Gippsland services were provided via telehealth (10.1% in Victoria)

- Vocationally Recognised GPs made up between 48% (Heyfield) and 100% (Omeo) of GPs in Gippsland GP catchment areas while GP trainees made up between 0% (Omeo and Churchill) and 52% (Heyfield).
- A very high proportion of GPs aged 65 years or older in Neerim South (66%) and Omeo (54%). Areas with the highest proportion of GPs aged under 40 years were Trafalgar (62%) and Heyfield (58%).

- Across Gippsland, 41.4% of GP FTE was provided by female doctors:
  - Neerim South (63.9%), Warragul (54.9%) and Orbost (55.3%) had the highest per cent female GPs; while
  - Yarram (19.5%), Lakes Entrance (28.2%) and Bairnsdale (28.7%) had the lowest per cent female GPs.

Table 81. GPs and GP services by LGA and GP catchment, 2019-20.

LGA	GP catchment	Number of GPs	Total GP FTE	Change in FTE since 2015-16	GP FTE per 1,000 people	GP services to own catchment	GP services to rest of Victoria	GP services to rest of Australia
East Gippsland	Bairnsdale	69	28.2	+6.4	1.0	82.8%	15.5%	1.6%
	Lakes Entrance	35	10.3	+0.3	0.9	80.5%	18.0%	1.5%
	Mallacoota	12	1.9	+0.1	1.6	NP	8.5%	2.9%
	Omeo	13	0.9	-0.1	0.6	NP	10.4%	2.4%
	Orbost	40	3.8	-0.1	0.9	88.5%	8.8%	2.7%
Wellington	Heyfield	12	3.5	+0.1	0.9	72.2%	26.7%	1.0%
	Maffra	23	8.0	+0.1	1.0	69.1%	29.7%	1.1%
	Sale	47	27.4	+1.9	1.1	78.3%	19.5%	2.1%
	Yarram	20	4.1	+0.5	0.9	85.1%	12.5%	NP
Bass Coast	Cowes	21	11.0	+0.8	0.9	81.7%	17.0%	1.2%
	Wonthaggi	63	29.2	+4.3	1.2	74.6%	24.1%	1.2%
South Gippsland	Foster	23	8.4	-0.6	1.2	76.5%	22.0%	1.2%
	Korumburra	21	7.6	+0.9	0.9	71.4%	27.8%	NP
	Leongatha	43	17.1	+1.9	1.3	66.1%	32.4%	1.3%
Baw Baw	Drouin	48	22.0	+4.7	1.2	56.7%	42.0%	1.3%
	Neerim South	8	3.6	+0.6	1.2	62.1%	36.6%	1.2%
	Trafalgar	33	8.7	+0.9	1.1	55.4%	43.4%	0.9%
	Warragul	75	36.8	+6.3	1.7	59.2%	39.6%	1.1%
Latrobe	Churchill	9	7.1	-0.8	0.8	70.6%	28.3%	1.1%
	Moe – Newborough	42	19.0	-4.5	0.9	80.8%	18.2%	1.0%
	Morwell	40	21.3	-2.8	1.4	56.9%	42.0%	1.0%
	Traralgon	56	33.5	-3.1	1.0	80.6%	18.2%	1.1%
Gippsland		**631**	**313.4**	**+17.8 (6.0%)**	**1.1**	**NA**	**NA**	**NA**
Victoria		**9,763**	**7,492**	**+875.1 (13.2%)**	**1.1**	**NA**	**NA**	**NA**

Source: DoH (2021b)

Lowest quartile

Highest quartile

Table 82. Residents in GP catchments and their use of GP services, 2019-20.

LGA	GP catchment	Per cent who used GP services anywhere	Change since 2015-16	Average number of GP services per person	Change since 2015-16	Per cent of GP services provided by GPs in catchment	Change since 2015-16
East Gippsland	Bairnsdale	90.1%	+0.7	5.9	+0.5	81.6%	+0.7
	Lakes Entrance	94.1%	+1.7	6.4	+0.1	67.5%	-3.9
	Mallacoota	104.6%	+7.0	NA	NA	NA	NA
	Omeo	83.2%	-5.3	NA	NA	NA	NA
	Orbost	95.1%	+0.8	6.1	0	70.9%	-6.2
Wellington	Heyfield	89.5%	NA	7.3	NA	62.9%	NA
	Maffra	91.2%	+0.1	6.5	+0.3	63.6%	-2.8
	Sale	94.4%	+4.3	7.0	+0.5	78.4%	+0.1
	Yarram	94.1%	+1.4	6.4	NA	60.4%	NA
Bass Coast	Cowes	93.6%	+0.1	7.5	+0.6	60.8%	-3.4
	Wonthaggi	92.8%	+0.7	7.7	+0.4	69.9%	-1.6
South Gippsland	Foster	95.3%	+0.4	7.3	-0.4	72.2%	-4.4
	Korumburra	94.8%	+2.7	6.4	+0.5	48.4%	+0.3
	Leongatha	92.5%	+1.8	6.7	+0.4	70.1%	-1.0
Baw Baw	Drouin	96.6%	+1.8	6.3	-0.1	54.4%	+2.5
	Neerim South	98.6%	NA	6.7	NA	54.5%	NA
	Trafalgar	94.8%	-0.4	6.2	0	52.8%	-3.8
	Warragul	97.3%	+1.0	7.4	0	69.9%	-0.4
Latrobe	Churchill	93.8%	+0.4	5.9	-0.4	52.6%	-1.8
	Moe – Newborough	95.0%	+0.6	6.9	-0.3	64.4%	-5.6
	Morwell	99.1%	-1.5	6.5	-0.4	62.1%	-3.7
	Traralgon	91.7%	-1.8	6.3	-0.3	73.7%	-3.3
Gippsland		**NA**	**NA**	**6.4**	**NA**	**NA**	**NA**
Victoria		**NA**	**NA**	**6.6**	**NA**	**NA**	**NA**

Source: DoH (2021b)

Lowest quartile

Highest quartile

Nursing workforce

A total of 4,039 nurses were employed in Gippsland in 2019 (DoH 2021b) with an estimated total FTE of 3,109, see **Table 83**). The number of nurses in primary care and community was 821, with 2,197 in hospitals and 1,021 in aged care.

The number of nurses working in primary and community care per population was higher in East Gippsland, Latrobe and Wellington. Changes since 2015 indicate less increase in workforce in Gippsland compared to Victoria as a whole.

85% of nurses working in primary and community care and 86% working in hospitals were registered nurses, while 44% of nurses working in aged care in Gippsland were registered.

Table 83. Nursing FTE by job setting, LGA and GP catchment, 2019*

		Primary and community care			Hospital		Aged care	
LGA	**GP catchment**	**FTE per 100,000 people**	**FTE**	**Change in FTE since 2015**	**FTE per 100,000 people**	**FTE**	**FTE per 100,000 people**	**FTE**
East Gippsland	Bairnsdale	238	70.1	+13.4	474	187	342	104
	Lakes Entrance		25.5	-3.7		2.2		35
	Mallacoota		3.9	-2.2		NA		NA
	Omeo		5.6	+2.4		8.5		13
	Orbost		8.8	-5.0		26		10
Wellington	Heyfield	205	2.5	-1.7	530	10	293	4.7
	Maffra		8.2	+3.1		19		31
	Sale		68.8	+7.6		182		83
	Yarram		8.7	+2.6		22		11
Bass Coast	Cowes	189	9.7	-0.1	388	3.7	305	7.2
	Wonthaggi		58.9	+4.2		137		74
South Gippsland	Foster	191	11.3	+2.6	370	26	296	15
	Korumburra		24.4	-2.0		28		31
	Leongatha		21.3	-1.0		57		42
Baw Baw	Drouin	176	8.9	+1.5	461	2.1	276	43
	Neerim South		3.3	+1.6		10		4.2
	Trafalgar		5.2	-2.4		3.1		23
	Warragul		75.7	-2.7		229		77
Latrobe	Churchill	225	3.5	-0.5	978	1.1	239	7.2
	Moe – Newborough		20.6	-0.8		7.4		63
	Morwell		55.8	+10.8		60		26
	Traralgon		92.5	-0.6		673		85
Gippsland		**207**	**593**	**+27.2 (4.8%)**	**591**	**1,696**	**285**	**819**
Victoria		**162**	**10,673**	**+1,599 (17.6%)**	**726**	**47,890**	**207**	**13,639**

Source: DoH (2021b)

* Includes nurses registered and employed in their profession. Job setting and location is derived from the location of main job where available; otherwise, location of principal practice is used as a proxy. If principal practice details are unavailable, residence is used. See HeaDS UPP tool for full definitions. FTE per 100,000 people calculated by Gippsland PHN based on data in HeaDS UPP.

Low compared to Victoria, >25% lower rate

High compared to Victoria, >25% higher rate

Allied Health workforce

Allied health professionals working in the primary and community care setting are listed with the FTE by LGA in 2019, **Table 84**. The change in total FTE for Gippsland PHN highlights that psychologists working in the primary care or community setting across Gippsland has decreased by 15.7 FTE between 2015 and 2019. All other allied health professions saw some increase.

Table 84. Allied health professionals working in the primary and community setting, Full Time Equivalents by local government area in Gippsland, 2019 and change 2015 until 2019.

Registered professional	Bass Coast	Baw Baw	East Gippsland	Latrobe	South Gippsland	Wellington	Gippsland	Change since 2015
Chiropractors	7.0	10.3	6.1	14.2	3.8	12.5	53.9	+8.4
Dental practitioners	20.4	28.6	22.8	37.5	10.9	20.4	140.6	+12.4
Occupational therapists	11.8	18.6	13.9	27	3.3	13.8	88.4	+39.5
Optometrists	2.2	7.5	10.8	13.9	2.7	7.9	44.9	+5.2
Osteopaths	2.2	5.8	4.9	2.1	9.2	7.2	31.4	+15.0
Pharmacists	23.4	25.1	31.7	56.2	21.3	23.2	180.9	+8.1
Physiotherapists	14.2	30	10.8	31.4	10.9	12.5	109.8	+12.6
Podiatrists	7.0	7.9	3.6	13.3	2.0	3.6	37.6	+1.8
Psychologists	7.8	13.1	13.6	20.4	3.5	14.6	73.1	-15.7

Source: DoH (2021b)

Professional stakeholder perspective

A general practice survey was conducted by RWAV in December 2020 to inform their 2021 Health Workforce Needs Assessment (RWAV 2021). In Gippsland, 81 GPs responded (the State response rate was 23%); seven were registrars. The survey provides a snapshot of Gippsland GPs and their experience with the health care system:

- average age was 55 years; 33% were aged 49 years or under

- 40% females and 52% males
- 20% were based in a large town (MMM3), 57% in a medium town (MMM4) and 23% in a small town (MMM6)
- Eight of the respondents provided locum services (10%) and 30 provided VMO services (37%)
- 57% received their primary medical training in Australia; 7% UK, 6% Sri Lanka, 4% Russia, Pakistan, Iran and China, 2% Ireland and Egypt and another eight countries with only one respondent
- Cultural training had been received by 33% of respondents; 10% of respondent's main practice did not record Aboriginal or Torres Strait Islander status of their patients.
- 60% of GPs felt like they belong in their community
- 55% were moderately or very satisfied with collegiate support provided
- Factors that would increase the likelihood of GPs staying in their current practice were often related to personal or family life, including recreation, schools and childcare. Other main themes were about reduced workload, increased support for credentialing and other career opportunities and a supportive well-functioning practice.
- Top training needs reported by 26 GPs were skin cancer (31%), obstetrics and gynaecology (23%), mental health (15%), sports medicine and joint injections (12%), palliative care (12%); also mentioned was dermatology, paediatrics, anaesthetics, alcohol and other drugs, geriatrics / aged care, emergency, surgery and internal medicine.
- Barriers when referring to other professions were most commonly reported for psychiatrists (84%), psychologists (65%) and ENT specialists (52%).
- Concerns about credentialing included difficult application process, impact on patient continuity of care, reduced scope of care and reduced willingness of hospitals to rely on GPs to provide care.
- Barriers to providing VMO services included a lot of paperwork, low remuneration, a perceived lack of interest by the hospital to work with GPs and poor work life balance.

A Gippsland PHN workforce survey targeting health professionals working in behavioural health, including mental health (clinical and non-clinical), alcohol and drug, specialist counselling, primary care (excluding General Practitioners), allied health and aged care, was conducted in January-February 2021 (GPHN 2021h). Some key findings relevant across professions include, (see **Mental health and wellbeing, including suicide prevention** and **Alcohol and other drugs** sections for specifics for those areas):

- 347 respondents from across the six Gippsland local government areas (LGAs) included health professionals working in mental health or behavioural health (n=143, 41%), primary care and allied health (n=91, 26%), other specified sectors (n=87, 25%) and the aged care sector (n=26, 8%).
- The most common competency reported by the primary care and allied health sector was infection control followed by mental health and wound management.
- The top three categories for preferred professional development topics of the aged care sector were: palliative care; mental health and pain management; and infection control.
- The top five most cited encouraging factors for workforce retention across all sectors were:
    - family ties to the local area and amenities (lifestyle and community);
    - positive employment conditions (flexible work arrangements, job security and stability);

    - colleagues; convenience (close to home); and
    - access to professional opportunities (employment, career growth and professional development).
- The top five most cited discouraging factors for workforce retention were:
    - lack of professional opportunities (limited career growth opportunities, training, and peer support);
    - workplace issues with management or bullying;
    - issues with the area (lack of local amenities);
    - lack of services and referral options (most cited by Eastern subregion, mental health sector and early career respondents); and
    - negative employment conditions (low remuneration, lack of flexible work arrangements).
- Suggested improvements to recruitment and retention included:
    - Focus on staff wellbeing and education
    - Increase remuneration to reflect the importance of work in the human services sector
    - Incentivise potential recruits with temporary accommodation options or increased pay for working in a regional area
    - Conduct incentivised swaps for early/late career to work in rural/regional areas
    - Support for local young professionals to connect with each other
    - Highlight local experts to graduates and using them in professional development
    - Targeted scholarships to work or study in regional areas
    - Secondment with aligned services e.g., AOD with forensic system, justice, mental health and headspace
    - Fieldwork placements for young graduates in AOD sector

Key themes from professional stakeholder, including Clinical Councils have noted (GPHN, 2021f), see **Mental health and wellbeing, including suicide prevention** and **Alcohol and other drugs** sections:

- Evidence based workforce recruitment and retention strategies are important to support existing staff to stay as well as attracting new professionals.
- GPs willing to accept the responsibility of 24 hours coverage can be hard to find, leading to recruitment issues in rural areas.
- A limited workforce skilled in the use of digital technologies to allow ongoing support during times of disaster.
- Irrespective of recent disasters, many service gaps identified in stakeholder consultations by Gippsland PHN during 2021 are affected by workforce limitations, including in disability services, paediatric care and Indigenous health.
- Ongoing workforce issues are particularly evident in East Gippsland and Wellington LGAs. Recruitment and retention are ongoing challenges and shortages of staff impact access to services for local communities. Locations at risk of interrupted medical services include Yarram, Omeo, Orbost and Mallacoota.

    "Medical workforce shortage issues continue … Omeo workforce issues continue with a risk of service closure"

- There are also still reports of severe shortages of GPs in Latrobe with many practices not taking on new patients. Latrobe was not classified as a DPA in 2019 when this system was first introduced, reportedly leading to greater difficulty in attracting doctors to the area.
- A barrier for metropolitan GPs to travel to rural communities has been the lack of emergency upskilling prior to relocating.

- Placement and employment opportunities for Advanced Skills Training of Rural Generalist doctors are reliant on support by health services and the engagement model with the local GP workforce. Recognition and a credentialing endpoint needs to be confirmed and accepted by the profession.
- Practice management challenges include:
    - Nursing and practice staff support to GPs important (e.g., time management)
    - Challenging to run a bulkbilling practice that is viable and inclusive of practice nursing and support staff
    - Suggestion to have primary health vacancies listed on Gippsland PHN website
    - Administrative issues around provider numbers and lack of MBS training
- Challenges with housing for local workforce (moving out from metro area and overseas trained doctors).

Community, consumer and carer perspective

Health workforce was a theme noted as important to improve people's health (GPHN, 2021d). It was noted that 'retention of health workforce', 'recruitment of health workforce' and 'wellbeing support for staff' are important components to enable people to access health care to meet their needs.

"My current GP is the third. She is very good, and I hope she will remain working here for a long time. I wonder why good doctors can't stay in this small town for long?"

"The mental health impacts on GP's operating this way is not sustainable."

Community engagement continues to highlight access to GP services as the most common health issue (GPHN 2016 and GPHN 2021d). Specific challenges include;

- compromised continuity of care due to lack of access to usual GP / general practice during business hours (43% of respondents),
- long waiting times (24% of respondents),
- availability of bulk billing GPs,
- affordable after-hours access to GPs, and
- access to GPs who do home visits.

"We need more doctors - we have an elderly one here who wants to retire but he can't"

"Doctors keep changing and you have to keep explaining"

Access to specialist doctors and allied health services were also common themes from community engagement;

"Everything is in Melbourne or if they come here, they can be very hard to get into"

The Latrobe Health Advocate (LHA 2020b) has identified difficulties accessing a GP as key need in the Latrobe community. The report highlights the need for the greater primary care system to work together to improve access to GPs. Recent engagement has noted the following:

- In 2020 people were frustrated about waiting days or weeks to see a doctor, now some people are waiting weeks or months, which may be a direct result of COVID-19.
- 39% of survey respondents said it is hard to get an appointment.

- 7.5% of survey respondents said they could not access a clinic as the clinic was not accepting new patients.
- The number of people suggesting they would go to the emergency department if they could not access a GP, has doubled from 32% in 2020 to 60% in 2021.
- More people are saying they utilise Nurse on Call if they cannot access a GP.
- The number of people reporting that they would do nothing if they can't get in to see a GP has increased from 13% in 2020 to 25% in 2021.
- Almost half of the survey respondents said it was essential or very important to them that they have an ongoing relationship with their GP. The rationale for wanting access to a GP of choice remains consistent; knows my history, don't want to retell story, trusted relationship.
- It is noted that Latrobe could be more welcoming and empathetic towards GPs; be less demanding, be less racist, be nice to doctors, provide spaces at clinics, build relationship with GP to make them feel worthwhile, support doctors' families to settle in the region.
- Examples of progress include roll out of telehealth and other digital tools.

12. Digital health

"Trying to solve the service navigation issues usually has an assumption that everyone has a computer and Wi-Fi and quite often they don't." [Workshop participant]

"I would like more video calls as we are an isolated community. I would like all my records available digitally to any medical person- also for my ill son- so everyone is aware or can be aware of past treatment." [Survey respondent]

The purpose of digital health is to integrate clinical and patient needs to improve both the provider and consumer experience and ultimately to meet the community's health needs in a sustainable way. Digital health can enable the building of a contemporary, quality health system that is outcomes-focused and value based.

Regional context

- In 2016, 77.7% of households in Gippsland had broadband internet connection compared to 83.7% in Victoria; East Gippsland had the lowest proportion (74.7%), (ABS 2016).
- People with low socio-economic status and younger people are more likely to use mobile devices rather than stationary devices in the home (GPHN 2019).

See **15.** Factors affecting health (or social determinants of health) for socio-economic indicators, such as income and education, which may impact the use of digital health tools.

- New MBS items introduced in March 2020 for telehealth services (phone and video) have been extended and expanded to cover additional services, including psychological therapies. GP providers are still required to have an existing relationship with the patient (November 2021).

There are 89 general practice locations in Gippsland, including five ACCOs. See Gippsland health services.

Digital Health Maturity Assessment

In 2020, Gippsland PHN conducted a Digital Health Maturity Assessment to understand the readiness of general practices within Gippsland to implement digital health tools (GPHN 2021n). By assessing key technical, cultural and change factors through a quantitative scoring process, general practices were placed into one of the foundational, intermediate or advanced tiers, signifying their current level of digital health maturity.

- 13 practices assessed at level 1 - Foundational
- 48 practices assessed at level 2 - Intermediate
- 16 practices assessed at level 3 - Advanced

Classifying general practices allows Gippsland PHN to provide targeted assistance to practices based on their current capabilities and to ensure that any new digital health solutions or models of care implemented by the PHN can be undertaken with the appropriate level of support to make them successful.

The digital health maturity assessment informed the following conclusions based on results from 74 practices (91% of practices in Gippsland in 2020):

- **There remain several deeply embedded technology usage patterns within clinical cultures that represent barriers to further digital maturity**
    - Most general practices use fax machines (66 of 74 – 89.2%).
    - Many general practices receive discharge summaries via fax despite having secure messaging software installed (36 of 74 – 48.6%).
    - Usage of the My Health Record has not become embedded in clinical workflow across most general practices (42 practices report 0-50% of GPs using the My Health Record).
- **Telehealth usage remains immature**
    - Most general practices report the use of telehealth solutions that were not designed for usage in healthcare (63 of 74 – 85.1% of general practices report using Skype).
    - Additional questions are required regarding the use of phones as part of telehealth, as assessment on a national level show that GPs are using phone for telehealth more than any other technology.
- **Self-assessed "progressive culture" not always translating into the use of digital health platforms**
    - Most (60) of general practices claimed to have a progressive culture (strongly agree or agree), but many of these are not making use of available digital health platform such as the Digital Health Guide and Gippsland HealthPathways.
- **The My Health Record is being used widely, but not deeply**
    - Usage of the My Health Record has not become deeply embedded in clinical workflow across most general practices (42 practices report 0-50% of GPs using the My Health Record). It appears that (in most cases) usage is more about receiving the digital health **Practice Incentive Payment (**PIP) than significantly changed behaviour.
- **The Quality Improvement (QI) PIP seems to have had a deeper impact than the digital health PIP**
    - 64 general practices (86%) are claiming the QI PIP
    - 59 general practices (80%) claiming the digital health PIP
- **General practices have a strong level of interest in implementing new digitally-enabled models of care**
    - 71.6% of general practices are interested in implementing new models of care for chronic disease management.
    - 70.3% of general practices are interested in implementing new models of care for mental health.
    - 45.9% of general practices are interested in implementing new models of care for social prescribing.
- **Other notable results include:**
    - 4 general practices (5%) claim to receive no discharge summaries from hospitals.
    - 2 general practices (3%) have GPs who still use paper record keeping.
    - 21 general practices (28%) do not provide an after-hours model.
    - GPs in 52 general practices (70%) are making use of Gippsland HealthPathways.
    - 36 general practices (49%) "Strongly agree" or "Agree" that they would like to learn more about digital health.

- 58 general practices (78%) “Strongly agree” or “Agree” that they currently provide additional care to patients outside of claimable Medical Benefits Schedule (MBS) items.

Digital health tools

Use of digital health tools in general practice and by other primary health care providers is increasing. There has also been an expanded list of tools made available to providers in the past three years. (GPHN 2021l). See **Table 85. Digital health tools and their use in Gippsland, 2021.**. for an overview of digital tools and an estimate of the number of general practices and other providers using them.

The Gippsland PHN **One Good Community GP grant program** aim is to support recipients to adopt, enhance and embed tools from a **Digital Health Toolbox**. The program seeks to drive positive change in health behaviours through the adoption and use of digital health tools and technologies by healthcare providers in Gippsland. Building an integrated system of health that considers multiple, interconnected factors across the lifespan inclusive of community, carers and consumers.

The One Good Community Digital Health Toolbox is guided by a set of principles:

- Quality and Safety: Engage the patient in the care they need using digital technologies in an accessible, safe and effective manner.
- Quality Improvement: Drive quality improvement using digital tools and technologies to promote optimal patient experience and outcomes.
- Drive digital advancement: Through the introduction and maintenance of innovative digital and population health resources and tools to support advancement in digital health maturity.
- Plan for sustainability: Establish new workflows and ensure the entire workforce has the digital skills and knowledge to achieve long term sustainable improvements in delivery of quality care.
- Deliver patient-centred care that considers social determinants of health: By offering patient- centred care that facilitates service access and monitoring of activities between providers that leads to goal setting, self-management, health outcomes and greater efficiency.

Table 85. Digital health tools and their use in Gippsland, 2021.

Tool	Users	Description
POLAR GP	78 general practices (88%)	POLAR (Population Level Analysis and Reporting) is an ‘in practice’ software product for GPs, practice managers and other staff to use within their practice to support internal operations, patient-centred care, quality improvement and business development. De-identified data is shared with Gippsland PHN and used for population health planning, research and evaluation.
Practice Incentive Program Quality Improvement (PIP QI)	63 general practices (71%) (↑ 8.6% from 2020 FY)	The PIP QI supports general practice activities to support continuous quality improvement. For 2020-21 results, see Chronic disease

My Health Record	69 general practices (78%), (up from 64 in 2018) 177 Gippsland organisations; 76 retail pharmacies 7 public hospitals 6 other healthcare services 4 pathology and diagnostic imaging services 2 private hospitals 2 specialist medical services	My Health Record allows secure storage and sharing of information between healthcare professionals and with the consumer, carer or family member. 10,604 Shared Health Summaries, 1,009 Event Summaries, 2,596 Discharge Summaries, 784,417 Prescription Records and 914,441 Dispense Records. It is noteworthy that there has been a 13.9% increase in Shared Health Summary uploads by Gippsland providers and a 55% increase in discharge summary upload by Gippsland hospitals.
e-prescribing	40 general practices (45%)	Instead of receiving a paper prescription, e-prescribing allows your general practitioner to send what is called a token to your mobile phone or email.
Secure messaging	70 general practices* (79%)	Secure Messaging enables the safe, secure, interoperable and confidential information sharing across all healthcare providers and consumers. Gippsland healthcare providers use a variety of secure messaging service providers.
Digital Health Guide	642 Gippsland users registered 111 new users 2020-21	The Digital Health Guide is an online resource to help health professionals find and prescribe the right health app for patients. Users include 149 Medical Practitioners, 165 Nurses, 129 Allied Health professionals, 20 pharmacists and 179 identifying as non-clinical users.
Gippsland HealthPathways	52 general practices (58%), (at least one GP using)* 3,820 active user sessions 240 new users 2020-21	HealthPathways Gippsland is an online portal, designed to be used by health professionals at the point of care. Each pathway provides guidance for the assessment and management of patient with a symptom or condition. Local referral information is included. Gippsland HealthPathways also includes a service directory of local information. 483 total pathways with 111 new pathways developed for 2020-21, including for eating disorders, dementia, mental health referral, thunderstorm asthma, COVID-19, COPD and obstetrics.
Capacity Tracker	36 general practices (40%) 1 Residential Aged Care Facilities	The Capacity Tracker is a cloud-based, online tool to support general practices, residential aged care facilities (RACF) and Aboriginal Community Controlled Organisations (ACCO) during emergencies. Details uploaded include staff, PPE supply, capacity and capabilities.
Remote Patient Monitoring - using Lifeguard	12 general practices (13%) 3 health services 3 bush nursing services	Remote patient monitoring enables patients with Chronic disease conditions to be monitored from their own homes via a smart device, recording patient reported outcomes (symptoms and vital signs). Monitoring templates for the top 20 chronic diseases in Gippsland have been developed.

	34 providers trained as Care Coordinators 17 patients recruited	
Social Prescribing – digitally enabled using Kaleidoscope	13 general practices (15%)	Social prescribing enables healthcare professionals to prescribe non-medical referral options, complimentary to existing clinical treatments to improve health and wellbeing by addressing the social determinants of health. The in-built Community Service Directory has 503 community groups listed, with 54 registered to receive referrals.
Telehealth	72 general practices (81%)*	Healthdirect Video Call Service supported by Gippsland PHN; used by 24 general practices (↑ 50% from 2020 FY)
Train IT eLearning	20 general practices (22%)	A series of Train IT Medical eLearning courses to support general practices get the most out of their clinical software, including for clinical data and quality improvement activities.
Smart forms	62 general practices with capability (70%)	Engagement indicates that pharmacies do not use smart forms. 11 Optometry practices have Oculo Smart Forms and 1 Podiatry practice has HealthLink Smart Forms capability.

Source: GPHN (2021l) * Based on an estimate from GPHN (2021n)

DigitalCare@Home is a collaborative remote patient monitoring project between Gippsland PHN and the Royal Flying Doctors Service, Service. The project focuses on improving the health outcomes of patients living with chronic disease in far East Gippsland by enabling access to care coordination and timely decision making within or close to their home.

Gippsland PHN is working closely with the **Central Gippsland Health Values Based Health Care** project team to implement remote patient monitoring as a key component of the project. The project aims to deliver improved health outcomes to patients and the community, in a financially sustainable manner.

Remote monitoring of Patient Reported Outcome Measures (PROMs) and vital signs of **COVID-19 patients** will act as a funnel into the hospital system to support health services/hospitals ensure the best use of clinical resources and potentially reduce the burden of inappropriate hospitalisation. Monitoring of patients stratified as medium risk and patients with chronic disease will occur through the Lifeguard software.

Service use

General practice data

The proportion of active patients with a Shared Health Summary (SHS) uploaded to My Health Record was 6.6% (GPHN 2021e) with a total of 43,963 SHSs uploaded. See **Table 86**:

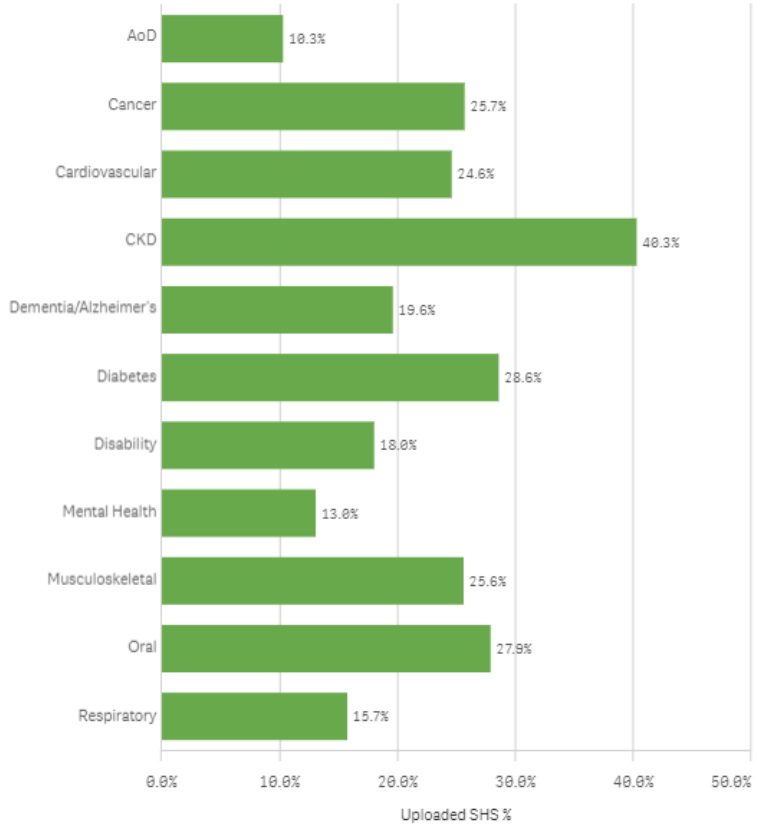
- 8.8% of Baw Baw patients had an uploaded SHS, compared to 5.1% in Wellington.
- 40% of active patients with chronic kidney disease (CKD) diagnosis had a SHS, compared to 10% of patients with an AOD diagnosis and 13% of patients with a mental health diagnosis had a SHS (see **Figure 47**).

Table 86. Gippsland patients with Shared Health Summaries (SHS), October 2021

LGA	Number of SHS uploaded	Proportion of patients with a SHS
Bass Coast (S)	4,959	5.6%
Baw Baw (S)	17,835	8.8%
East Gippsland (S)	7,119	6.2%
Latrobe (C)	12,936	5.3%
South Gippsland (S)	6,516	6.3%
Wellington (S)	9,468	5.1%
Gippsland	43,963	6.6%

Source: GPHN (2021e)

Figure 47. Proportion of active patients with a chronic disease with a Shared Health Summary.



Source: GPHN (2021e)

Gippsland PHN commissioned services data

The **One Good Community GP grant program** aim is to support recipients to adopt, enhance and embed tools from a Digital Health Toolbox. The program seeks to drive positive change in health behaviours through the adoption and use of digital health tools and technologies by healthcare providers in Gippsland. Building an integrated system of health that considers multiple, interconnected factors across the lifespan inclusive of community, carers and consumers.

The One Good Community Digital Health Toolbox is guided by a set of principles:

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- Deliver patient-centred care that considers social determinants of health: By offering patient-centred care that facilitates service access and monitoring of activities between providers that leads to goal setting, self-management, health outcomes and greater efficiency.

See **Table 87** for the number of practices receiving support by tool. Please refer to **Table 85** for an estimate of the total number of practices using the tools.

Table 87. Digital Health Tools selection from general practices, 2021.

Tools and technologies general practices introduced or enhanced	Grant recipients
POLAR GP	27
My Health Record	26
eLearning Management System	23
E-Prescribing	22
Lifeguard remote patient monitoring (digital health level 2 and 3 only)	21
Secure Messaging	18
Digital Health Guide	16
Healthdirect Video Call Service	15
Digitally enabled social prescribing (digital health level 2 and 3 only)	14
Gippsland HealthPathways	13

Professional stakeholder perspective

Feedback about the One Good Community GP program grant included the following themes;

- Healthdirect video call service has been used for the first time by many practitioners and found to be very simple and easy to use for different purposes:
    - GP consultation where the GP was at home and the patient attended the clinic and was supported by a practice nurse.
    - Patient admitted to hospital and the hospital nurse placed a laptop on a trolley, wheeled it to the patient's room and oversaw the consult with the GP.
- My Health Record uptake has improved but there are challenges for busy GPs to incorporate its use in their daily practice. Methods to increase the uploading of Shared Health Summaries onto My Health Record have included in practice competitions and reminders to upload the Shared Health Summaries in the clinic software for each high-risk patient.

In other engagement with professional stakeholders it was noted that (GPHN 2021f):

- The COVID-19 pandemic has fast tracked the implementation of many technologies in health care.
- Telehealth has been a great opportunity but with challenges, including concern about missing diagnoses due to lack of examination.
- Use of HealthPathways noted and challenge of keeping referral information up to date.
- Communication between the hospital system and general practice still has some major gaps, impacting patient safety. Receiving timely discharge information from hospital is particularly important.

  "I'm still trying to find out if my patients go to hospital" (GP)

- There is continued growing awareness of My Health Record and potential benefits are seen by a wide range of professionals including GPs, specialist, pharmacists and allied health providers. Clinicians have reported benefits of having access to a patients record when seeing new patients. More documents are uploaded but not downloading in general practice.

  "… the quality of your medical record is really important otherwise things are forgotten about or ignored or not acted upon."

  "… the doctor in ED of a hospital can login to My Health Record and retrieve the information, so whether it is allergies, any medications they might be taking, any conditions they might have, they will be well aware of when treating the patient in ED."

  "The COVID-19 vaccine roll-out had resulted in greater exposure to MHR as general practitioners are required to review immunisation history for patients" – Gippsland General Practice

- About a remote patient monitoring project:
  "By regularly monitoring their symptoms our participants have found that they are more aware of the early signs and with the education from their nurse consultant have adapted their behaviour in response to these symptoms rather than ignoring them, minimizing the escalation of their condition and keeping them feeling stronger healthier and more confident in managing their condition" – Values Based Healthcare project team

Telehealth has potential but further developments are required to ensure it meets provider and patient needs (AHHA 2020):

- Patients often prefer in person consultations, including for challenging diagnoses such as cancer, as seen during the COVID-19 pandemic
- Offers an alternative model that could be integrated as a component of routine care to offer patients choice
- A study examined trends in the uptake of telehealth items for mental health during the first six months of the COVID-19 pandemic (Jayawardan et al 2021). Key findings were:
  - A 50% reduction in face-to-face consultations for mental health appointments was noted, alongside an uptake of telehealth appointments of equal proportion.
  - Young women aged between 25 and 34 years had the highest utilisation for both video conference and telephone items.
  - Almost 75% of the total uptake of video conference items were by those below the age of 45 years.
  - Victoria had the highest uptake for video conference items of Australian States and Territories.

Community, consumer and carer perspective

Community engagement during 2021 (GPHN 2021d) included a survey with specific questions about digital technologies and their use for health care. It was found that (**Table 88**):

- 88% of respondents use a smart phone or other smart device.
- 76% have reliable home internet
- 53% have access to support with any technical issues

Table 88. Current use of technology by survey respondents for any purpose.

	PER CENT	TOTAL RESPONDENTS
Use a smartphone or smart device	88%	1,231
Worry about how much data I use	20%	1,089
Use a desktop computer at home	71%	1,180
Home internet is reliable and allows me to access what I need	76%	1,167
If I am having a technical issue, I have someone I can go to and see regularly	53%	1,058

Source: GPHN (2021d)

People were asked if they wanted to use digital technologies for their health and the following proportions reported that they already use or would like to use them as often as possible (**Figure 48**):

- 35% already use mobile apps for their health or would like to use them as often as possible
- 49% - text messages
- 18% - social media
- 36% - link to websites
- 55% - phone calls with doctor or other professional
- 33% - video call with doctor or other professional

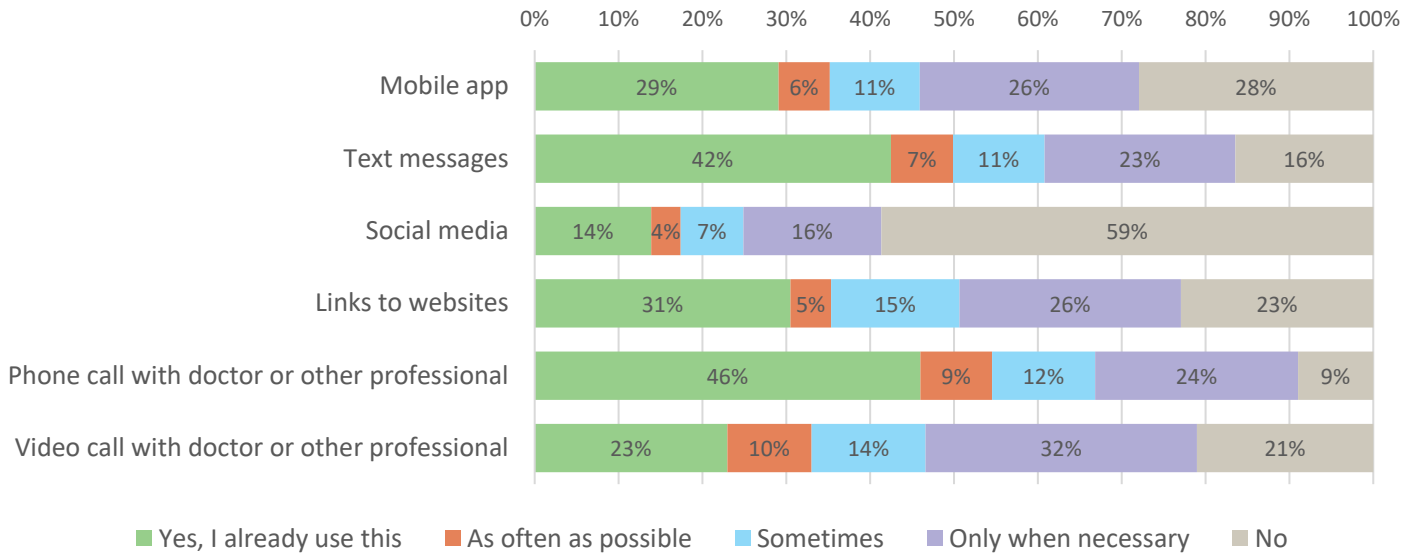
A higher proportion of the population are confident using these technologies.

Some differences between population groups were noted:

- Females were more likely to already use or want to use digital tools for their health compared to males;
    - 38% of females wanted to use mobile apps (31% of males)
    - 58% phone calls (52%)
    - 36% video calls (31%)

- Younger people were more likely to want to use digital tools for their health compared to older people, but phone calls were accepted by more than half of respondents of all ages;
    - 51% of 26-45 year olds use mobile apps, compared to 23% of people aged 75 years or older
    - 42% of 18-25 year olds use video calls, compared to 24% of people aged 75 years or older
- East Gippsland respondents were;
    - less likely to use a smart phone / smart device or a desktop computer;
    - less likely to have reliable internet access; and
    - less likely to have someone to ask for help if they have a technical issue.
- Willingness to use video calls was reported by 50% of LGBTIQ+ people, and by 33% of parents; around 40% of people with a disability, carers and CALD people wanted to use video calls.
- Willingness to use mobile apps was highest for parents and people who are LGBTIQ+ (48%), while people with a disability were less likely (31%); 38% of carers and people from a CALD background wanted to use mobile apps.
- Willingness to use mobile apps and video calls for health was more likely for people with a higher level of education. All groups had a similar proportion of people who were willing to use phone calls for their health.

Figure 48. Responses to 'Would you like to use the following technologies for your health?'



Source: GPHN (2021d)

Community engagement during 2021 (GPHN 2021d) identified barriers, enablers, benefits and concerns about using technology for health care. See **Figure 49**.

"Living regional using technology to access health support is vital to keeping me safe as well as saving money and time on travel."

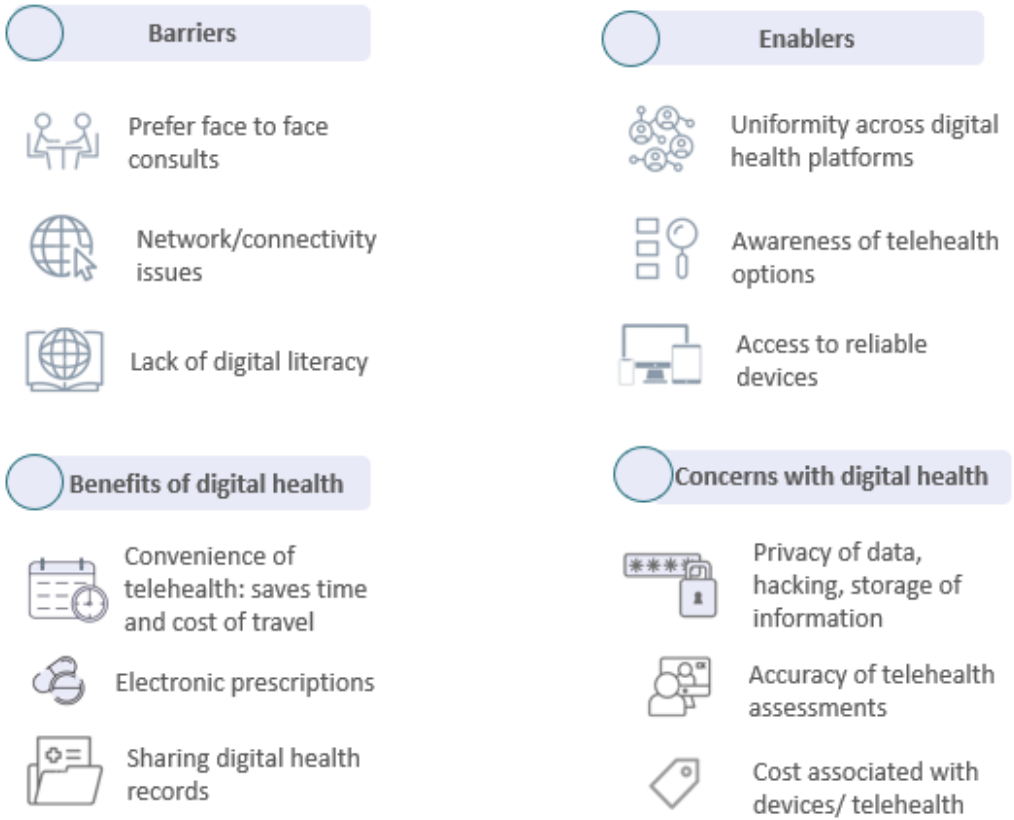
"Things like on-going scripts should definitely be done over the phone or using an app.'

"My concerns are privacy issues, and the fact that I do not feel comfortable about speaking to the doctor while I am at home. Other people might hear me and I want my privacy."

"I don't have a smartphone… My mobile phone is old and only set up for text messages, not video or apps."

"Sometimes I don't understand how it works or can't get it working- frustrating."

Figure 49. Using technology for health, findings from community engagement in Gippsland, 2021.



Source: GPHN (2021d)

Suggestions for improvements included:

- Availability of video call rather than just phone call with more providers (many just to phone)
- Uniformity and streamlining services.

  "It would be advantageous to have a more streamlined approach to services where you can engage with an app, make a booking, put in your notes in there and not have to repeat yourself."

- Education for service providers and clients.

  "Now telehealth has the potential to be fantastic in this area, but I think you've got to educate people, you would have to have internet access, you might have to have somebody explaining [how to use the platform] ...*"*

- Improving access to devices
- Awareness of telehealth options, but only as an option.

  "*Feel pushed to telehealth*"

- Accessing information on providers in the region.
- Shared digital health records, using health data to personalise care.
- Updating websites, improving functionality of applications.

13. Access to care that meets people's needs

"If you don't have a service there it doesn't matter if its good or not, it starts with access…" [Workshop participant]

"I am included in my journey." [Workshop participant]

"Health literacy is very important, and health literacy training for health professionals, so they know how to engage with diverse community…" [Workshop participant]

Health status

There are many things that influence a person's decision and ability to access care to meet their needs. See **Factors affecting health (or social determinants of health**. Some main factors include basic needs such as housing, safety and social connections and also income, education, distance and ability to understand and use health information effectively (health literacy). Simply accessing a service does not lead to improved health and wellbeing; the service needs to be able to address the person's needs in a way that they can integrate into their life.

Population groups more likely to experience access issues include the following; many are further described in other chapters in this document:

- **Aboriginal and Torres Strait Islander health and wellbeing**
- **Children and young people (0-25 years)**
- **Family violence**
- **People 65 years or older**
- **People with a disability**

To address health literacy in a coordinated way, action needs to be taken across three areas (ACSQHC 2014):

  - Embedding health literacy into systems
  - Ensuring effective communication
  - Integrating health literacy into education

Service system

See **Gippsland health services** for an overview of main health services available by geography.

Specialist palliative care services are delivered by (GRPCC 2021):

- The Gippsland Palliative Care Consultancy Service provides advice and consultancy for complex palliative care symptoms.
- Eight funded specialist community palliative care services (Bairnsdale Regional Health Service, Bass Coast Health, Central Gippsland Health, Gippsland Lakes Complete Health, Gippsland Southern Health Service, Latrobe Community Health Service, West Gippsland Healthcare Group, Yarram and District Health Service).

After hours services

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

Options for a direct consultation with a medical practitioner during the after-hours period are listed by Local Government Area (LGA) in **Table 89**. Emergency Departments have a staff doctor in attendance overnight, while Urgent Care Centres are staffed by GPs who also work in private practice and provide specialist medical services such as inpatient obstetrics, anaesthetics and medical. A combination of funding sources are often relied upon. In Gippsland, many general practices operate an after-hours service which may be bulk billed or there may be a cost to the consumer. Funding support can be through MBS items for face to face and telehealth services and/or an after-hours practice incentive payment (PIP). 40 GP practices (42% of practices) in Gippsland received the level 5 after-hours incentive payment in quarter 2, 2018; up from 38 in quarter 2, 2017 (DoH 2021e).

Nurse on Call (1300 60 60 24) is available for advice 24 hours a day, 7 days a week and provides advice and information about options for care after hours, based on the National Health Service Directory, complemented by a referral to an online doctor if relevant based on nurse triage.

Table 89. After-hours medical service options (excluding phone advice) in Gippsland by LGA and type, 2021.

LGA	Emergency Departments		Urgent Care Centres - GP operated		Gippsland PHN supported after-hours services		Additional information of note
Bass Coast	1	Bass Coast Health, Wonthaggi	1	The Phillip Island Health Hub, Cowes, operated by BCH	1	**Cowes** Medical Centre	
South Gippsland	0		3	Gippsland Southern Health Service; **Leongatha** and **Korumburra** South Gippsland Hospital; **Foster**	1	**Leongatha** Health Care Group; service through GSHS UCCs	
Baw Baw	1	West Gippsland Healthcare Group, Warragul	0				
Latrobe	1	Latrobe Regional Hospital, Traralgon	0		1	**Moe** After-Hours Medical Service Central Gippsland Family Practice and Latrobe Community Health Service	
East Gippsland	1	Bairnsdale Regional Health Service	2	**Omeo** District Health **Orbost** Regional Health	2	**Omeo** District Health **Orbost** Regional Health Support for UCCs	Bush nursing services: **Cann Valley, Ensay, Gelantipy, Buchan** and **Swifts Creek.** **Mallacoota** has an Urgent Care type service staffed by Mallacoota Medical Centre and supported by the Ambulance Service.
Wellington	1	Central Gippsland Health Service, Sale	1	**Yarram** District Health Service	0		Bush nursing service in **Dargo**
GIPPSLAND	**5**		**7**		**5**		

Service utilisation

Nurse on Call

A Healthdirect snapshot of calls from Gippsland residents to Nurse on Call (Healthdirect 2021) over two months (1 July 2021- 28 August 2021) shows that:

- There were a total of 3,507 calls handled; suggesting an annual call volume of over 20,000.
- The top presenting symptoms (based on preliminary assessment) among callers were abdominal pain (5.8%), medication enquiry (4.6%), chest pain (3.9%), head injury (3.1%) and medication questions (2.5%).
- The level of care required for the callers was assessed as;
    - 27% attend ED immediately
    - 14% see a doctor within 12 hours
    - 11% see a doctor within 2 hours
    - 9% activate 000
    - 9% self-care advice
    - 9% see a doctor within 6 hours
    - 8% see a doctor within 1-3 days
    - 3% schedule a routine appointment with your doctor
    - Less common were: refer to poisons center, immediate 000, phone consultation with doctor, consultation with alternative professional
- The top outcomes of the call, considering local and personal factors, were; 32% ED, 13% after hours GP, 11% home care advice.

Ambulance services

Ambulance Victoria provided a total of 19,849 Code 1 responses across Gippsland in 2020-21, this is up from 18,366 in 2019-20 with an increase seen in each LGA.

- The COVID-19 pandemic has had a significant impact on demand for services with a greater increase in demand in rural areas. Response times have increased.
- AV is partnering with Scope Australia to develop new training and communication resources to better meet the needs of people with a disability. Gippsland and Metropolitan Melbourne are the trial sites for this work. Baseline research has been completed with paramedics and focus groups identifying opportunities to better support patients with complex communication needs.
- Research into the types of patients requiring an ambulance service has found that (Ambulance Victoria 2021b):
    - There appears to be a strain on GP services with people reporting being unable to get an appointment
    - Calls for an ambulance were usually not unnecessary
    - There is a tendency for medical professionals to train at risk patients to call an ambulance if in doubt
    - It can be difficult to access trusted medical advice quickly and, in many cases, if they do, they are advised to call 000 anyway
    - The report concludes that the ambulance service will need to grow to meet demand, but there may be opportunities to improve decision making to better match health system response to patient need

Table 90. Ambulance activity, code 1 first response (as number of responses) by LGA, Gippsland, 2020-21.

LGA	15 minutes or less in response time	Average response time (min:sec)	Total number of responses
Bass Coast	65.3%	15:13	2,655
South Gippsland	46.3%	18:57	1,711
Baw Baw	68.2%	14:34	3,200
Latrobe	78.9%	11:45	6,326
East Gippsland	60.2%	16:36	3,288
Wellington	58.4%	16:26	2,669
Victoria	**77.2%**	**12:48**	**313,424**

Source: Ambulance Victoria (2021a)

Medicare funded services

A comparison of Medicare subsidised services for people in Gippsland (**Table 91**) shows that:

- In 2020-21, 88.6% of people in Gippsland had a GP attendance recorded, down from 90.7% of people in 2018-19, but higher than across Australia (87.8%); lowest rate in Gippsland was in Wellington.
- 6.4% of people in Gippsland attended a GP after-hours compared to 17.2% across Australia.
- There was an average of 7.0 attendances per person, up from 6.4 in 2018-19 and higher than 6.3 across Australia; East Gippsland (6.4) and Wellington (6.5) had the lowest number in Gippsland.
- 40.9% of people saw an allied health professional (Australia 38.5%), most commonly optometry.
- 10.7% had Medicare subsidised services by a nurse or Aboriginal health worker, higher than in 2018-19 (6.7%), but lower than Australia (11.6%).
- 36.4% had a specialist attendance (Australia 31.5%); these proportions have remained steady.

See **Mental health and wellbeing, including suicide prevention** for items related to mental health.

Table 91. Gippsland population use of Medicare subsidised services, by Gippsland SA3, 2020-21.

Indicator	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South-West	GIPPSLAND	Australia
Allied health attendance (total)	40.6%	39.4%	42.6%	41.0%	41.4%	40.9%	38.5%
Allied health attendance - optometry	32.5%	32.4%	37.1%	34.7%	32.4%	33.6%	30.7%
Allied health attendance - physical care	6.1%	4.2%	3.5%	4.3%	5.6%	4.8%	5.2%
Allied health attendance - podiatry	5.4%	5.1%	3.7%	4.1%	7.0%	5.2%	4.6%
Diabetes education	0.2%	0.9%	0.2%	0.9%	0.3%	0.5%	0.2%
Diabetes mellitus cycle of care	1.4%	0.8%	0.5%	0.6%	0.6%	0.8%	0.6%
Diagnostic imaging	44.6%	40.7%	40.7%	40.3%	41.8%	41.62	38.9%
GP attendances - average number per person	7.6	7.0	6.4	6.5	7.5	7.0	6.3
GP attendance	89.8%	88.5%	88.5%	87.0%	88.7%	88.6%	87.8%
GP attendance - chronic disease management	15.6%	13.5%	10.6%	15.9%	14.6%	14.0%	15.9%
GP attendance - health assessment	3.9%	2.8%	3.4%	4.3%	2.2%	3.2%	4.2%
GP attendance - telehealth support for specialist consult	0.2%	0.2%	0.9%	1.7%	0.4%	0.6%	0.1%
GP attendances - after-hours	10.9%	6.4%	4.7%	3.2%	6.0%	6.4%	17.2%
Nursing and Aboriginal health worker services	11.6%	11.5%	4.8%	12.1%	12.3%	10.7%	11.6%
Specialist attendance	37.2%	37.8%	33.2%	36.1%	36.5%	36.4%	31.5%

Source: AIHW (2021p)

High compared to Australian SA3s, top 25% of values
Low compared to Australian SA3s, bottom 25% of values

The ABS Patient Experiences survey is conducted annually and includes indicators reported by PHN. Sample size for Gippsland is limited and results need to be interpreted with caution. A few notable findings for adults in Gippsland (2019-20 reports of health care in past year):

- 17.8% saw GP more than 12 times; high compared to Australia 10.5% and highest reported for any PHN
- 14.7% saw a GP for urgent medical care; high compared to Australia 10.0% and highest reported for any PHN
- 39.3% saw a dentist, hygienist or dental specialist; low compared to Australia (48.9%)
- 42.5% saw a medical specialist (Australia 36.5%)
- 42% could not access their preferred GP (Australia 28%)

- 90% reported their GP always or often listened carefully (Australia 92%)
- 93% reported their GP always or often showed respect for what they had to say (Australia 95%)
- 88% felt their GP always or often spent enough time (Australia 91%)
- 27% had delayed seeing a dentist, hygienist or dental specialist (Australia 19%)
- 24% saw three or more health professionals for the same condition (Australia 17%)
- 41.8% had private health insurance (Australia 56.5%); lowest PHN in Australia
- Several indicators without reliable estimate for Gippsland, including about delaying care due to cost

General practice

Activity in general practice in 2020-21 shows that:

- 20.0% of activity was after-hours (compared to 16.3% in 2019-20)
- 46.7% of activity by general practice during the after-hours period was for people with a healthcare card (compared to 40.6% of activity in business hours)
- 1.7% was for Indigenous people
- 0.6% was for people in a residential aged care home
- After-hours activity increased with age:
    - Young people aged 0-24 years had 13.0% after-hours activity in 2020/21 (compared to 13.4% in 2019/20)
    - People aged 25-44 years had 16.8% after-hours activity (16.0% in 2019/20)
    - People aged 45-64 years had 16.6% after-hours activity (15.6% in 2019/20)
    - People aged 65 years and over had 20.4% after-hours activity (19.5% in 2019/20)
- The busiest time of day for after-hours activity were:
    - Between 6-7pm on weekdays (51.7% of all after-hours activity)
    - Between 7-8pm on weekdays (18.3%)
- The busiest weekday for after-hours activity was Wednesday (21.4% of all after-hours activity)
- The least busy weekday for after-hours activity was Friday (13.6%)
- Saturday (2.7%) and Sunday (3.2%) had low after-hours activity

Commissioned by Gippsland PHN

Services delivered by the Place Based Flexible Funding (PBFF) – allied health services program (2019-20):

- 2,143 people accessed 10,578 PBFF services (average of 5 sessions per person)
- 56% of participants identified as female.
- 8.9% identified as Aboriginal and/or Torres Strait Islander
- Most services were delivered in the East Gippsland, Wellington and Bass Coast LGAs
- The PBFF services most accessed by clients were Chronic Disease Management, Podiatry, Nursing, Physiotherapy, Counselling, Dietetics

- Actual cost per service was $128 (target cost $112); down from $144 in 2018-19

After-hours services delivered:

- Total of 10,584 after hours sessions delivered in 2019-20, at a unit cost of $23.
- Total of 8,015 after hours services delivered in 2020-21, at a unit cost of $30.

Urgent care centres

Total activity at the seven urgent care centres in Gippsland is summarised by sub-region in **Table 92**. It can be noted that:

- Increase in activity in Bass Coast/South Gippsland between 2019-20 and 2020-21, due to the Philip Island Health Hub commencing operation in 2019-20 and increased activity at Leongatha.
- Reasonably stable activity in East Gippsland/Wellington across the four years of analysis.

Table 92. Urgent care centre activity (as number of service events) by LGA of provider, Gippsland.

Gippsland sub-region	2017-18	2018-19	2019-20	2020-21
Bass Coast/South Gippsland	5,478	5,909	13,751	21,083
Baw Baw/Latrobe	NA	NA	NA	NA
East Gippsland/Wellington	4,523	4,733	4,281	4,504
Gippsland TOTAL	**10,001**	**10,642**	**18,032**	**25,587**

Source: VAHI (2021a)

Hospital admissions

- 77.8% of hospital admissions for Gippsland residents are in public hospitals, compared to 60.0% for Australia, see **Table 93**.
- High admission rates can be noted in Latrobe (both males and females) and Bass Coast (males) compared to Australia.
- Potentially preventable hospitalisations (PPHs) can be used to indicate activity that may be preventable in the primary care setting (AIHW 2020b).
    - Across Australia, around 7% of public and private hospital admissions were considered potentially preventable and nearly 10% of bed days.
    - PPH rates are higher for some populations and these gaps may be widening for Indigenous people, in regional and remote areas, areas with more socio-economic disadvantage and for older adults.
    - In Gippsland, high rates can be noted for chronic conditions and in the Latrobe area (see **Table 94**).

Table 93. Hospital admissions for Gippsland residents to public and private hospitals, excluding same day admissions for renal dialysis, age-standardised rates per 100,000 population, 2018-19.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Per cent of total admissions in public hospitals	77.8%	77.5%	68.7%	80.7%	83.8%	82.1%	77.8%	60.0%
Total admissions	40,150	36,863	36,519	45,549	36,305	38,306	39,512	40,165
Total admissions – males	37,539	33,609	32,837	41,531	33,837	35,195	36,077	37,162
Total admissions - females	42,439	41,503	39,904	49,342	38,983	41,503	42,709	43,107

Source: PHIDU (2021e)

High compared to Victorian LGAs, top 25% of values
Low compared to Victorian LGAs, bottom 25% of values

A Gippsland PHN analysis of Major Diagnostic Categories (MDCs) provide a snapshot of the reasons why patients are admitted to hospital (DH 2021b), see **Table 95**.

- Diseases and disorders of the kidney and urinary tract is the top category with haemodialysis making up around 80% of these admissions
- Diseases and disorders of the digestive system was the second most common
- Neoplastic disorders was the third most common group, same day admissions for chemotherapy make up 86% of these admissions.
- Admission rates per population, LGA and MDC were analysed for 2017-18, 2018-19 and 2019-20;
    - Latrobe and East Gippsland had a high rate for Diseases and disorders of the kidney and urinary tract compared to Victoria and other LGAs, indicating a high rate of chronic kidney disease
    - Latrobe and East Gippsland also had the highest rates for Disease and disorders of the digestive system

Table 94. Potentially preventable hospitalisations for Gippsland residents by SA3, age-standardised rates per 100,000 people, 2017-18.

PPH categories and sub-categories	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South West	GIPPSLAND	VICTORIA	Australia
Potentially preventable hospitalisations - all	**2,959**	**3,421**	**2,916**	**2,741**	**2,870**	**3,010**	**2,697**	**2,793**
Total acute and vaccine preventable	**1,224**	**1,698**	**1,532**	**1,380**	**1,623**	**1,514**	**1,412**	**1,590**
Dental conditions	268	263	312	371	259	287	278	293
Urinary tract infections, including pyelonephritis	196	351	202	215	336	273	246	282
Cellulitis	190	247	357	202	345	270	207	258
Ear, nose and throat infections	176	245	188	203	176	201	179	194
Convulsions and epilepsy	138	257	196	143	196	192	150	158
Pneumonia and influenza (vaccine preventable)	119	153	137	134	149	140	159	207
Total Chronic	**1,745**	**1,747**	**1,415**	**1,367**	**1,260**	**1,513**	**1,306**	**1,233**
Iron deficiency	316	582	387	419	242	399	358	241
Diabetes complications	816	267	190	208	207	324	204	187
Type 1 Diabetes complications	176	95	82	101	80	104	70	64
Type 2 Diabetes complications	636	170	89	108	126	214	130	121
COPD	208	356	257	268	303	284	229	267
Congestive heart failure	168	234	183	203	207	202	213	206
Asthma	105	176	161	92	121	135	138	134
Angina	76	65	178	112	122	108	90	110

Source: AIHW (2020b)

High compared to Australian SA3s, top 25% of values
Low compared to Australian SA3s, bottom 25% of values

Table 95. All hospital admissions for Gippsland residents by main diagnostic category, public hospitals only.

Main diagnostic category	2017-18		2018-19		2019-20	
	Admissions	Per cent	Admissions	Per cent	Admissions	Per cent
Diseases and disorders of the kidney and urinary tract	20,937	18.2%	22,239	18.6%	23,406	19.8%
Diseases and disorders of the digestive system	13,000	11.3%	13,605	11.4%	14,488	12.3%
Neoplastic disorders (haematological and solid neoplasms)	12,107	10.5%	11,736	9.8%	10,838	9.2%
Diseases and disorders of the circulatory system	8,483	7.4%	8,973	7.5%	8,892	7.5%
Diseases and disorders of the musculoskeletal system and connective tissue	8,942	7.8%	9,526	8.0%	8,725	7.4%
Diseases and disorders of the nervous system	6,108	5.3%	6,369	5.3%	6,361	5.4%
Diseases and disorders of the respiratory system	6,104	5.3%	6,384	5.3%	5,859	5.0%
Pregnancy, childbirth and the puerperium	4,945	4.3%	4,991	4.2%	4,619	3.9%
Diseases and disorders of the skin, subcutaneous tissue and breast	4,262	3.7%	4,414	3.7%	4,454	3.8%
Diseases and disorders of the ear, nose, mouth and throat	3,528	3.1%	3,558	3.0%	3,482	2.9%
Newborns and other neonates	3,357	2.9%	3,347	2.8%	3,228	2.7%
Injuries, poisoning and toxic effects of drugs	2,405	2.1%	2,848	2.4%	3,004	2.5%
Diseases and disorders of the blood and blood forming organs and immunological disorders	2,967	2.6%	2,840	2.4%	2,839	2.4%
Factors influencing health status and other contacts with health services	3,037	2.6%	2,961	2.5%	2,724	2.3%
Diseases and disorders of the eye	2,894	2.5%	3,434	2.9%	2,663	2.3%
Diseases and disorders of the female reproductive system	2,756	2.4%	2,588	2.2%	2,616	2.2%
Endocrine, nutritional and metabolic diseases and disorders	2,058	1.8%	2,165	1.8%	2,487	2.1%
Diseases and disorders of the hepatobiliary system and pancreas	2,049	1.8%	2,062	1.7%	2,218	1.9%
Mental diseases and disorders	1,823	1.6%	1,890	1.6%	1,971	1.7%
Infectious and parasitic diseases	1,400	1.2%	1,634	1.4%	1,473	1.2%
Diseases and disorders of the male reproductive system	1,347	1.2%	1,331	1.1%	1,247	1.1%
Alcohol/drug use and alcohol/drug induced organic mental disorders	522	0.5%	523	0.4%	556	0.5%
Burns	85	0.1%	101	0.1%	101	0.1%
Total	**115,116**		**119,519**		**118,251**	

Source: DH (2021b)

Emergency department presentations

- Lower urgency emergency department (ED) presentations (category 4-5) are high across Gippsland (182 per 1,000 people), compared to Australia (117) except for South Gippsland residents (no ED available within LGA). See **Table 96**.
- The highest rates are seen among children and young people.

An analysis of all ED activity for Gippsland residents show that in 2020-21:

- There were a total of 122,306 ED presentations; up from 113,329 in 2017-18 and 31.2% were for Latrobe residents
- 53.3% of ED presentations were lower urgency; down from 58.4% in 2017-18 (55.2% in 2019-20)
- 52.0% of ED presentation were after-hours; down from 54.1% in 2017-18 (see **Table 97**);
    - 25.2% of all presentations were on weekends, 16.3% between 6pm and 11pm weekdays and 10.5% after 11pm or before 8am on weekdays.
- The average time waiting for treatment in Gippsland was similar across all triage categories when comparing to the state average.

Table 96. Use of emergency departments for lower urgency care, rates per 1,000 population, by SA3, 2018-19.

Category of lower urgency ED presentations	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South West	Gippsland	Australia
All lower urgency presentations	174	217	176	211	131	182	117
Children 0-14 years	255	328	233	311	177	262	181
Young people 15-24 years	221	302	286	319	191	265	144
People 65 years or older	122	127	117	136	96	117	80
After-hours presentations	56	102	80	102	58	85	62

Source: AIHW (2020b)

High compared to Australian SA3s, top 25% of values
Low compared to Australian SA3s, bottom 25% of values

Table 97. Emergency department presentations to public Victorian hospitals by time of day, Gippsland residents.

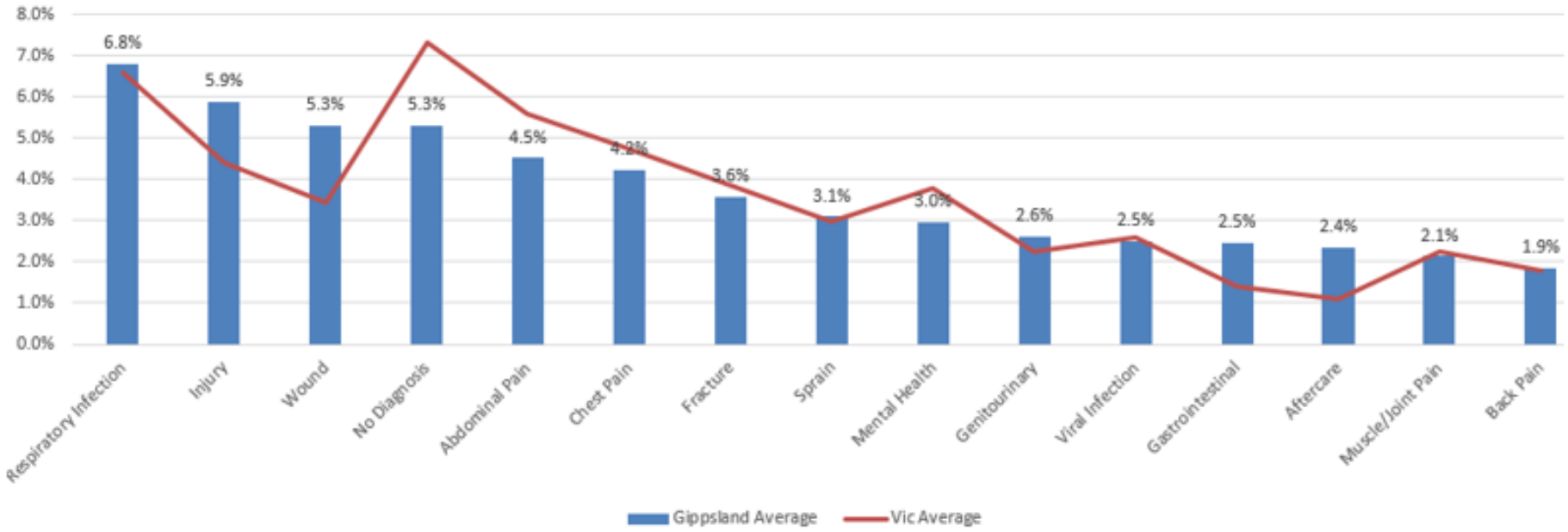
Time of day	2017-18		2018-19		2019-20		2020-21	
	Presentations	**%**	**Presentations**	**%**	**Presentations**	**%**	**Presentations**	**%**
Business hours Weekdays 8am – 6pm Saturday 8am - noon	52,031	45.9%	55,808	46.3%	56,880	47.7%	58,751	48.0%
Total after hours	61,288	54.1%	64,718	53.7%	62,407	52.3%	63,552	52.0%
Weekday sociable Weekday 6-11pm	19,525	17.2%	20,574	17.1%	19,817	16.6%	19,904	16.3%
Weekday unsociable Weekday after 11pm Weekdays before 8am	11,945	10.5%	12,646	10.5%	12,672	10.6%	12,816	10.5%
Weekend Saturday before 8am Saturday after 12pm All day Sunday	29,818	26.3%	31,498	26.1%	29,918	25.1%	30,832	25.2%
Totals	**113,329**		**120,532**		**119,287**		**122,306**	

Source: DH (2021c)

An analysis of the top diagnoses in ED data shows that the most common reason for presentation to ED for Gippsland residents was treatment for a respiratory infection (6.8%) similar to the state average of 6.6%. See **Figure 50**.

- ED presentations for trauma related reasons (injuries and open/closed wounds) made up a higher proportion in Gippsland than Victoria.
- ED presentations with no diagnosis recorded made up a smaller proportion of presentations in Gippsland (5.3%) than across Victoria (7.3%).
- Presentations categorised as mental health made up a smaller proportion of presentations in Gippsland (3.0%) than Victoria (3.8%); see also **Mental health and wellbeing, including suicide prevention**.

Figure 50. Top fifteen categories of ED presentations for Gippsland residents as per cent of all presentations, compared to Victoria, 2017-18 to 2019-20.



Source: DH (2021b)

Palliative care

Nationally, of people aged 65 years or older, 50% die in hospital and 36% die in residential aged care (AIHW 2021y); a higher proportion of older people die in aged care; 47% of people aged 85-94 years.

- Cause of death varied by setting; people with cancer and respiratory conditions were more likely to die in hospital, while people with dementia and coronary heart disease were more likely to die on residential aged care.
- 27% of people who died in residential aged care had used a hospital in their last month of life
- 28% had used palliative care services (prescribed medications or seen a palliative medicine specialist or been admitted to hospital for palliative care) in the year prior to their death.
- Palliative care use was less common among people who died in residential aged care (18% had accessed in the year prior to their death), compared to 39% of people who died in hospital and 25% of people who used other aged care services.

It is estimated that 1 in 1,000 general practice consultations are palliative care related (AIHW 2021z). GPs play an important role in supporting palliative care to manage pain relief and other symptoms, supported by palliative medicine specialists.

A Gippsland study into anticipatory prescribing (Khalil et al 2021) found that:

- prescribing of anticipatory medications in general practice was only seen for a small proportion of palliative care patients; and
- there is some confusion about identifying patients needing anticipatory medications and mixed knowledge about palliative care referral pathways.
- The researchers conclude that improved knowledge about appropriate referral pathways for palliative care patients visiting general practice is needed. Similarly, knowledge of screening tools to assist in identifying patients with palliative care needs may be useful for health care practitioners to support patients and ensure timely care is provided.

Palliative care has been identified as a priority in the Latrobe community (LHA 2021b). Work on priority areas in is on-going and includes the following outcomes:

- improved awareness of death and dying in the community
- improved awareness of palliative care in primary care to enable early referrals
- improved access to specialist palliative care, including medicine, psychosocial care and grief and bereavement services
- palliative care services are available when they are needed, including after-hours and at home
- all providers, including hospital, specialist community services and general practice work together, including seamless sharing of patient information
- people die in their place of choice.

Similar themes have been noted in other stakeholder engagement (GPHN 2021):

- Pain management is a service gap
- Grief and bereavement services are needed
  "Demand outstrips the capacity of community services associated with palliative care … respite …"
- There is a need for early referral to palliative care and to strengthen specialist palliative care capacity.

A Victorian survey (VAHI 2021b) found that:

- A higher than average proportion of adult Victorians had a formal written end of life or palliative care plan if they lived in Gippsland, and in particular Baw Baw, East Gippsland or South Gippsland.
- The proportion of people who said they had made an end of life or palliative care plan after speaking with family was higher than average for those living in Gippsland, and in particular Bass Coast, Baw Baw, East Gippsland and Latrobe.

Professional stakeholder perspective

Consultations with clinicians and other professional stakeholders by Gippsland PHN have noted the following main themes (GPHN 2021f):

- Access to services locally was consistently a top-rated priority area among workshop attendees.
- Low health literacy is common in the Gippsland population.

  "Need to meet people where they are at" (health literacy as a professional's responsibility)
- Issues around accessing aged care services and supports and especially coordination between providers.
- Advance care planning (ACP) presents challenges of integration across primary health and hospitals:
    - GPs are supportive of ACPs, but 82% were concerned about a lack of consistency between hospitals and the primary care settings
    - Enablers for ACP included passionate clinicians, inclusion in checklist for 75 year health assessment, funding and high level organisational support.
    - Hospital activity is focused on internal processes to ensure staff are trained and Advance Care Directives are acted on
    - Lack of My Health Record interoperability with hospital systems
    - Hospitals identified primary and aged care personnel as best placed to facilitate Advance Care Plans
    - The COVID-19 pandemic has led to renewed sense of urgency around ACP
- The importance of clinicians communicating well to ensure they are able to understand the bigger picture.

  "...treat people - not disease"
- Place-based planning of an integrated health service system has strong support and the COVID-19 pandemic has led to some practical examples.
- Funding models continue to present barriers to providers working together for improved patient outcomes.
- Service gaps include:
    - Transport 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.

- After-hours presents some unique challenges including:
    - Making it financially attractive for GPs to provide an after-hours service without increasing the cost for consumers.
    - Potential expansion of nurse led models, including practitioner, bush nurse, which are well regarded where implemented.
    - Increased demand for mental health services and chronic disease management.
    - High proportion of patients with low socio-economic status leading to high demand for bulk billing or preference for ED.
    - Workforce challenges in outer regional areas could be addressed by additional incentives for international graduates and funding for locum cover.
    - Tourism activities can lead to added pressure on after-hours services.

Community, consumer and carer perspective

Gippsland PHN community, consumer and carer consultations consistently highlight some key themes that continue to be relevant based on more recent consultations during 2021 (GPHN 2021f):

- The coordination of care between the primary care setting and the acute setting can be very challenging, especially for certain disease types, including chronic disease, cancer and for persons with complex needs that require the involvement of numerous providers.
- A lack of information about existing services and how to access them continues to be raised as an issue, in particular for alcohol and other drug treatment services, mental health services and after-hours medical services.
- Difficulties in accessing a GP, and especially a preferred GP in a timely manner, continues to be a top-rated concern, noted by 43% of survey respondents (GPHN 2016). This often leads to people having to repeat their history every time a new GP or other service provider is seen, even within the same GP practice.
- People continue to report not feeling as if their doctor has understood their health issues, leading to un-helpful consultations (including inappropriate prescribing and referrals) and sometimes a reluctance to continue seeking help for the issue.
- The most commonly reported barriers to accessing health care (GPHN 2016) were:
    - 32% cost
    - 24% a too long wait for an appointment
    - 10% couldn't get to the health care they needed
    - 6% of all respondents reported that they did not feel comfortable accessing the service they needed
    - 4% of all respondents reported that they did not know how to access the service
- The most common service gaps:
    - access to a GPs offering continuity of care, bulk billing and after-hours access
    - 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 and counselling (affordable)
    - specialist health care, including early assessment and intervention for children, diagnostic services, rehabilitation
    - allied health services, especially paediatric allied health, audiology and speech
- In 2018, 10% of survey respondents reported having an Advance Care Plan (GPHN 2018); 82% of interviewed consumers had no working understanding of advance care planning, 40% reported a poor experience with death and 78% would welcome a discussion about ACP at their next GP appointment

A Gippsland PHN survey was conducted in 2021 (GPHN 2021d); for methods see **Stakeholder consultation**. It was found that 76.6% of respondents had a usual doctor, while 11.6% did not have a usual doctor or other healthcare provider; 10.5% had a usual healthcare provider who was not a doctor. That group includes respondents who have a usual medical centre and people who have a nurse or other professional as their usual provider. See **Table 98**.

Table 98. Survey respondents by usual health care provider, n=1,365.

PROVIDER TYPE	NUMBER	PER CENT OF TOTAL (%)
Usual doctor (general practitioner / GP)	1,060	76.6%
No usual doctor or other health care provider	172	11.6%
Usual health care provider is not a doctor (specified below)	145	10.5%
• medical center	37	2.7%
• bush nurse	16	1.2%
• hospital	10	0.7%
• professional (nurse practitioner or other)	14	1.0%

A usual healthcare provider was less common for:

- People who identify as LGBTIQ+ (24.5% did not have usual healthcare provider)
- People from a culturally or linguistically diverse background (19.6%)

A usual healthcare provider was more common for:

- People with a long-term health condition limiting daily activities moderately or a lot (7.7% did not have a usual healthcare provider)
- People with a disability (8.6%)
- People in Baw Baw (8.3%)

74% of East Gippsland respondents had a usual doctor compared to 87% of Baw Baw respondents.

4.8% of respondents had a long-term health condition that limited their activity a lot, while 13.3% had a condition that limited activity moderately; a total of 18.1% with moderate or severe limits to daily activity from a long term health condition, see **Table 99**.

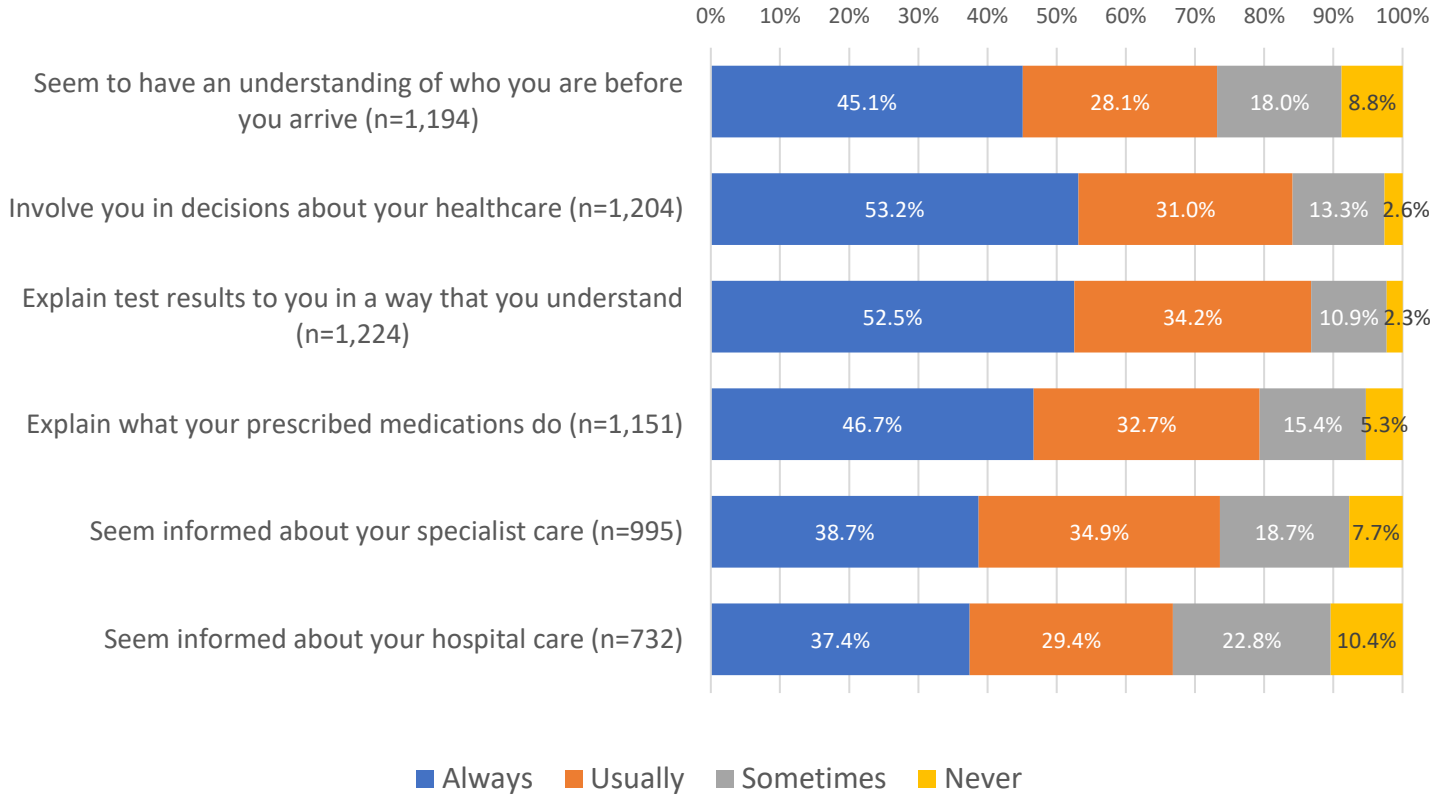
Table 99. Survey respondents by long term health condition and limit to daily activity, n=1,275

LONG TERM HEALTH CONDITION	NUMBER	PER CENT OF TOTAL (%)
No long-term health condition	462	36.2%
Yes, but no limit to daily activities	282	22.1%
Yes, limited a little	301	23.6%
Yes, limited moderately	169	13.3%
Yes, limited a lot	61	4.8%

Survey respondents ranked how often their usual healthcare provider did certain things (see **Figure 51**). The proportion reporting that their provider usually or always do the following:

- 73% seemed to understand who they were before they arrived
- 84% involved them in decisions about their healthcare
- 87% explained test results in a way they could understand
- 79% explained what their medications do
- 74% seemed informed about specialist care (such as what their specialist had done about their health)
- 67% seemed informed about hospital care (such as medication changes)

Figure 51. Survey respondents ranked how often their usual healthcare provider did the following.



Source: GPHN (2021d)

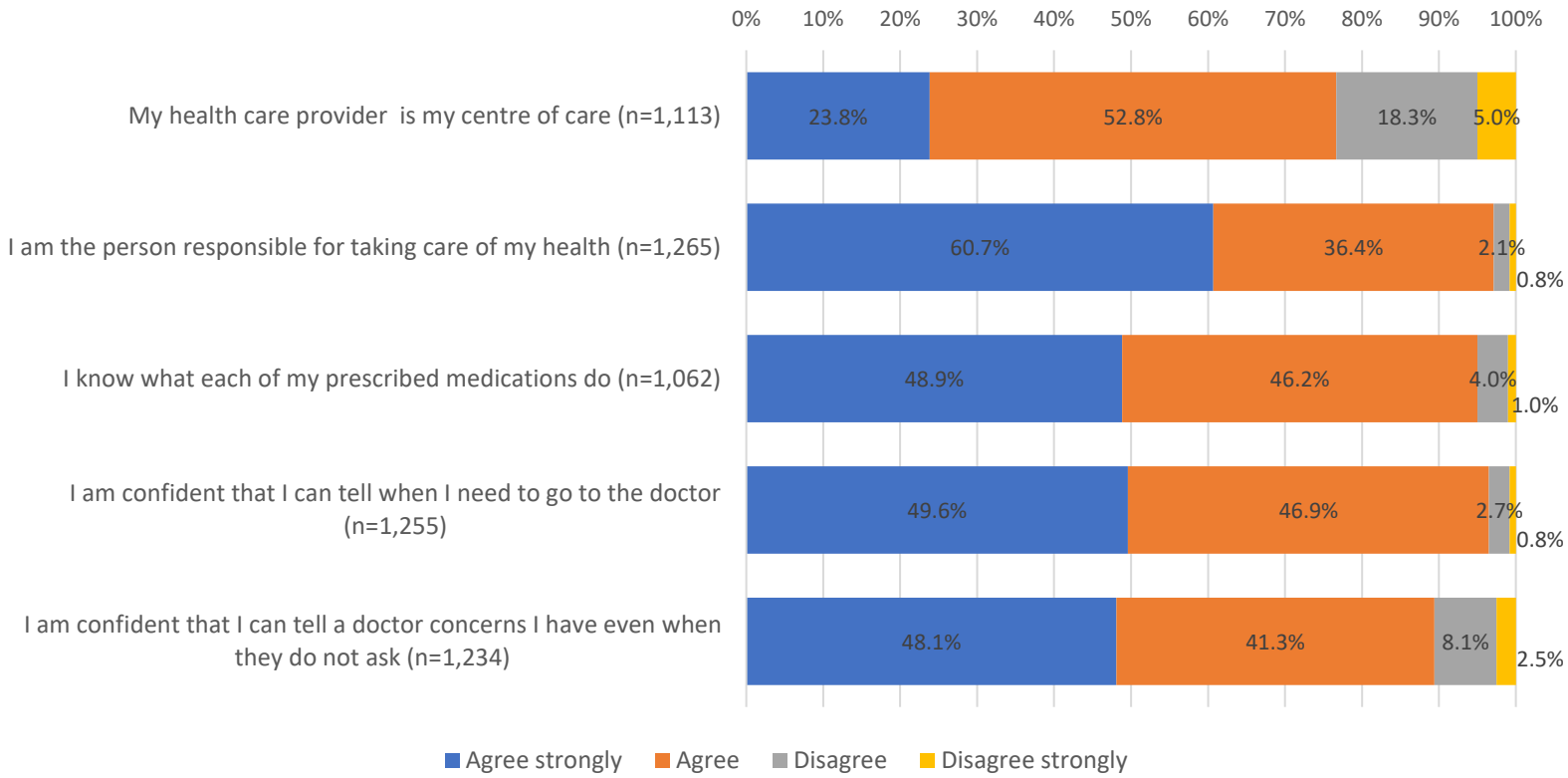
Differences were noted between groups of respondents:

- 72% of females had a provider who seemed informed about their hospital care compared to 60% of males
- Older respondents were more likely to have a provider who was informed about their hospital care (85% of respondents aged 75 years or older compared to 26% of 18-25 year olds)
- LGBTIQ+ people least likely to have a provider who seemed to understand who they were before they arrived (48% compared to 73%)
- LGBTIQ+ people least likely to have a provider who is informed about their specialist and hospital care (around 50% compared to around 70%)
- Carers least likely get an explanation about what prescribed medications do (48% compared to 78%)
- Latrobe respondents were least likely to have a provider who seemed to know them before they arrived (65% compared to 73% or more in other LGAs)

Survey respondents also ranked how they felt about certain aspects of health, see **Figure 52**. The proportion who agreed or strongly agreed:

- 77% thought their healthcare provider was their center of care
- 97% agreed they are responsible for taking care of their health
- 95% know what each of their prescribed medications do
- 97% feel confident they can tell when they need to go to the doctor
- 89% felt confident they can tell a doctor their concerns even if not asked

Figure 52. Survey respondents ranked how they feel about healthcare, Gippsland 2021.



Source: GPHN (2021d)

Differences were noted between groups of respondents:

- Younger respondents were less confident;
  - knowing when to go to the doctor; 84% of 18-25 years olds compared to 96% or more for people 46 years or older
  - knowing what their medications do; 82% of 18-25 years olds compared to 97% or more for people 46 years or older
  - telling their doctor about their concerns if they did not ask; 52% of 18-25 years olds compared to over 90% of people 46 years or older
- People with higher education were less likely to see provider as their centre of care (68% of people with a bachelor's degree compared to 80% or more for other groups)

The top theme identified as important to improve people's health was '**timely access to services'** (GPHN 2021d), with sub-themes described as 'continuity of care', availability of services locally and accessibility of services. These themes are described in **Table 100**. Respondents described a need for timely access to services including specialists, general practitioners, nursing and allied health and emergency services. Accessing consistent care including regular check-ups with a health professional of their choice was important.

Table 100. Survey themes describing timely access to services.

THEME	DESCRIPTION	QUOTES
CONTINUITY OF CARE	• Challenging to build a rapport with the same doctor due to high staff turnover or unavailability of their usual doctor. • Health professionals who stay in the area.	*'A more consistent doctor service- too much changeover within few months, they don't know who you are!!'* *'Having GP's that actually stay…that we can build a working relationship with.'*
AVAILABILITY OF SERVICES LOCALLY	• Access to local services • Limited availability of appointments locally • Long wait times	*'Availability of doctors. Waiting weeks to see doctor is a challenge. Having to travel to Melbourne for specialists.'*
ACCESSIBILITY OF SERVICES	• Cost of services • Travel to access services • Access to bulk billed services, reducing gap payments • Choice of accessing private or public health services	*'Assistance with cost of fuel…'* *'Decreasing of large gap payments on health fund claims.'* *'I know a lot of people who put off going to GP because of expense.'*

Service gaps were described in local areas and include residential respite and rehabilitation, mental health crisis support, after-hours and weekend support.

"There's been a lot of initiatives [in mental health]… *they're centred around Traralgon with some outreach to Bairnsdale. Bairnsdale is two and a half hours from us and… Traralgon is four hour drive from us, so it doesn't actually help a lot of people in this community."*

The impact of cost as a barrier for service access was described and is made up of several components that can add up including; cost of service, travel cost, loss of income and sometimes a need for accommodation.

"Financially, it does require you to have a car that is in good enough condition to be able to get there and be able to afford the [fuel] *to be able to get there. For a lot of people, they don't have it at the moment."*

Main factors that facilitate access to health care include;

- Access to bulk billed services
- Reduced cost of specialist and private health services
- Awareness of available services and supports such as patient transport scheme
- Access to appropriate health professionals including specialists, GP, nursing and allied health, dental health

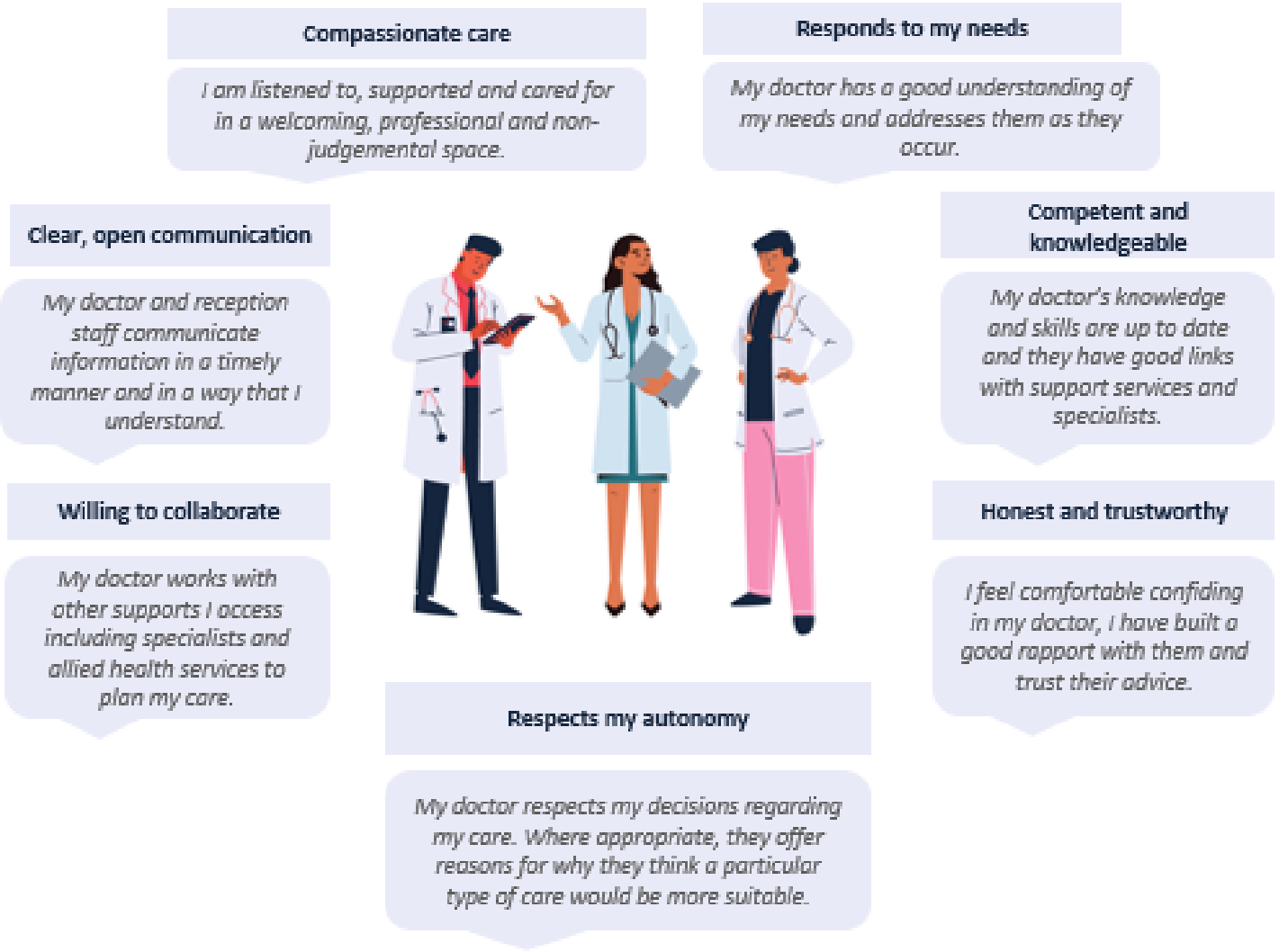
Interviewees were asked what is already working well with health care (GPHN 2021d) and a top theme was '**taking responsibility for their own health**'. This was described as being aware of preventative measures like a healthy lifestyle and knowing how to advocate for themselves. Adequate health literacy is an important foundation.

"Asking lots of questions and trying to be as well-informed as possible."

"Knowing reliable sources of health information and ability to read and understand health information."

'Improving patient experiences' was another top theme, outlining people's expectations of the care they received from health professionals and acknowledged the patient's role in their health care journey. See **Figure 53**.

Figure 53. Patient expectations of health care, Gippsland 2021.



Source: GPHN (2021d)

Care coordination was discussed, and some key themes noted that:

- Open communication between patient and clinicians is important.
- It is challenging when the responsibility of coordinating care is on the individual.
- It is helpful when the care coordinator has knowledge of services available and can refer client to appropriate services in a timely manner.
- There is a need for coordination between social services, community health and regional / metro health services.

"It would be good if there was some kind of central place you could go to that would put you in touch with all the specialties that you need. At the moment, it's very much up to the individual person to go out and find what they need and sometimes people don't know what they need." [About mental health services]

"The biggest disconnect I find is between GPs and these specialised providers… But I think for many people getting the right connections between their health care providers to build that team around you is really critical." [About chronic disease]

"Coordinated health care plan, for example a social worker, mental health support and palliative care"

Community workshops were held to hear from professionals and community members and these confirmed the importance of keeping the person central when coordinating care:

"It's all about service access…without that there's no point in focusing on anything else"

"I am at the centre of my care…" (too much focus on services doing the work – a handover should include the person)

"Trying to solve the service navigation issues usually has an assumption that everyone has a computer and Wi-Fi and quite often they don't."

"I want holistic care, no wrong door…too many services have exclusion criteria…"

"Basic care is our basic right – we're not getting out basic needs met"

Mallacoota is a very remote community in East Gippsland, close to the Victorian border with NSW. The total population is about 1,150 people with 23% aged 70 years or older (14% in Victoria) and significant seasonal tourism (East Gippsland Shire Council 2021). A Mallacoota specific community survey was conducted by the Health Issues Centre (commissioned by Gippsland PHN) in March 2021.

The purpose of the survey was to determine if local health services are meeting the needs of the community. The survey was available online and in hard copy through local social networks and community organisations. Community input was sought about:

- What services they use
- Frequency of service use

- Accessibility of services
- Quality of the services they use

There were 218 survey responses indicating that over 20% of the adult population participated. Major findings included:

- Generally happy with services considering the remoteness of the location.
- Difficulty accessing specialist care.
  "…those most likely to require specialist care, i.e. the old and frail or those with chronic conditions, are least able to manage the ordeal of travelling."
- There is a need to travel for services beyond basic primary care and an overnight stay is often needed, adding to the cost. There is a lack of transport options available particularly for those that need additional assistance.
- Opportunity to improve telehealth options to improve access to services.
- An after-hours care option is needed. An after-hours ambulance service is available but there were concerns about the need to be transported to a regional hospital for care.
- There is a need for better aged care and palliative care services. This was related to the after-hours theme.
- People believe that their care could be better coordinated between the local health service providers.

Figure 54. Sue's journey – Access to care that meets people's needs.

Sue's journey

Sue is 67 years old, she is a pensioner and lives with her partner on a rural property. She lives with a disability. As she ages, living rurally concerns her. She feels that her access to health care is limited and prevents her from remaining in the community she loves.

Sue is diabetic, her mobility is impaired and she is struggling with daily tasks like cooking.

She worries that in an emergency, the nearest hospital is a two hour drive away.

Her partner cannot drive her to her GP appointments and they cannot afford a taxi.

Sue books a telehealth consult with her GP but feels anxious about using technology.

The reception staff call her and organise transport to the clinic instead.

Sue feels comfortable with this arrangement and discusses her concerns with her GP.

Her GP liaises with local services to provide regular home help and meals for Sue and her partner.

What doesn't help?

- Distance from GP, emergency and respite services.
- Feeling anxious about using telehealth.
- Not having access to reliable transport to access the services she needs.

What helped?

- Being able to see her GP in person.
- Having access to the patient transport scheme to help her attend appointments.
- GP partnering with aged care and community services to meet her needs including cleaning and meals.

Key messages

Concerns of the ageing population:

- Timely access to emergency, general practice and respite services.
- Maintaining independence through home help services such as cleaning and meals.
- Remaining connected to their community and their interests.

Source: GPHN (2021d)

14. Family violence

"I prioritised family violence as it's coming across our tables daily and the impact to the age range 0-25 and housing and family connections." [Workshop participant]

Health status

There are many forms of family violence and many are not well recognised, see **Table 101**.

Table 101. Definitions and examples of family violence.

Type	Definition and examples
Physical	Kicking, pushing, punching, slapping, hitting, smashing things, strangulation
Psychological	Threats to harm/ kill/ suicide, standing over, intimidation, gas lighting, driving too fast
Stalking	Following, checking emails, monitoring vehicle mileage, secret cameras & recording devices, social media
Social	Geographic isolation, not allowing partner to see friends and family, making social events uncomfortable
Sexual	Rape, forcing unwillingly sexual acts, forced to watch pornography, image based abuse, reproductive coercion
Financial	Controlling employment, taking control of money and assets, having to account for all spending
Emotional	Name calling, put downs, humiliating and degrading
Spiritual	Not allowing practice of beliefs, forced to change religion, not respecting religious practices

Source: GWH (2021b)

- Gippsland experiences high rates of family violence incidents, including some of the State's highest rates in Latrobe, East Gippsland and Wellington. See **Table 102**. Rates have been consistently high in recent years.
    - Bass Coast rates are also higher than State rates and the year to March 2021 saw an increase.
    - Baw Baw and South Gippsland also have higher rates of family violence incidences than Victoria with an upwards trend recorded in the year ending March 2021.
- Family violence is an important factor affecting health, especially impacting affected women's and children's mental health and is recognised as a factor in homelessness (Council to Homeless Persons 2021).
    - Indigenous women and children are more likely to be affected.
    - The health costs of family violence are very high.

The Australian Institute of Health and Welfare: Family, domestic and sexual violence report (AIHW 2021aa) has noted:

- **3 in 10** assault hospitalisations for people aged 15 and over were due to family and domestic violence.
- Almost 31% (6,500) of the 21,300 assault hospitalisations for adults aged 15 and over were a result of family and domestic violence. Of these:
    - 73% (4,800) were female and 27% (1,700) were male
    - 65% (4,300) had the perpetrator reported as a spouse or domestic partner
    - 35% (2,300) had the perpetrator reported as a parent or other family member.
- Almost 38% (8,100) of assault hospitalisations did not specify the relationship between perpetrator and victim.
- In 2015, it was reported that family violence and violence against women and their children is costing Australia $21.6 billion each year with estimates if no further action is taken to prevent violence against women, the costs will accumulate to $323.4 billion by 2045.
- In 2015, it was estimated that if no female aged 15 and over had experienced partner violence in 2015 there would have been:
    - 41% less homicide & violence (where females were the victim)
    - 18% less early pregnancy loss
    - 19% less suicide & self-inflicted injuries
    - 19% less depressive disorders
    - 12% less anxiety disorders
    - 4% less alcohol disorders

Table 102. Family violence crime rates in Gippsland LGAs, rates per 100,000 people.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	VICTORIA	Data source
Alcohol - definite or possible family violence incidents	355	160	197	842	824	418	173	Turning Point (2021b)
Police call outs for family violence incidents	2,429	1,621	1,751	3,226	3,166	3,118	1,389	CSA (2021a)
Incidents where young people witnessed family violence	210	194	289	1,025 ***(#1 in Victoria)***	503 ***(#5 in Victoria)***	430 ***(#7 in Victoria)***	NA	CSA (2021b)

High compared to Victorian LGAs, top 25%

Significant implications for children and young people witnessing family violence (CSA 2021b):
- Children witness family violence at rates 1.8 higher in regional and remote areas than in major cities.
- 77% of children who witnessed a family violence incident reported to police had a future justice system interaction within five years of witnessing the incident.
- 62% of children became protected persons on Family Violence Intervention Orders, and over half (54%) witnessed subsequent family violence incidents.

The prevalence of Acquired Brain Injury (ABI) among victims of Family Violence has been reported (Brain Injury Australia 2021):

- 40% of victims attending a Victorian hospital over a 10 year period sustained a brain injury.
- 31% of victims of family violence attending Victorian hospitals over a 10 year period were children under the age of 15; 25% sustained an ABI.
- Perpetrators of intimate partner violence were twice as likely to have sustained an ABI as a sample size of the general population.

Findings from the Victorian Population Health Survey 2017 (VAHI 2021c) notes that among adults:

- Women, Aboriginal Victorians, and adults who identify as LGBTIQ+ are particularly vulnerable to family violence. Emotional violence is the most commonly reported type of family violence, followed by physical violence.
- Family violence occurs at all levels of socioeconomic status, but its prevalence increases with decreasing socioeconomic status.
- One-quarter (25%) of adults who experienced family violence in Victoria did not access or have contact with any family violence–related service.
- The finding that two-thirds (67%) of women who experienced family violence had been diagnosed by a doctor with depression or anxiety suggests that prioritising access to quality mental health care for women who experience family violence should be considered.
- 55% of adults who experienced family violence had ever been told by a doctor that they had depression or anxiety, significantly higher than 26% among adults who had not experienced family violence.
- 27% did not know where to get outside advice or support for family violence.
- 13.4% of LGBTIQ+ adults living in Victoria experienced family violence; significantly higher than the heterosexual, non-LGBTIQ+ population (5.1%), (VAHI 2020).

Family violence impacts Aboriginal children and young people at a high rate:

- Family violence is the primary driver of Aboriginal involvement with Child Protection (FVPLS 2015).
- Family violence was the primary reason for 35% of Aboriginal young people accessing homelessness services in 2018-19, up from 15% in 2011-12 (DET 2021).

Service utilisation

- 66% increase in calls to 1800RESPECT during pandemic (GPHN 2021o).
- Latrobe has the highest rate of ambulance call outs for domestic / sexual violence events in Victoria; East Gippsland and Wellington also had high rates, ranking 11th and 23rd in Victoria. See **Table 103**.
- National data shows that 37% of clients seeking assistance from homelessness services had experienced family and domestic violence, one of the most common reasons for seeking assistance (AIHW 2021ab).

Table 103. Ambulance call outs for domestic / sexual violence events in Gippsland LGAs, rates per 100,000 people.

Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington
75.5	97.5	77.8	246.7	146.8	126.7

Source: CSA (2021c)

High compared to Victorian LGAs, top 25%

Professional stakeholder perspective

Gippsland PHN professional stakeholder input, including from Clinical Councils (GPHN, 2021f):

- Family violence was consistently a top-rated priority area among workshop attendees.
- Incidence and level of violence has increased tremendously. Orange Door / Salvo Care unable to get a worker for extreme crisis clients. Noted lack of ability to connect to emergency housing.
- MARAM Framework and Information Sharing Schemes (child and family violence).
- Family and domestic violence as contributing factor to poor health.

Feedback via Gippsland Women's Health

- Family violence is recognised as an important factor affecting health with reports of service gaps.
- Gippsland services reporting increased trauma in children who have experienced family violence.
- Gippsland services reporting increased family violence related to homelessness, mental distress and substance use.
- Family violence practitioners in Gippsland are seeing an increase in diagnosis of ADHD and/or ADD in children who have a history of experiencing family violence. Practitioners are concerned that the children's trauma history is going unexplored throughout the diagnostic process.
- Women with intellectual disability are presenting with increasingly complex cases.
- Family violence victims are presenting with increasing complexity of mental distress and substance abuse, along with home insecurity and other welfare concerns.
- Increasingly there are more than one perpetrator involved within the family, whether that be multiple ex partners or extended family such has fathers, uncles and mother in laws.

The role of the general practitioner is critical in identifying, supporting and referring appropriately. The following key points support the need for additional training and support within the health sector (Hegarty et al, 2020):
Healthcare providers, particularly GPs, nurses, psychologists, and therapists receive 53% of current family violence disclosures and 44% of disclosures of past family violence.

- Healthcare professionals receive more disclosures than the police.
- Healthcare workers are more likely to only have between 2-4 hours of total training on the subject throughout their careers and they do not have any expectation or requirement to update knowledge on a regular basis.
- GPs are more likely to view physical harm as a high-risk factor and ignore threats to harm or coercive control when undertaking risk assessments.

Family violence is included as a priority in some updated Municipal Public Health and Wellbeing Plans (MPHWP), reflecting a growing awareness and community support for action to create a safe community. This includes in Baw Baw (Baw Baw Shire Council, MPHWBP 2021-2025, personal communication) and Wellington (Wellington Shire Council, Healthy Wellington, MPHWBP 2021-25, personal communication), noting that not all were finalised at the time of writing.

Community, consumer and carer perspective

- Family violence was identified as a top priority for health during engagement with community across Gippsland (GPHN 2021f):

  "…whilst we're in that space [FV], *it's very difficult to think, act, do anything clearly, or make any steps forward or take on any education or any advice around anything."*

  "People don't understand what family violence looks like"
- Community input noted service gaps for family violence, including sexual assault (ANROWS 2021).

Key points from engagement by the Latrobe Health Advocate include (LHA 2021c):

- Some of the challenges victim survivors come across; little to no access to maternal child health nurses during COVID-19 lockdowns, the isolation of parenthood, lack of time, financial hardship, ongoing exposure to violence within family or social networks, gender inequality, difficulties interacting with social workers or police, limited access to transport, family doctors and other health professionals.
- Connecting with the right people can really help; coffee with friends, support from parents, family and friends, going to work, access to health information on the internet, people showing that they care and going out of their way.
- Education about what family violence is, how harmful it is and where people can go for help.
  "We heard that it is so easy to become homeless and that some people may not have the skills to address this issue when they experience it."

15. Factors affecting health (or social determinants of health)

"We need to focus on key drivers and things to address those, which will hopefully improve everything else." [Workshop participant]

It is well recognised that health inequities are related to many factors, including where people live, economic circumstances, social situation, safety and many more (AHHA 2021f). To address these health inequities:

- Indicators of key factors affecting health to help understand the issues and to enable progress to be made through reporting.
- Health and social services must coordinate their assessment and response to community health needs at a regional level. This requires a governance structure to support integration at a regional level, timely data to inform policy decisions and allocation of funding, and transparent monitoring and reporting.
- Racism and other forms of discrimination must be redressed as factors affecting health for minority groups, including Aboriginal and Torres Strait Islander people.

Equity is included as a priority in some updated Municipal Public Health and Wellbeing Plans, reflecting a growing awareness and community support for action to create a safe and respectful community where diversity is celebrated, and people can enjoy health and wellbeing. This includes in Bass Coast (Bass Coast Shire Council, Healthy Communities Plan 2021-25, personal communication) and Wellington (Wellington Shire Council, Healthy Wellington, MPHWBP 2021-25, personal communication), noting that not all were finalised at the time of writing.

Housing

- A large proportion of clients who received support from Specialist Homelessness Services in Victoria between 2017 to 2021 experienced family and domestic violence, mental health issues, and/or problematic drug or alcohol issues, (AIHW 2021ab).
- In 2019-20 7,746 people in Gippsland received assistance from homelessness services (see **Table 104**); more than 2,500 are likely to have a mental health issue based on national estimates, (AIHW 2021o).
- National monthly data show fluctuations in the use of homelessness services, with highest levels since 2017 seen March-June 2021. Additional details for June 2021 show vulnerable groups:
    - Females are the main recipients of homelessness services
    - Financial difficulties and family and domestic violence (37%) are the most common reasons for seeking assistance
    - 26% of clients were Indigenous
    - 30% had a current mental health issue
- The COVID-19 pandemic has led to increased housing prices and Gippsland stakeholders are reporting a significant influx of people presenting as homeless due to housing availability and affordability. The severity of this appears to be escalating, (GPHN 2021f).

  "Housing and emerging housing is most significant issue at the moment" [Workshop participant]

Table 104. Housing related indicators by Gippsland LGA.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland	Victoria	Reference
Rental stress (low income households spending 30% or more on rent) (2016)	37.6%	33.4%	32.7%	32.6%	34.0%	28.1%	32.9%	27.2%	PHIDU (2021a)
Number of clients of homelessness services (includes assistance to people at risk of homelessness) (2019-20)	722	495	753	2,707	1,414	1,655	7,746	99,311	AIHW (2021ab)
All homeless persons (2016)	45	48	92	226	212	69	692	24,828	ABS (2016)

High compared to Victorian LGAs, top 25%

Income

- Median weekly income in Gippsland is significantly lower than Victoria. See **Table 105**.
- Gippsland has a higher proportion of people receiving an age or disability support pension.
- 13.6% of people in Gippsland are health care card holders, compared to 11.3% across Victoria; highest rates are in East Gippsland, Bass Coast and Latrobe.
- 36.2% of people accessing Gippsland PHN commissioned mental health services were health care card holders and 2.7% were NDIS participants, (GPHN 2021k).
- The source of cash income for people accessing Gippsland PHN commissioned mental health services was mainly pension (29.4%) with only 16.8% in paid employment, (GPHN 2021k).

Table 105. Income related indicators by Gippsland LGA.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Median weekly income (personal)*	$507	$537	$585	$544	$506	$562	$540	$644
Low income households (households in bottom 40% of income distribution)	52.3%	49.0%	44.2%	47.3%	52.6%	46.3%	52.2%	40.9%
Received an unemployment benefit (proportion of 16-64 year olds) (2020)	14.5%	9.9%	9.2%	14.8%	14.6%	11.7%	12.7%	8.8%
Unemployment rate (2019)	4.8%	3.1%	3.4%	7.1%	6.1%	4.8%	5.2%	4.8%
Age pension recipients per cent of people 65 or over (2020)	67.4%	59.2%	64.5%	72.2%	66.8%	65.4%	66.7%	58.3%
Disability support pensioners (proportion of 16-64 year olds) – (2020)	8.0%	6.3%	5.4%	9.9%	9.9%	7.4%	8.1%	4.2%

Health care card holders (2020)	15.0%	11.6%	11.1%	14.8%	15.6%	12.9%	13.6%	11.3%

Source: PHIDU (2021a) *ABS (2016)

High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

Socioeconomic disadvantage

Parts of Gippsland rates poorly on numerous socio-economic indicators, reflected in low Socio-Economic Indexes for Areas (SEIFA) scores (see **Table 106**). The LGAs of Latrobe and East Gippsland have the lowest scores but pockets of disadvantage are evident across Gippsland.

Table 106. Socio-Economic Indexes for Areas (SEIFA), scores for Gippsland LGA, 2016.

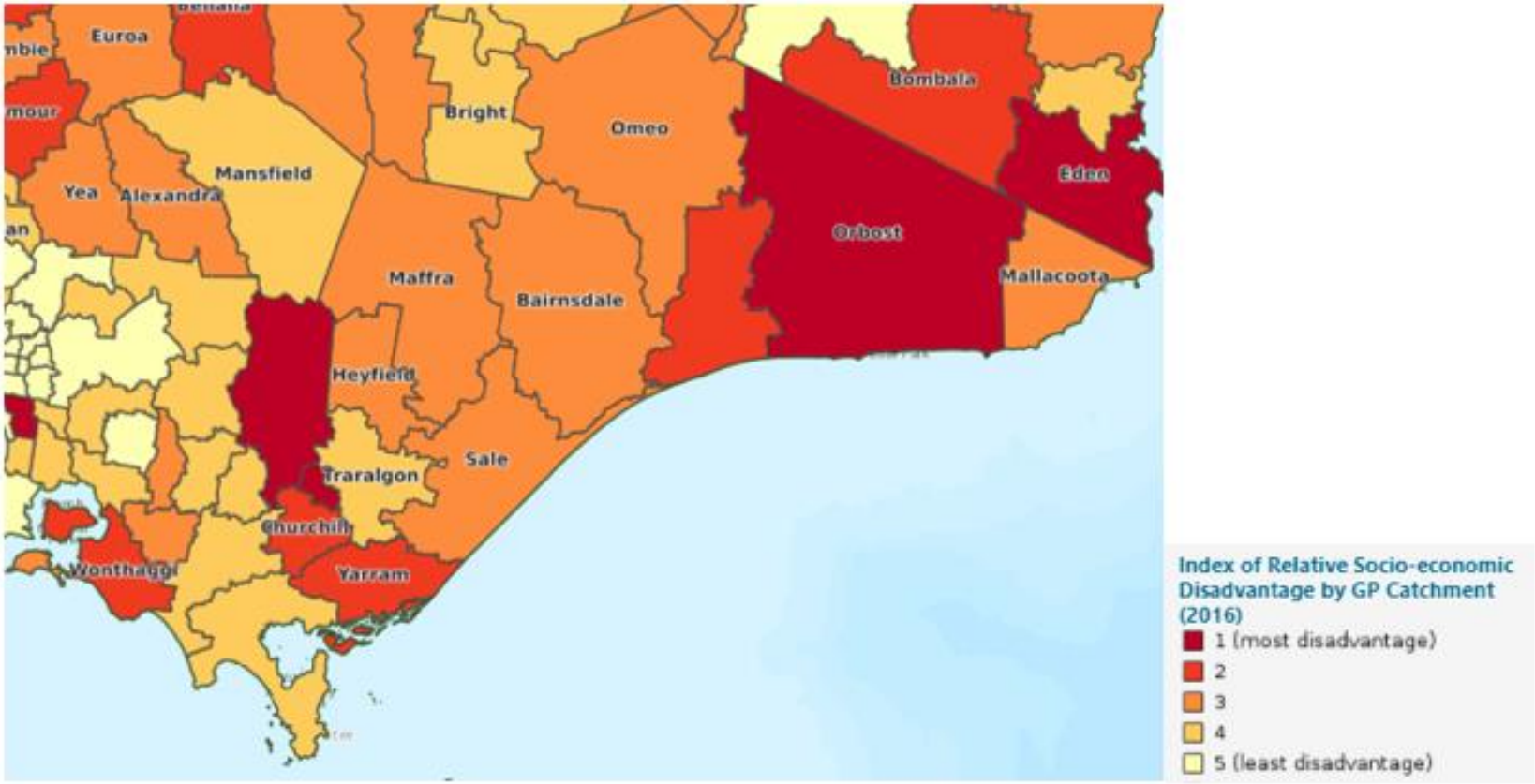
Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland	Victoria	Australia
SEIFA index of relative socio-economic advantage and disadvantage (IRSAD)	945	965	976	916	937	954	944	1009	1,000
SEIFA index of relative socio-economic disadvantage (IRSD) - most disadvantaged (lowest decile)	11.5%	1.2%	7.8%	28.0%	14.2%	13.3%	14.9%	*NA*	10.0%

Source: ABS (2016)

High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

The Relative Socio-economic Disadvantage of GP catchment areas in Gippsland is shown in **Figure 55**, with the highest levels of disadvantage found in Orbost, Morwell and Moe-Newborough (dark red areas). High levels of disadvantage are also found in Wonthaggi, Churchill, Yarram and Lakes Entrance (orange red areas on map).

Figure 55. Index of Relative Socio-Economic Disadvantage by GP catchment area, 2016.



Source: DoH (2021b)

- Low socioeconomic status is associated with poor health outcomes in general and for specific issues including chronic disease, mental health, capacity to adopt healthy lifestyles and access to services.
- Stakeholder input from consumers, clinicians and other stakeholders shows strong support for addressing issues faced by this population group, (GPHN 2021f).

  "It is important to know that all underlying factors which determine access to health care and health outcomes are also being addressed."

"Helping people to improve their lives, access the right supports and involve themselves in community activities."

- Community input confirmed that people with low socio-economic status experience significant barriers accessing health services, especially significant for this group were cost and transport, (GPHN 2016).

Education and training

- Labour force participation in Gippsland is lower than Victorian and Australian rates. It is especially low in Bass Coast and East Gippsland.
- Education, training and workforce indicators for Gippsland compared to Victoria show that (PHIDU 2021a):
  - 59.7% of the Gippsland population participated in the labour force (66.2% across Victoria).
  - 20.7% of school leavers participated in higher education in Gippsland (39.3% in Victoria).
  - 80.8% of young people in Gippsland participate in secondary school education.
- The highest level of education among people aged 15 years or older in Gippsland (ABS 2016):
  - 11.5% had a bachelor's degree or above (Victoria 24.3%)
  - 28.7% had completed a certificate (level III or IV) or a diploma (23.6% in Victoria)
  - 11.1% year 12 (15.9% in Victoria)
- Indicators of participation in education by Aboriginal and Torres Strait Islander people in Gippsland are presented in **Table 107**.
- Aboriginal participation in full-time secondary school education (2019) varied; 63% in Baw Baw, 70% in Wellington/East Gippsland, 94% in Latrobe and 100% in Gippsland South-West (PHIDU 2021a).

Table 107. Indictors related to Aboriginal education and training, age-standardised rates per 100, 2019.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland	Victoria	Australia
Non-Aboriginal participation in vocational education and training	18.2	18.6	18.7	18.1	18.9	18.5	18.5	14.4	17.1
Aboriginal participation in vocational education and training	38.9	28.5	30.8	34.0	32.9	33.3	33.1	34.3	22.9

Source: PHIDU (2021a)

High compared to Victorian LGAs, top 25%

Social connections and inclusion

- The Victorian Population Health Survey found that 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 (DH 2017b).
- 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 (DH 2017b).
- It is estimated that around 19% of the Gippsland population experience high or very high social isolation, **Table 108**.
- 29% of adults in Gippsland participate in volunteering, compared to 23% across Victoria.
- 45% of adults in Gippsland agree that multiculturalism makes life better; significantly lower than across Victoria (56%) (**Table 109**); earlier data suggests a slight increase (from 40%) and least agreement in Wellington, East Gippsland and Latrobe (**Table 108**).

Table 108. Indictors related to social connections and inclusion in Gippsland LGAs.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland	Victoria	Source
High or very high social isolation - adults	9.7%	22.5%	15.7%	20.6%	24.4%	18.5%	18.7%	17.3%	DH (2017b)
Households with broadband internet connection	77.5%	78.3%	81.0%	77.3%	74.7%	77.7%	77.7%	83.7%	
Think multiculturalism makes life better	53.3%	53.2%	45.6%	32.2%*	37.4%*	31.0%*	39.7%*	55.4%	
Volunteering- adults	32.4%*	34.6%*	32.6%*	22.1%	30.2%*	33.1%*	29.4%	23.2%	PHIDU (2021e)

*Significantly different to Victoria

Table 109. Indictors related to social connections from the 2019 Victorian Population Health Survey.

INDICATOR	GIPPSLAND	VIC
Membership of an organised group:		
Sports	24.4%	23.8%
Religious	16.3%	15.8%
School	14.8%	12.2%
Professional	15.2%	20.6%
Think multiculturalism definitely makes life better	45.4%*	55.6%

Source: DH (2019a); *Significantly different to Victoria

- A Latrobe City Council community survey found (Federation University 2021b):
  - Friends and family was the most common reason why participants believed that Latrobe City was a good place to live, with Location in Victoria, Affordability and Natural environment rounding off the top four responses.
  - Safety, Economy and Built environment were considered the things most important for Latrobe City Council to focus on.

- Stakeholder input from consumers, clinicians and other stakeholders has confirmed that social connections and inclusion is an important factor influencing health and wellbeing, (GPHN 2021f).

  "Greater focus on social engagement, wellbeing/self-care activities that encourage improvements in one's life as opposed to a need to escape life through the use of drugs/alcohol."

  "… social isolation in aged."

  "Is social prescribing the answer?"

  "It is so important to support young people who are socially isolated – it makes a huge difference for their wellbeing."

Crime

- Safety is a basic need that must be met in order for people to enjoy good health and wellbeing. Crime rates in Gippsland are higher than the Victorian rates, particularly in Latrobe, East Gippsland and Wellington (see **Table 110**).

Table 110. Crime rate per 100,000 people by Gippsland Local Government Area.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	VICTORIA
Crimes against the person	1,822	1,526	1,765	3,163	2,496	2,287	1,257
Drug offences	322	226	788	1,576	884	707	597
Total offences	7,948	6,166	8,952	17,147	10,603	10,919	7,951

Source: CSA (2021a)

High compared to Victorian LGAs, top 25%

Additional factors

There are many additional factors that can influence health and wellbeing and they include:

- Culture and language (**Table 111**); Gippsland has a low proportion of people who were born in a non-English speaking country and who have low English proficiency.
    - A study into the needs of the multicultural community in Gippsland found that the top themes were: access to information and relevant services (supported by CALD led cultural awareness training), building relationships in the community (for example through multicultural festivals) and access to transport (public transport and support to get a driver's license and a car), (Gippsland Strategic Partnership 2021).
- Transport is often a limiting factor for people in Gippsland to access services and supports. See **Table 112**.
    - A high proportion of people in Gippsland travel to work by car, but access to public transport is limited, making it difficult for people who are not able to drive themselves.
- Additional factors include food security and gambling, see **Table 113**.

Table 111. Indicators related to culture and language by Gippsland Local Government Area.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA	Reference
Born in a non-English speaking country	5.9%	4.6%	4.8%	7.3%	4.7%	5.2%	5.6%	22.0%	ABS (2016)
Low English proficiency	0.5%	0.3%	0.3%	0.7%	0.3%	0.4%	0.4%	3.7%	
Permanent Settlers with date of settlement between 1 July 2020 and 30 June 2021- family stream	53	30	50	77	44	41	295	22,456	Australian Government (2021)
Permanent Settlers date of settlement between 1 July 2020 and 30 June 2021 - skilled stream	21	10	33	79	77	36	256	33,260	
Top languages spoken at home (other than English)	Italian German Greek Dutch Mandarin	Italian German Dutch Malayalam Mandarin	Italian Mandarin Dutch German Greek	Italian Greek Mandarin Dutch Maltese	Italian German Mandarin Vietnamese Dutch	Italian Mandarin Tagalong Dutch German			ABS (2016)

Low compared to Victorian LGAs, bottom 25%

Table 112. Transport characteristics by local government area in Gippsland and comparison to Victoria.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Population within 400 m of tram/bus or 800m of train	36.7%	8.5%	20.9%	63.5%	19.7%	26.6%	34.0%	73.9%
Travelled to work by car	70.4%	66.0%	73.4%	78.6%	71.0%	70.3%	72.7%	68.3%
Travelled to work by public transport	1.1%	0.8%	2.8%	1.8%	1.0%	0.7%	1.5%	12.6%
Dwellings with no motor vehicle	5.4%	3.7%	4.7%	7.3%	3.6%	5.0%	5.3%	7.9%

Source: ABS (2016)

High compared to Victorian LGAs, top 25%
Low compared to Victorian LGAs, bottom 25%

Table 113. Selected additional social and economic indicators by Gippsland Local Government Area.

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	GIPPSLAND	VICTORIA
Food insecurity - Adults worried about food insecurity with hunger (interpret LGA data with caution)	17.8%	12.9%	20.7%	16.6%	8.7%	11.8%	14.9%	12.5%
Food insecurity - Parents who relied on un-healthy low-cost food (interpret LGA data with caution)	23.7%	20.4%	17.4%	17.0%	19.6%	29.3%	20.7%	13.0%
Gaming machine losses per head of adult (18+) population*	$611	$302	$369	$769	$638	$657	591	$553
Pokies machines, number per 1,000 adults*	7.2	4.5	5.7	8.7	8.6	9.1		
Pokies expenditure per adult*	$439	$218	$302	$580	$516	$488		

Source: DH (2014) *VRGF (2021)

High compared to Victorian LGAs, top 25%

Stakeholder perspective

Social determinants and their significant impact on health and wellbeing has been recognised in several updated Municipal Public Health and Wellbeing Plans (MPHWP) across Gippsland, noting that not all were finalised at the time of writing. In East Gippsland, recent years have added significant stress to a community with underlying disadvantage (East Gippsland Shire Council, MPHWBP 2021-2025, personal communication). East Gippsland covers a large area and East Gippsland Shire Council recognise 12 small geographical planning areas, some of which experience significant disadvantage. As an added burden, a prolonged drought affected the area until 2019. On top of that, wide-spread bushfires burnt around half of the LGA over a period of several weeks and this was immediately followed by the COVID-19 pandemic.

"*The community hasn't had a chance to recover."*

- A survey conducted in a very remote part of East Gippsland illustrates some of the challenges (personal communication):
    - Distance to travel to access a doctor or other health care was up to 1,000 km
    - Cost of travel and time off other activities puts a significant strain on budgets
    - Many residents are willing to access online services if appropriate facilities were available and with assistance as needed
    - Concern about emergency access and lack of local capacity

"Have chosen to be here for the natural environment – to help my COPD and mental health"

16. Healthy and safe environment (climate change, pandemics, natural disasters)

"The impacts of climate change are really concerning, climate anxiety, impacts of bushfire, drought, floods, impacts on not just mental health, physical health, increased risk of family violence, AOD use, and we know this will only get more frequent and worse …" [Workshop participant]

Health status

- Coordinated, urgent and timely action in response to climate change is required (United Nations 2015).
- Extreme weather events and natural disasters driven by climate change will increasingly define the work of PHNs as they are recognised as the logical co-ordinators of regional primary care emergency response (PHN Cooperative 2020).
- Climate change has resultant effects on the social and environmental determinants of health, manifesting in global increased costs for health and increased mortality rates (WHO 2018).
- Health care contributes more than 4.4% of net global climate emissions, which is equivalent to 514 coal-fired power plants (Health Care Without Harm 2019).
- The Hazelwood Health Study commissioned by the Victorian Department of Health in response to community concerns about the long-term health effects following the fire in the Morwell open cut mine during 2014, has found:
    - 34% increase in ambulance call outs for anxiety and a 36% increase in Emergency Department presentations for depression, (Carroll et al 2021a).
    - 3-4 month delay in education outcomes (NAPLAN) for Morwell students that hadn't fully recovered in the years after the fire, (Gao et al 2021).
    - continuing relationship between participants' level of exposure during the 2014 mine fire and the level of ongoing psychological distress they associated with the event, with the most exposed people reporting higher distress levels, (Carroll et al 2021b).
- Findings from the Beyond Bushfires 10 years Report: Community, Resilience and Recovery Study (Gibbs et al 2020) highlight long term impact, especially on mental health:
    - People affected by the 2009 Victoria Bushfires reported
        - Post traumatic growth particularly for people from high impact communities
        - Comparable rates of psychological distress, Post Traumatic Stress Disorder, Depression and resilience for men and women.
        - Extended impacts on mental health and wellbeing, especially for those who had to deal with other major life stressors such as financial stress.
        - Elevated levels of anger and exposure to violence.
    - Perception of recovery at 10 years- People who felt 'mostly' or 'fully recovered':
        - 86.8% were from low impact communities
        - 75.4% were from medium impact communities
        - 62.6% were from high impact communities
    - Mental health related recommendations to service providers:
        - Establish a **5-year framework** for recovery for major disasters to account for extended mental health impacts and support short- and long-term recovery, resilience and community connectedness.

    - Provide advisory and support services within bushfire affected communities that focus **on reducing the compounding impacts of major life stressors** (e.g., financial advice, guide to building regulations, relationship counselling, job retraining).
    - Embed **community-based strategies** in disaster mental health planning, in addition to mental health services to maximise the contribution of social networks and community groups to recovery.
    - Increase provision of **family violence prevention** strategies and support services for high impact communities
    - Build capacity of government staff and service providers to **recognise and address anger.**
    - Ensure adequate provision of mental health services where providers have appropriate **training in trauma related mental health treatment.**
    - Fund evidence-based task-shifting models where trained health care providers (such as community nurses or community health workers) can deliver **low intensity interventions for people with adjustment difficulties.**
- Nationally, the impact of the COVID-19 pandemic has been seen across many areas of health care (AIHW 2021ac), including:
    - Use of mental health services increased;
        - 50% of MBS mental health services were delivered via telehealth in April 2020 and 22% in June 2021
        - Mental health related PBS prescriptions were higher than usual between May 2020 and 2021
        - Increase in call volume to phone help lines (Lifeline, Kids Helpline and Beyond Blue)
    - Fewer emergency department presentations and reduced hospital activity during periods of lockdown
    - Breast screening suspended March-April 2020
    - COVID-19 mortality was highest in the lowest socio-economic areas
    - Young people have reported higher levels of psychological distress, likely related to reduced social connections, reduced employment and education participation and financial difficulties, including paying rent
- In a national survey, 34% of women reported that their health was worse than before COVID-19 (Jean Hailes for Women's Health 2020).

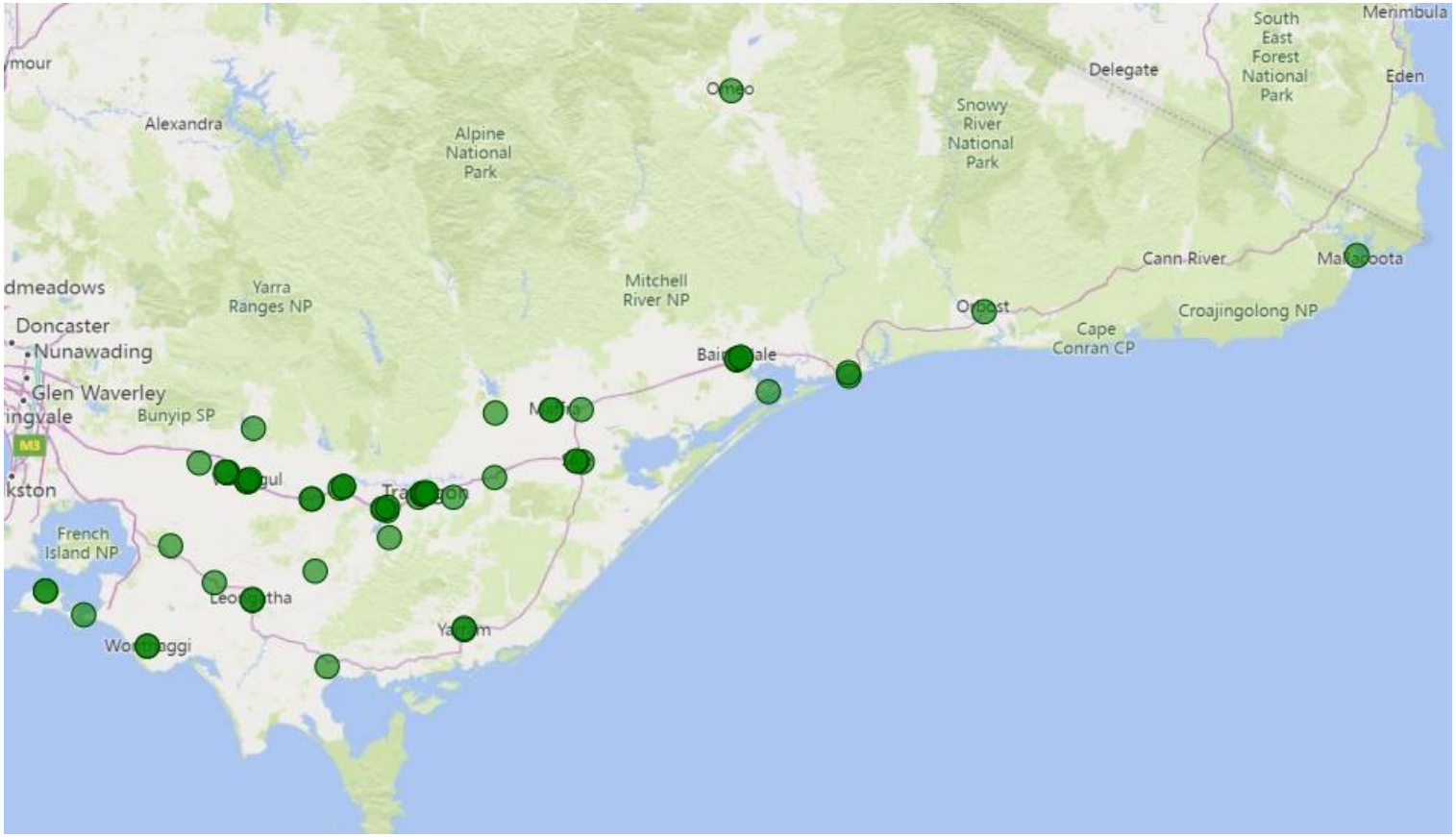
Service utilisation

General practice

- General practices responded quickly to managing patient care during the COVID-19 pandemic.
    - Six Respiratory Clinics have performed over 110,000 COVID-19 tests and 60,000 COVID-19 vaccinations since their opening in April 2020 (GPHN 2021l).
    - In total, 61 practices are providing COVID-19 vaccinations (69% of practices), see **Figure 56**; achieving good geographical coverage of the region.
- Based on analysis of de-identified data from Gippsland general practice using POLAR (GPHN 2021e):
    - telehealth delivery became as common as face to face services during the first (March-April 2020) and second waves (July-September 2020)
    - 95% or more of telehealth consultations were by phone rather than videoconference
    - overall, GP contacts and prescriptions remained steady; reduced pathology and radiology during lockdown periods
- There is also evidence of (GPHN 2021o):
    - an increase in mental health diagnoses, particularly anxiety

- prescribing for mental health issues increased
- people with an exisiting mental health condition presented to general practice more frequently
- there were more child and adolescent mental health presentations
- chronic disease did not receive the usual preventative care and management during the early stages of the pandemic

Figure 56. General practice locations administering COVID-19 vaccinations, Gippsland PHN, October 2021.



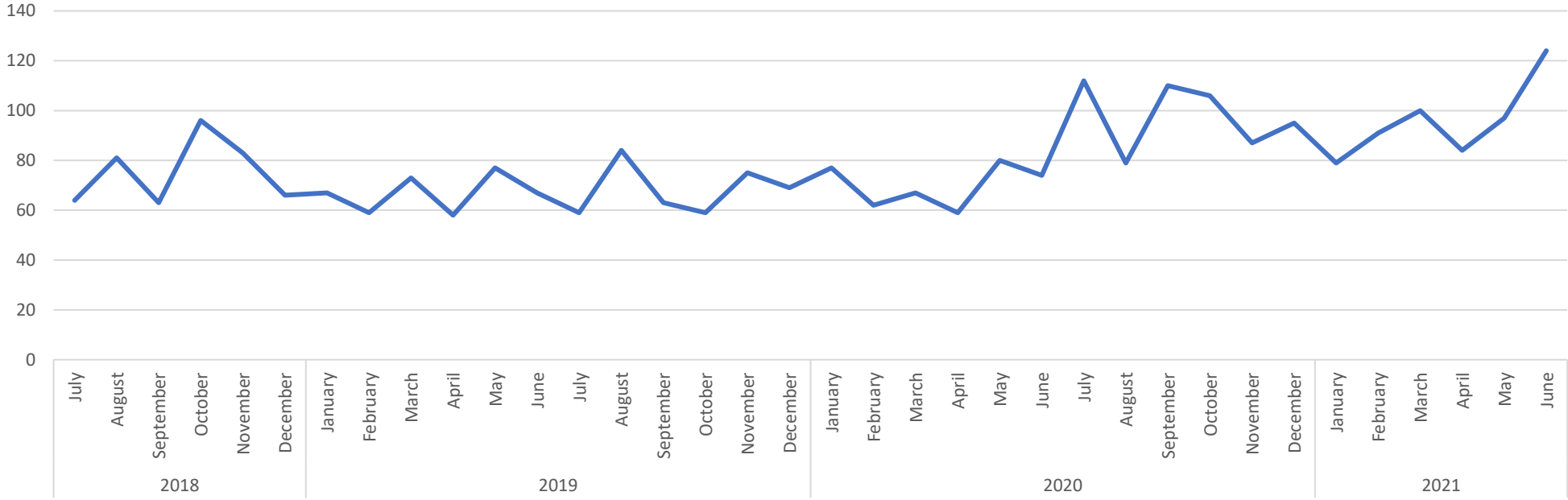
In a series of publications based on analyses of general practice data from Victoria and NSW, covering around 30% of the population, the following was found:

- After the introduction of telehealth MBS items in April 2020, face to face consultation claims comprised 57.7% (compared to 95.7% in 2019); video consultation claims comprised 1.1% and telephone consultations 37.8%. (Hardie et al 2020)
    - Females used telehealth consultations more and face-to-face consultations less compared to males. (Hardie et al 2021a)
    - Face to face consultations were used the most in the younger brackets 0-19 years, while telehealth including video and phone was used more by adults (20-70+ years).
    - For telehealth consultations, patients in lower SES postcodes used telehealth type consultations less compared to higher SES postcodes.
- GP consultations in residential aged care facilities changed with a decline in visits by up to 37% and greater use of phone consultations (Dai et al 2021)
- Fewer mammograms, cervical cancer screening tests (Imai et al 2021a).
- A decline in HbA1c testing by about 25% was noted at the start of the pandemic (Imai et al 2021b).
- Overall prescribing counts were very similar in 2020 compared to 2019 (Wabe et al 2021).

Acute services

- The number of admissions for mental health diagnoses by month shows a low in April 2020 (59 episodes) and a spike in July 2020 (112 episodes) and June 2021 (124 episodes). See **Figure 57**. Admissions are consistently higher from July 2020 until June 2021 compared to 2018 and 2019.

Figure 57. Mental health related inpatient episodes for Gippsland residents, July 2018 - June 2021.



Source: DH (2021b)

Head to Help Program

The HeadtoHelp service was funded by the Commonwealth Department of Health in August 2020 in response to the Victorian COVID-19 pandemic. There are 15 HeadtoHelp hubs across Victoria, with two Gippsland hubs located in Warragul and Sale. The HeadtoHelp service can be accessed via phone regardless of location. It is open to Victorians of any age who may be experiencing distress or mental ill health.

A total of 1,717 people were seen between September 2020 and 2021 (**Table 114**) and a gradual increase in monthly contacts to a high of 1,129 in August 2021 was seen (**Figure 58**), (GPHN 2021k).

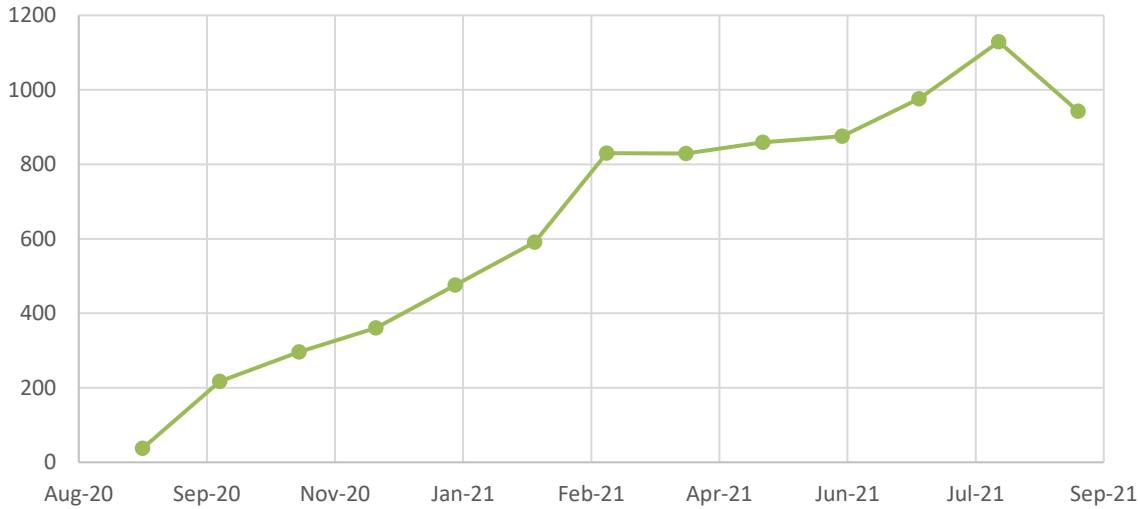
Table 114. HeadtoHelp overall volumes by Principal Focus of Treatment for Gippsland; 14/09/2020 - 30/09/2021.

Principal Focus of Treatment Plan	Active Clients	Active Episodes	Service Contacts
Psychological therapy	1,316	1,335	6,298
Low intensity psychological intervention	114	114	453
Clinical care coordination	52	52	413
Child and youth-specific mental health services	16	16	102
Psychosocial Support	233	236	1,118
Other	8	8	34
TOTAL	**1,717***	**1,761**	**8,418**

Source: GPHN (2021k)

* This is a unique count of clients, not the sum of the individual rows. Clients may be counted in more than one row.

Figure 58. HeadtoHelp service contacts, number by month for Gippsland, 14/09/2020 - 30/09/2021.



Source: GPHN (2021k)

Mental health response to bushfires

The Mental Health Supports for Bushfire Affected Australians funding Schedule specifies five key activities to be delivered, including free counselling and support to communities, individuals, families and emergency services workers and communities grants to promote mental health healing and post-trauma recovery.

- The frontline counselling bushfire response program delivered a total of 3,513 occasions of service during 2020-21.
- A total of 24 grants were awarded to organisations in East Gippsland, with most grant activities commencing in mid to late April 2021. Community feedback from the grants suggest a positive impact on people's health and wellbeing and a more connected community:

  "It was a safe and supportive environment to share the journey of each session. The facilitator and other participants were great, and it was lovely to connect with them through the experience."

  "It has been great to see so many people laughing and connecting with each other, as they have been so flat after the bushfires and the COVID lock-downs."

  "Getting out of the house for a purpose has been good for me."

  "We have developed our own network of support through shared experiences."

  "Very useful information and connections through guest speakers."

  "Not everyone has access to the internet so this face to face course has been helpful."

  "In regional/remote communities this connection is really essential."

  "It motivated me to download a meditation app to help with stress."

One Good Community Wellbeing grants

The One Good Community Wellbeing Grants (OGCWG) Program, was an amalgamation of *Empowering our Communities* (drought) and *Supporting Communities in Recovery* (bushfire) funding. The purpose of these grants was to facilitate community-led activities to support mental health, social and emotional wellbeing, and suicide prevention initiatives for people living in drought and bushfire-affected regions. A total of 24 grants were awarded to organisations in East Gippsland with activities occurring during 2021. The grants enabled a wide range of community activities including gymnastics program, creative writing and projects targeted at farmers. Some feedback from grant recipients and participants included:

"I enjoyed the social inclusion with a group of happy people."

"We had 23 people come through the High Country men's shed on the open day…"

"The fire has taken away their feeling of safety and security … this has provided something positive for them to focus on"

Professional stakeholder perspective

COVID-19 impact

Gippsland PHN, including Clinical Councils and partner organisations have noted the following impact of the pandemic (GPHN 2021f):

- The COVID-19 pandemic has led to increased housing prices and Gippsland stakeholders are reporting a significant influx of people presenting as homeless due to housing availability and affordability. The severity of this appears to be escalating.
- Stress on families due to home schooling, change of routine and isolation; especially for families caring for children with a disability or on the spectrum.
- Reduced appointments for routine care, especially for people who may already be hesitant to access care such as Aboriginal or Torres Strait Islander people.
- Sub-regional cluster planning in response to the pandemic provides evidence of a best practice model involving primary and acute care as well as aged care facilities and private providers. These localised groups are now moving to "business as usual" inclusive of care in the home using digital technology.
- Some concern about short term funding by multiple organisations leading to fragmented service systems and 'intervention fatigue', for example in bushfire affected communities.

The Latrobe Health Advocate heard from health professionals and other professional stakeholders during the COVID-19 response (LHA 2021d), with the following noted:

> *"Health professionals are concerned that reduced Emergency Department presentations and declining demand on other services such as pathology and radiology, may result in longer term complications for patients and increased burden on the health system."*
>
> *"… Alcoholics Anonymous (AA) has observed a decline in newcomers…the cornerstone of AA is meetings and meetings aren't happening."*
>
> *"Local services have observed that some people don't have technology or the ability to link to technology and they are really feeling it."*
>
> *"A local exercise group for older people is seeing signs of people's health deteriorating as a result of not being able to participate in classes. They have observed an increase in falls and decline in mental wellbeing for some participants."*

There is evidence of impact on many conditions and groups of people as a result of the COVID-19 pandemic:

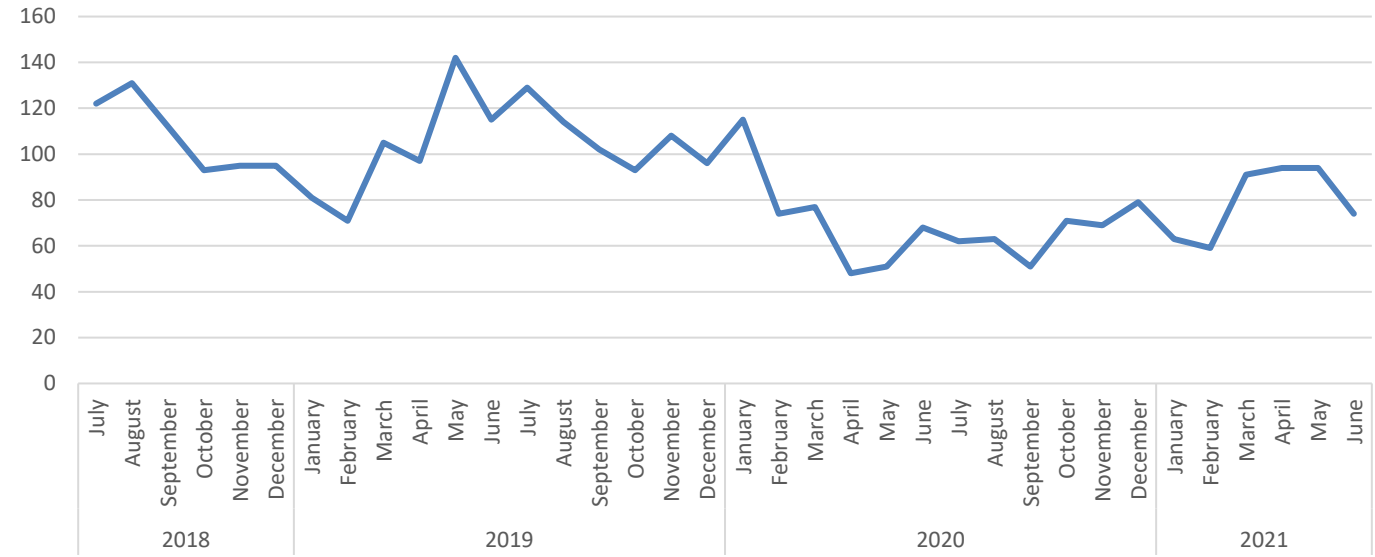
- Mode of delivery trends for Gippsland general practices show (GPHN 2021e):
  - telehealth delivery became as common as face to face services during the first (March-April 2020) and second waves (July-September 2020)
  - 95% or more of telehealth consultations were by phone rather than videoconference
- Dementia (Dementia Australia 2021b):
  - 32% of family carers indicated they had experienced poorer mental health or loneliness due to COVID-19 restrictions.
  - 30% of people living with dementia and 34% of family carers indicated their physical wellbeing had declined due to COVID-19 restrictions, respectively.
  - 43% of people living with dementia and 38% of family carers had postponed health or medical visits due to COVID-19 restrictions, respectively.
- Indigenous people (GPHN 2021l)

- Some of the observable impacts have been worsening mental health, parental alcohol and drug misuse, overcrowding, food insecurity, and a decline in access to services.
- For some, home schooling has resulted in greater bond between parents and children. Children have engaged with virtual learning where they received consistent service support.
- An increase in children going into out of home care and a decrease in foster carers. In particular, sibling contact was significantly impacted. These impacts are attributed to culturally unsafe practices of child protection, inadequate resourcing of the sector to support children in the system, and the reduced supports available to families due to COVID-19 restrictions. The knock-on impact of disconnection from family and culture is more Aboriginal youth coming into contact with the justice system.
- The pandemic severely disrupted construction, impacted household incomes, and depleted housing stock causing increased housing stress.
- An increase in demand for emergency relief and material aid was observed.
- Three most difficult things reported by Gippsland Aboriginal community: separation from family and friends; mental health and wellbeing; and not being part of the community and community events.
- Workforce challenges and changed work practices due to pandemic were noted within the ITC program. These included a reduced workload for outreach workers but increased demand for other services such as accessing and delivering prescriptions from pharmacies.
- ACCOs reported using regular phone calls to communicate with patients/clients to establish wellbeing, health, and current medical needs. Community members more often requested support relating to their uncertainty of the future and compromised wellbeing during pandemic.

An analysis of hospital admissions over time shows the impact of COVID-19 on chronic disease. Heart failure admissions were similar or higher during the pandemic while COPD admissions were down to half of normal activity during some months (**Figure 59**).

- There was a decline in admissions with a principal diagnosis of COPD in 2020 with the lowest number of monthly admissions (April 2020 - 48 episodes) coinciding with the commencement of the first COVID lockdown.
- There was a slight dip in the number of inpatient admissions with a principal diagnosis of Heart Failure at the start of the COVID lockdown (April 2020 - 207 episodes) however numbers quickly returned to previous rates with a spike in October 2020 of 335 episodes.

Figure 59. COPD inpatient episodes for Gippsland residents, by month



Source: DH (2021b)

Climate change and bush fires

The impact of climate change threatens health and communities through extreme weather events. There is a need for (AHHA 2021g):

- Health systems to plan and prepare for extreme weather events and emerging health challenges.
- Environmental sustainability needs to be considered in all strategies, with a deliberate focus on supporting populations who are most vulnerable to the impacts of climate change.
- Health service funding models need to incentivise innovation and environmental sustainability (e.g., blended payment models, low interest loans).
- Health workforce impacts may be particularly felt in rural and remote areas with an existing shortage.

A healthy and safe environment was consistently a top rated priority area among workshop attendees, (GPHN 2021f).

Health and Climate change is included as a priority in the updated Wellington Municipal Public Health and Wellbeing Plan (Wellington Shire Council, Healthy Wellington, MPHWBP 2021-25, personal communication), noting that there is a legal requirement for all MPHWPs to have regard to climate change. The Wellington plan describes that:

"Climate change will impact Wellington Shire in many ways including greater risk of bushfires, more hot days and warm periods, more frequent and intense storms, fewer frosts and less rainfall in winter and spring."

The highest health and wellbeing risks due to climate change in Wellington Shire are:

- Injuries or death as a result of increased bushfire, floods and storm frequency and intensity,
- Premature deaths as a result of heatwaves,
- Mental ill health after disaster events (bushfires, floods),
- Increased thunderstorm asthma as a result of changing rainfall patterns and extreme weather,
- Increased vector borne diseases (e.g. Ross River virus),
- Social and economic impacts from prolonged drought….

An East Gippsland progress report of the Connect Well project (Connect Well 2021) notes that "there has been a compounding effect on people's mental health and wellbeing with 41% of people in bushfire-affected areas reporting higher levels of psychological distress after the first lockdown (May 2021) compared to just 16% across Victoria." The project aims to improve the mental health and wellbeing of people in the region who have been impacted by drought and fire, supported by three strategic pillars: partnerships for integrated service delivery, mental health literacy and community strengthening and resilience.

The Royal Commission into National Natural Disaster Arrangements Report (Commonwealth of Australia 2020) found that:

- Greater inclusion of primary care in disaster management is recommended to build on local knowledge and skills.
- It is important to focus on 'more than just the acute response', mental health issues often take longer to emerge and may be masked by physical symptoms.
- Ensure mental health services are evidence based and include support from specialist mental health providers including trauma specialists.

Gippsland PHN recognises that there is an urgent need for action on climate change and have developed a Climate Change Position Statement (GPHN 2021p). It sets out a commitment to be proactive about climate change and to influence, advocate and show leadership.

Community, consumer and carer perspective

The Latrobe Health Advocate is a key mechanism of the Latrobe Health Innovation Zone. The first of its kind in Australia, the Latrobe Health Innovation Zone is a dedicated place where people can have a say in the planning and delivery of better health outcomes by being a part of decision-making, design, planning and delivery of services and programs. Community engagement is the Advocate's core business. Due to the impact of COVID-19, the Advocate utilised virtual techniques for most engagement, including hearing from people experiencing financial stress. People were invited to participate in activities and share their experiences via telephone conversations or video calls.

During the COVID-19 response, the Latrobe Health Advocate (LHA 2021d) heard from the community:

"People living with disabilities have said that some of their peers understand what's happening and some don't. There is a reliance on social supports to translate complex information and provide access to technology."

"LGBTIQ+ communities would usually rely on local events and gatherings to prevent the impacts of feeling marginalised or detached from society. COVID-19 has meant that they are not able to get out to have fun and celebrate with each other."

"People are longing for physical connection with others and feeling the mental health impacts of isolation. They have said, "You don't get touch and hugs through a screen"."

A Gippsland PHN survey in 2021 (GPHN 2021d) included a few mentions of concerns related to the environment:

"My only real health issue is a growing anxiety about the worsening climate situation, and lingering grief about the devastation of the 2019 fires."

An Australian survey examining the emergency experiences of people who lived through a disaster between 2008 and 2019 found (Randrianarisoa et al 2021):

- The source of preparedness advice matters to people's feeling of being in control and confidence in the decisions they made during the disaster
- Feeling prepared reduces stress levels which improves self-reported recovery outcomes
- As expected, the more people do to get prepared, the more they feel prepared
- Protecting important items and managing stress is at the top of what people want to do better
- Preparedness actions can be grouped in three categories: 'Protect my personal matters', 'Build my readiness' and 'Be pragmatic'
- People who had not recovered from an earlier disaster feel less prepared, more stressed, and not as confident and in control during an emergency

Other identified needs (not priorities but for further monitoring)

ISSUE/GROUP	HEALTH AND SERVICE NEEDS ANALYSIS

LGBTIQ+	The Victorian Population Health Survey 2017 found that (VAHI 2020) LGBTIQ+ adults were:
	• Significantly more likely to:
	  ○ have a total annual household income of less than $40,000
	  ○ be unable to raise $2,000 in two days, in an emergency
	  ○ experience food insecurity
	  ○ be current smoker
	• Significantly less likely to have private health insurance or a total annual household income of $100,000 or more.
	• More likely to have mental health issues:
	  ○ 45% diagnosed with anxiety or depression by a doctor, significantly higher compared with heterosexual, non-LGBTIQ+ adults (27%)
	  ○ 24% had high or very high levels of psychological distress compared with 15% of heterosexual, non-LGBTIQA+ Victorians
	  ○ However, 22% rated what they did in life as worthwhile, a higher proportion compared with heterosexual non-LGBTIQ+ adults (16%)
	  ○ 37% had sought professional help for a mental health problem in the year before the survey. This proportion was significantly higher compared with the proportion in heterosexual, non-LGBTIQ+ adults (17%).
	• More likely to experience discrimination:
	  • 34% experienced discrimination, or were treated unfairly by others, in the last year compared with 16% of heterosexual, non-LGBTIQ+ adults. This included at home, in hospitals or a doctor's surgery, by doctors, nurses or other staff and in public places.
	• In Gippsland PHN community engagement during 2021 (GPHN 2021d), 49 people who identified as LGBTIQ+ (3.5% of respondents). They were:
	  ○ Less likely to have a usual doctor or health care provider; 24.5% compared to 11.6% for all respondents. They were also the group least likely to agree that their doctor seemed to know who they were before they arrived and for their doctor to be informed about any relevant specialist consultations or hospital stays (around 50% agreed compared to around 70% of all respondents).
	  ○ Less likely to see their health care provider as their centre of care (60% compared to 77% of all respondents).
	"No one is out, many are hated by their families" [Workshop participant]

CARERS	• Carers are recognised as crucial supports for many people and this has been recognised under several priority areas, including;
	  ○ People with a disability
	  ○ Dementia
	  ○ Chronic disease
	  ○ People aged 65 years or older
	  ○ Mental health and wellbeing, including suicide prevention
	• In Gippsland PHN community engagement during 2021 (GPHN 2021d), 229 people identified as a carer of someone with a disability or long-term health condition (16.6% of respondents);
	  ○ 92% owned a smartphone or smart device (88% of all respondents)

	○ 38% already use or would like to use a mobile app for their health care (35%) ○ 62% would like to use or already use a phone call with their doctor or other health care provider (55%) ○ 42% already use or would like to use video calls with their doctor or other health care provider (33%) • 48% agreed that their usual provider explained what their medications do so they can understand it (compared to 79% of all respondents)
ORAL HEALTH	• 38% of adults in Inner Gippsland and 35% in Outer Gippsland avoided or delayed visiting a dental professional due to cost in 2017, compared to 34% across Victoria, (DH 2017a). • 26% of adults in Inner Gippsland and 25% in Outer Gippsland rated their dental health as fair or poor in 2017, compared to 24% across Victoria, (DH 2017a). • There were 287 potentially preventable hospitalisations due to dental conditions per 100,000 people in Gippsland (age-standardised) compared to 278 in Victoria in 2017-18, (AIHW 2020a). • In Gippsland PHN community engagement during 2021 (GPHN 2021d), ten people said access to dental or oral health care was a concern. *"…one issue I would really like considered is assistance for dental work, especially for older people."* [Workshop participant]
CULTURALLY AND LINGUISTICALLY DIVERSE (CALD)	• In Gippsland PHN community engagement during 2021 (GPHN 2021d), 51 people identified as culturally or linguistically diverse (3.7%) and were: ○ less likely to have a usual doctor or health care provider; 19.6% didn't compared to 11.6% for all respondents ○ 94% use a smartphone or smart device (88% of all respondents) ○ 37% already use or would like to use a mobile app for their health care (35%) ○ 53% would like to use or already use a phone call with their doctor or other health care provider (55%) ○ 39% already use or would like to use video calls with their doctor or other health care provider (33%)
MEN'S HEALTH	• Men have a lower life expectancy compared to females and a higher rate of avoidable deaths. See **Gippsland main health issues.** • Men have a higher suicide rate than women. See **Mental health and wellbeing, including suicide prevention**.
INJURIES	• The rate of hospital admissions related to motor vehicle crash injuries was high in Gippsland compared to Victoria over a five year period (2015-16 to 2019-20); 176 admissions per 100,000 population compared to 123, (DH 2021a). There were an average of 461 admissions per year; 69% were for males.
BLOOD BORNE VIRUSES	• Chronic hepatitis B and C prevalence rates in Gippsland are similar or lower than across Australia. Treatment rates for hepatitis C are relatively high, (WHOCCVH 2020). • General practice data (2019-20) shows 9,601 patients with any hepatitis pathology across Gippsland (3.1% Aboriginal or Torres Strait Islander). ○ 2,461 patients with any hepatitis related diagnosis (includes vaccinations) ○ 847 patients with active diagnosis of viral hepatitis C (0.3% of all patients)

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Appendix I – Alcohol and other drug service map

LGA	Provider	Locations	General																	Indigenous Specific														Youth Specific								Other					
			Intake (1 300 022 760)	Forensic Assessment	Assessment Voluntary	Brief Intervention	Counselling voluntary and	AoD Family Counselling	Pharmacotherapy program	Risk of overdose	Mobile Drug Safety Worker	Dual DX Secondary	Care and recovery	AoD ED nurse	Residential Withdrawal	Residential rehab	Therapeutic day rehab (incl	Withdrawal non-residential	Intake /Assessment	Bridging	Counselling voluntary and	Care and Recovery	Withdrawal	Aboriginal AOD nursing	AoD Worker voluntary	Aboriginal AOD worker	Youth support	Youth outreach	Dual diagnosis nurse	Family support	AoD intake screening	Outreach (voluntary and	Counselling Voluntary	Counselling Forensic	Support services	Withdrawal	Residential rehab	Innovative Services for	Breaking the Cycle-Non	Integrated Hep Nursing	AoD education	Needle syringe program	SMART Recovery Peer
Barr Court	ACSO	Outreach / Phone	✕	✕		●																																	◊					
	BCH	Woolhaggi			✕	●	✕	✕	✕				✕					✕																											
		Cowra			✕	●	✕	✕	✕				✕					✕																											
		Grenfell			✕	●	✕	✕	✕				✕					✕																											
	TSAS+	Outreach (12-25 years)																												◊	✕	●	●	●	●				◊					
Bass Coast	ACSO	Warragul	✕	✕		●		●																															◊					
	LCHS	Warragul			✕		✕		✕	✕			✕				✕	✕														✕				✕								
	GEGAC	Outreach		●	●							◊						●		●	●	●			✕	✕	●	●		●								●		●			
	TSAS+	Outreach (12-25 years)																													✕	●	●	●	●				●					
East Gippsland	ACSO	Lakes Entrance	✕	✕		●		●																															◊					
		Orbost	✕	✕		●		●																																					
		Bairnsdale	✕	✕		●		●																																					
	GLCH	Bairnsdale					✕		✕				✕					✕							●	●					●	✕		●						◊	●				
		Lakes Entrance					✕		✕				✕												●	●					●	✕		●						◊	●				
		Orbost					✕		✕				✕																		●	✕		●						◊					
		Telehealth support across EG					✕		✕				✕																		●	✕		●						◊					
	GEGAC	Bairnsdale										◊						●	●	●	●	●	●	✕	✕	●	●		●										●					
	BRHS	Bairnsdale												✕	✕																									◊	●	●		
	Odyssey House	Bairnsdale (regional service)														✕																												
	LCHS	Bairnsdale								✕																																			
	Mungji AC	Orbost																							✕	✕			●															
	Lake Tyers	Lake Tyers																							✕	✕																		
	LEAHA	Lakes Entrance																							✕	✕			●															
Latrobe	ACSO	Morwell	✕	✕		●		●																															◊					
		Traralgon	✕	✕		●		●																																					
	LCHS	Morwell			✕	✕	✕		✕	✕	✕		✕				✕	✕														✕				●		●	●	●		●		
		Mar			✕	✕	✕		✕	✕	✕		✕				✕	✕														✕				●		●	●			●	●	
		Traralgon			✕	✕	✕		✕	✕	✕		✕				✕	✕														✕				●		●	●	●		●		
		Churchill			✕	✕	✕		✕	✕	✕		✕				✕	✕														✕				●		●	●			●		
	Ramahyuck	Morwell																						◊	✕	✕						◊												
	GEGAC	Morwell		●							◊							●	●	●	●				✕	✕	●	●	●	●		✕ #							●		●			
		Traralgon		●														●	●	●	●				✕	✕	●	●	●	●											●			
		Churchill		●														●	●	●	●				✕	✕	●	●	●	●											●			
		Mar		●														●	●	●	●				✕	✕	●	●	●	●											●			
	Uniting	Traralgon (regional service)																																		✕ #								
	LRH	Traralgon												✕																															
	TSAS+	Outreach (12-25 years)																												◊	✕	●	●	●	●				◊					
South Gippsland	ACSO	Outreach	✕	✕		●		●					✕		✕			✕																						◊					
	GSHS	Leongatha			✕		✕						✕		✕			✕																											
		Korumburra			✕		✕						✕		✕			✕																	◊							●			
		Foster (outreach)			✕		✕						✕					✕																											
		Mirboo North																✕																											
	TSAS+	Outreach (12-25 years)																												◊	◊	◊	◊	◊	◊				◊					
Wellington	ACSO	Sale	✕	✕		●		●																															◊					
	CGHS	Sale (also for Latrobe residents)									✕			✕	✕																										●	●		
	LCHS	Sale		✕	✕	✕	✕		✕	✕	✕		✕					✕														✕											
	Ramahyuck	Sale					◊						◊					◊																											
	TSAS+	Outreach (12-25 years)																												◊	●	●	●	●	●				◊					
Regional	LCHS										✕						✕	✕																						◊					

✕ State funded service
* Other funded service
◊ provider indicates that this is provided, but is not a funded activity
+ YSAS outreach sites have linkages to youth residential withdrawal units and youth residential rehabilitation programs
^ Outreach is defined as service delivery in a community location
# Not in operation (Nov 2021) - implementation phase

Latest update: November 2021
Please refer directly to providers for details and updates