phn GIPPSLAND

An Australian Government Initiative

Gippsland PHN

Health Needs Assessment

2025-28

November 2025 update

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Acknowledgements

Gippsland PHN acknowledges Aboriginal and/or Torres Strait Islander Peoples as the traditional owners of country throughout Gippsland, and their continuing connection to land, water and community. We pay our respects to them and their cultures, and to elders past, present and emerging.

We acknowledge the Victorian Department of Health (DH) as the source of Victorian Admitted Episodes Dataset (VAED) and Victorian Emergency Minimum Dataset (VEMD) data used for this report. We acknowledge North Western Melbourne PHN for support with analyses, including of Avoidable ED and Potentially Preventable Hospitalisations.

We acknowledge all internal and external stakeholders that supported, contributed and helped guide the development of the Gippsland PHN Health Needs Assessment 2025-28.

Versions

Version 1 of this report was submitted to the Department of Health, Disability and Ageing (DHDA) in November 2024 (N.b. there was a name change from Department of Health and Aged Care at the time of submission to Department of Health, Disability and Ageing in 2025).

Version 2 submitted to DHDA in November 2025 included changes as detailed below:

Report section	Version 2, November 2025 updates
What We Did	Details about 2025 Stakeholder Consultations added
Gippsland Geography and Population Profile	
Social Determinants of Health	Added section on Disadvantage
Gippsland Main Health Issues	
Gippsland Health Services	
Chapter 1: Aboriginal and/or Torres Strait Islander Health and Wellbeing	
Chapter 2: Healthy Ageing (People Aged 65+)	
Chapter 3: Alcohol and Other Drugs	
Chapter 4: Mental Health and Wellbeing, Including Suicide Prevention	Minor updates
Chapter 5: Health Workforce	Full update, including recent data and insights from consultations. A summary Table for LGAs has been expanded, additional context and possible solutions added and a section on Lived and Living Experience workforce added.
Chapter 6: Connected Care	
Chapter 7: Growing Up Healthy (0-25 years)	Minor updates
Chapter 8: Chronic Conditions	
Chapter 9: Family Violence	
Chapter 10: Access to Primary Healthcare for Marginalised Communities	Full update, including recent data and insights from consultations, especially for the section related to multicultural communities. Additional content was also added to the sections related to Homelessness, Poverty and Contact with Justice System.
Other Identified Needs	
References	Updated to reflect new content
Acronyms	Updated to reflect new content
Appendices	Updated to reflect new content

What We Did

Overview

Gippsland PHN's Health Needs Assessment 2025-28 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 numerous organisational processes that support the Health Needs Assessment, including:

- Evaluation of previous assessments and supporting documents,
- Purpose and Culture Governance Framework which emphasises this work as a cross organisational and on-going responsibility,
- Internal Populational Health project team,
- Planning and Commissioning Working Group, overseeing development and progress with contributions and involvement from teams across the organisation,
- Population Health Planning Adviser roles, filled by representatives from the Gippsland PHN Community Advisory Committee and Clinical Council who are called on for advice, including engagement activities, resource development, co-design activities and tender evaluations,
- Ongoing updates and improvement to the Gippsland Health Data Hub (GPHN 2024a) and other resources that are publicly available,
- And links to other Victorian PHNs via the Victorian and Tasmanian PHN Alliance.

The Gippsland PHN Purpose and Culture Governance Framework (GPHN 2024b) 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 and a full review and re-setting of priorities occurred in 2021 (GPHN 2021c). Another full review and re-setting of priorities has occurred during 2024 using the methods 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 (**Table 1**). Where possible, Gippsland PHN utilised established arrangements, such as existing meetings and stakeholder engagement opportunities arranged by other Gippsland PHN teams.

Table 1. Stakeholder consultation informing the Gippsland PHN Health Needs Assessment 2024, and the 2025 update.

Group	Timing	Method	Summary results
Gippsland PHN Clinical Councils and Community Advisory Committees	February, May and August 2024 February and August 2025	Workshops at quarterly meetings of 3 Clinical Councils and 1 Community Advisory Committee in 2024. Updates and additional advice during 2025.	Identification of emerging issues and involvement in priority setting and suggested options to address priority areas.
Key stakeholders, including local healthcare providers	Ongoing from August 2023	A Health Needs Assessment Advisory Panel was formed; workshops with Panel members in October 2023, February, May 2024, and July 2025. Contacts list for interested individuals and organisations established through the Tell Gippsland PHN website.	Involvement and advice from a broad range of key stakeholders including community and key partner organisations; including health services, universities, training providers, Gippsland Region Public Health Unit and service providers.
Community, consumers and carers	November 2023 until April 2024	Engagement project using conversations and group discussions to hear from people not accessing healthcare even if they have a health issue. Recruitment supported by community organisations including neighbourhood houses. (See more details below) Gippsland PHN Contacts process to stay in contact with interested individuals and organisations.	103 people took part in conversations and group discussions. 56 survey respondents. 116 Gippsland PHN Contacts for ongoing engagement (community and professionals). 16 community organisations supported recruitment.
Mix of professional stakeholders and community, consumers and carers	August 2024 On-going	Place-based interactive workshops with involvement by local stakeholders. The Tell Gippsland PHN survey and interviews.	Eight workshops (six face to face in each of Gippsland's six LGAs and two online workshops via Teams); 63 attendees in total. Total of 38 survey responses and 10 interviews/submissions.
Local Government	On-going	Existing structures to support the Municipal Public Health and Wellbeing Planning (MPHWP) process.	Alignment between LGA MPHWPs (2021-25 and 2025-2029) and the Victorian Public Health and Wellbeing Plan 2023-27, and Gippsland PHN priority areas.

Clinicians and other professional stakeholders	On-going	Existing meetings including Gippsland Alcohol and other Drug Service Providers Alliance and Gippsland Mental Health Alliance. General practice and commissioned services visits. Homelessness and multicultural health surveys and interviews during 2024. Multicultural engagement during 2025.	Up to date intelligence about health needs, service gaps and service mapping information gathered. Total of 33 survey responses (2024). In 2025, data from 44 practice respondents (gathered via practice visits) and 14 commissioned service providers (via an online survey) informed the update. Multicultural engagement in 2025 included a survey (21 responses), interviews (seven organisations) and a workshop (four participants).
Sub-group of the Health Needs Assessment Advisory Panel for Priority Setting	August 2024	Involvement of key partner organisations and community representatives. Individual review of documents and completion of a priority setting matrix. Attendance at online meeting.	Improved robustness and transparency of the priority setting process.
Gippsland PHN	Monthly Quarterly	Regular involvement facilitated through the Planning and Commissioning Working Group; monthly updates and quarterly evaluation of progress and involvement. During 2025, an internal Population Health Steering Committee was formed to provide strategic advice and operational guidance.	A whole of organisation approach.

An engagement project conducted during 2024, titled ***Tell Gippsland PHN why you don't access healthcare even if you need it*** (GPHN 2024c) helped inform the 2024 Health Needs Assessment. The purpose of this engagement activity was specifically designed to learn more from people at risk of the poorest health outcomes in the region, and why they may not access healthcare even if they have a health issue. We often don't hear the stories from the people living with an experience of marginalisation, for example those who experience poverty, homelessness and food insecurity or from people with a multicultural background. The project was also designed to hear from young people aged 16 to 25 years.

The project included three components with ethics approval for the project provided by Monash University Human Research Ethics Committee (MUHREC):

- A $500 grant to support recruitment was available to community organisations offering support for people to meet basic needs such as food, shelter and social connections. There were 16 successful grant recipients awarded to neighbourhood houses, youth organisations, homelessness support services and cultural groups.
- Conversations or group discussions were conducted between November 2023 to April 2024.
- A survey option (available online or in paper format) was open during the same timeframe for people who preferred to contribute in that format.

We heard from 103 participants who took part in conversations or group discussions between November 2023 to April 2024. We also received 56 survey responses (**Table 2**).

Table 2. Overview of conversation and group discussion participants.

Detail	Results
Sex	• Females: 62% • Males: 38%
Residential Location by Local Government Area	• Bass Coast: 17% • Baw Baw: 16% • East Gippsland: 24% • Latrobe: 25% • Wellington: 15% • South Gippsland: no grant applications received
Sub-groups	• People with a current or past experience of homelessness: 26 • People with experience of food insecurity: 53 • People aged 16-25 years: 13 • People with a multicultural background: 29 • People aged 65 years or older: 28 • People from another marginalised group (including disability, family violence or Aboriginal and/or Torres Strait Islander Peoples): 53

Quantitative data were analysed, and results of all consultations are reported under the relevant priority areas within the health needs assessment.

For the 2025 update of the Health Needs Assessment, targeted engagement activities to inform updates of two priority areas were undertaken. These were related to:

- Health workforce, and
- Access to Primary Healthcare for Marginalised Communities.

The Australian General Practice Training: Workforce Planning and Prioritisation Report (Murray PHN 2025) was informed by a survey which had 54 Gippsland respondents including GPs, practice managers, nurses, other professionals with an interest in workforce planning and community representatives. In addition, eight in depth interviews were conducted.

Gippsland PHN program delivery officers gathered insights from general practices during August-September 2025 related to health workforce and access to primary care for marginalised communities (GPHN 2025g). There were a total of 44 respondents, some representing multi-site practices.

Gippsland PHN commissioned services were invited to complete a survey during September 2025 to gather insights related to health workforce and access to primary care for marginalised communities (GPHN 2025h). The survey had a total of 14 respondents.

Engagement to inform multicultural access during 2025 (GPHN 2025d) included two components:

- Insights from healthcare and other providers who provide support to multicultural communities were gathered via semi structured interviews (n=7) and an online survey (n=21). In addition, a workshop to discuss preliminary findings was held online (n=4).
- Gippsland PHN program delivery officers gathered insights from general practices during February-March related to the use of interpreting services and data collection relating to multicultural communities through clinical software (55 respondents).

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 and multiple reports
- 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, Disability and Ageing (DHDA): HeaDS UPP Needs Assessment tool; National Health Workforce Dataset, Healthdirect healthmap
- Australian Commission on Safety and Quality in Healthcare: Australian Atlas of Healthcare Variation
- Gippsland PHN: de-identified GP data extracted by Outcome Health using POLAR
- Turning Point: Alcohol and Other Drugs (AOD) Stats.

Gippsland PHN also updated service mapping as part of the 2024 Health Needs Assessment.

Following a situation analysis of internal and external sources of information it was decided that the most beneficial and sustainable approach would be to build on existing mapping. The focus was on contributing to improvements in data quality in the National Health Service Directory (NHSD), related platforms and specialised service information platforms for specific conditions and population groups. This approach was taken to enhance support for both providers and consumers to access up to date service information for referrals and for people seeking suitable primary healthcare for themselves.

As part of this approach, Gippsland PHN has continued to work with primary care providers including general practices, commissioned service providers and the broader health system to share the latest resources and tools and to encourage them to keep all their details in the system up to date, rather than gather local data.

An analysis of data and service mapping information is included where relevant under the relevant priority areas within the health needs assessment.

For a full list of references for quantitative and qualitative data used in this report, refer to **References****.**

Triangulation and Prioritisation

The process of triangulation and priority setting used by Gippsland PHN was informed by the method used in 2021 (GPHN 2021c), with some modifications, including the establishment of a Gippsland PHN Health Needs Assessment Advisory Panel for advice on methodology. Outlined below is the process used to coordinate prioritisation. This includes not only the activities undertaken on direct prioritisation tasks (see stages), but also the activities that make sure this is done in a way that is:

- Evidence-based
- Balanced and taking account of the views of different groups and parties
- Using decision-making processes that are transparent, fair and reasonable.

Health needs and service issues were identified based on available data and information, including input from key stakeholders; priorities of the previous Health Needs Assessment were also 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 professional stakeholder intelligence.

The key steps in the priority setting process included:

	Steps
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 and external stakeholders
7	Organise the data collection, analysis, consultation and deliberation processes
8	Further development of the previously used scoring system
9	Adopt a plan for monitoring and evaluating the priority setting exercise
10	Collate and analyse the scores, as outlined in stages 1a and 1b (see below)
11	Present the provisional results for discussion and adjustment at a consensus meeting
12	Assess results based on stage 2 criteria (see below) and allocate final category
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
15	Assess options to address health problems based on stage 3 (see below)

The main stages to priority setting were:

Stage	Description and purpose
1a	The purpose of Stage 1 was to identify priority areas from the list of identified health needs. In Stage 1a, an assessment of health needs was made using a matrix with three criteria scored using a ten-point scale and detailed definitions: 1. Size and severity of issue (mortality, prevalence, incidence and impact on health) 2. Community consumer and carer reporting of need in this area 3. Professional stakeholder reporting of need in this area Overall scores were calculated applying a weighting of two to size and severity.
1b	Stage 1b added an assessment against two additional criteria to assess if addressing the need is within PHN scope and if there is an opportunity to address the need: 1. Alignment with PHN role and partner priority areas 2. Opportunity for change
2	Assessment of 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 (including both those with existing investment and new opportunities for investment).

Stakeholder engagement

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. Workshops were incorporated into quarterly meetings in February, May and August to advise on emerging issues, priority setting and options to address priority areas.
- A Gippsland PHN Health Needs Assessment Advisory Panel had a strategic advisory role in shaping each stage of the recommended method of priority setting. This group contained membership from stakeholders across local community, health and care providers, and government entities including local hospital networks and emergency planning and coordination structure. A sub-group of members were invited to rate potential priorities using an agreed matrix for Stage 1a.
- 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. These workshops included representation from local health professionals, service providers, and community members. See **Table 1** for additional information on stakeholder engagement.

In summary, throughout the health needs assessment engagement process, Gippsland PHN worked to engage across the following stakeholders:

- Local community, health and care providers:
    - Community and Clinical Advisory Committees
    - Local primary & mental health care providers, clinicians and consumer organisations
    - Aboriginal Community Controlled Organisations
    - Providers of commissioned services
    - Other regional care providers (e.g. hospitals, aged care and disability care providers)
- Government and other entities:
    - Commonwealth Department of Health, Disability and Ageing
    - Local Victorian hospital and health services
    - Local emergency planning and coordination structures.

Priority setting

Individual scoring in Stage 1a was completed by a sub-group of members from Gippsland PHN Health Needs Assessment Advisory Panel. Individual scores were reviewed and analysed during a consensus meeting to assign consensus scores. These scores and insights about how various needs may be related, recommended language and other context then informed Stage 1b, which took place internally with a select group of Gippsland PHN staff representing organisational teams and subject matter expertise.

All input from stakeholders was brought together with results from scoring exercises to inform recommended priority areas. These were then presented to the Gippsland PHN Planning and Commissioning Working Group and Executives, adding a final layer of PHN decision making before finalising recommended Gippsland PHN priority areas for 2025-28. Finally, the Gippsland PHN Board reviewed and endorsed the Health Needs Assessment method and revised priorities.

Evaluation

Following the submission of the Health Needs Assessment, Gippsland PHN will undertake an evaluation of the process to make further improvements prior to the next Health Needs Assessment deliverable. This will include:

- Reviewing feedback obtained through stakeholder consultation processes.
- Conducting an internal Health Needs Assessment evaluation session about strengths and areas for improvement within the process.
- Seeking additional external feedback to inform methods and resources.
- Consideration of an updated project plan to update the methodology as required.
- Utilise PHN Network collaboration to align methods for Health Needs Assessment as appropriate.

Key points for improvement will then be shared with the Executive, and relevant process documents will be updated in preparation for working on the annual update to this deliverable in 2025.

Notes on Data and Process

Gippsland PHN notes improvements in the availability of relevant data for the Health Needs Assessment since 2021. This includes further work by the Australian Institute of Health and Welfare (AIHW) presenting data by PHN and smaller geographies.

Since 2021, Gippsland PHN has undergone significant change in how data is analysed, with integration of analytical tools like Power BI and enhanced capabilities to process big data. This change is still in progress and as it matures will make internal processes more efficient and agile, allowing more time for assessment to better understand the Gippsland community, support annual updates and address the complex and inter-related needs of the Gippsland community.

Gippsland PHN acknowledges the support of North Western Melbourne PHN (NWMPHN) for assistance with summary data preparation for components of the Victorian Admitted Episodes Dataset (DH 2024a) and Victorian Emergency Minimum Dataset (DH 2024b).

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. Data limitations that remain or were identified are listed in **Appendix 1.**

Gippsland Geography and Population Profile

Geography

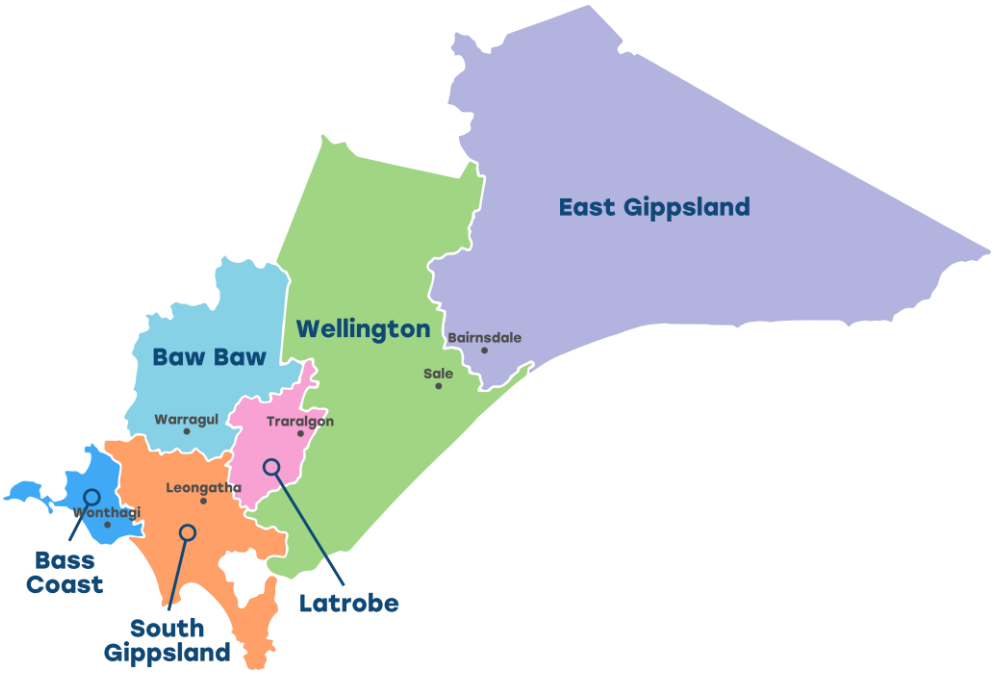
Gippsland Geography Snapshot

- 41,372 square kilometers
- Six Local Government Areas (LGAs)
- Five Statistical Area Level Three (SA3) sub-regions
- Four Modified Monash Model (MMM) remote area classifications
- Diverse geographical footprint

The Gippsland region is extensive, covering an area of 41,372 square kilometers (18.2% of the Victorian land mass), bordering metropolitan Melbourne from the Bunyip River in the west, to the New South Wales border in the east. The geographic footprint is diverse, encompassing a broad variety of developed and environmental areas, including but not limited to alpine regions, isolated townships, forested and farming land, coastal towns, a regional hub, and larger population centres.

The Gippsland region consists of six Local Government Areas (LGAs): Bass Coast, Baw Baw, Latrobe, South Gippsland, Wellington, and East Gippsland, as per **Figure 1** below.

Figure 1. Gippsland LGAs and major towns.



Statistical Areas Level Three (SA3) sub-regions[1] are also used throughout the report. Gippsland is made up of five SA3 sub-regions: Gippsland East (equivalent to East Gippsland LGA), Wellington, Latrobe Valley (equivalent to Latrobe LGA), Baw Baw and Gippsland South West (encompassing both Bass Coast and South Gippsland LGAs).

There are four Modified Monash Model (MMM) remote area classifications[2] used to describe Gippsland, from Modified Monash (MM) 3 (large rural towns) through to MM 6 (remote communities).

[1] Statistical Areas Level 3 (SA3s) create a standard framework for the analysis of ABS data at the regional level through clustering groups of Statistical Areas Level 2 (SA2s) that have similar geographic and socio-economic characteristics. They are designed for the output of regional data, including 2021 Census of Population. In general, SA3s are designed to have populations between 30,000 and 130,000 people. Further information is available here.

[2] The Modified Monash Model (MMM) defines whether a location is metropolitan, rural, remote, or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM1 to MM7 where MM1 is a major city and MM 7 is very remote. These classifications are based on the Australian Statistical Geography Standard – Remoteness Areas framework. Further information is available here.

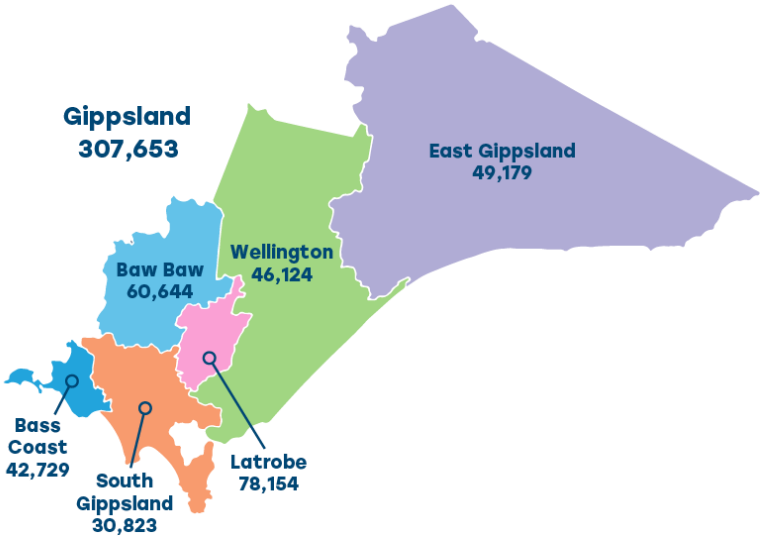
Population

Gippsland Population Snapshot

- **Total population:** 307,653 people (as of June 2023)
  - **Total percentage male:** 49.1%
  - **Total percentage female:** 50.9%
  - **Median age:** 46 years
- **Total Aboriginal and/or Torres Strait Islander population:** 5,819 people
  - **Total percentage male:** 50.3%
  - **Total percentage female:** 49.7%
  - **Median age:** 23 years
- **Top countries of birth:**
  - 80% of people in Gippsland were born in Australia,
  - 3.5% were born in England; and
  - 1.1% were born in New Zealand.
- **Top languages spoken at home:**
  - 87.6% of Gippsland residents speak English only at home,
  - 0.5% speak Italian; and
  - 0.3% speak Mandarin.
- **Median weekly household income:** $1,260
- **Level of highest educational attainment among people aged 15 years and over:**
  - 10.5% year 9 or below,
  - 30.8% Diploma or Certificate,
  - 14.0% Bachelor Degree level and above.

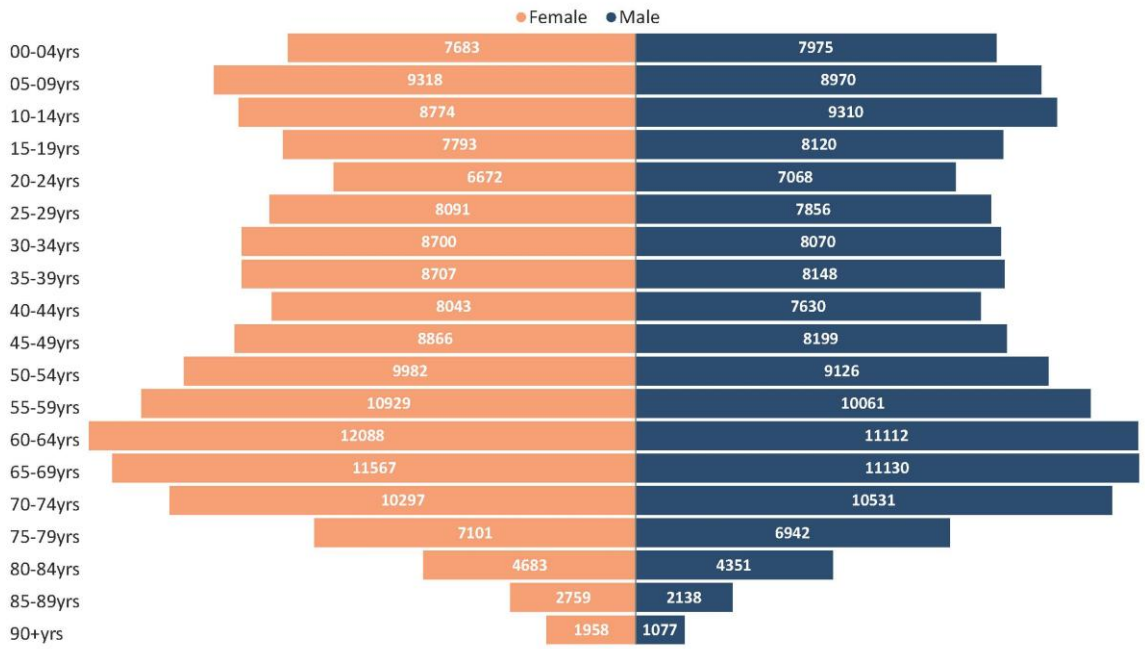
The Gippsland region is home to approximately 307,653 people, as of June 2023 (ABS 2024a), equivalent to 4.5% of Victoria's total population. The estimated population distribution per LGA is seen in **Figure 2** below, with the largest population located in the Latrobe LGA (ABS 2024a).

Figure 2. Population distribution by Gippsland LGA (ABS 2024a).



Gippsland population age and gender distribution are shown in **Figure 3.** The median age is 46 years in Gippsland, compared to 38 years in Victoria (ABS 2021a). Gippsland has a large percentage of individuals aged 55 and over (39.4%), which when compared to both Victorian and Australian averages (28.3% and 29.1% respectively) indicate an ageing population (ABS 2021a).

Figure 3. Age and gender distribution in Gippsland (ABS 2021a).



Aboriginal and/or Torres Strait Islander data

Aboriginal and/or Torres Strait Islander specific demographic data can be found in **Chapter 1. Aboriginal and/or Torres Strait Islander Health and Wellbeing.** All data in Chapter 1 are for Aboriginal and/or Torres Strait Islander peoples in Gippsland where available, with comparisons to Aboriginal and/or Torres Strait Islander peoples in Victoria and/or Australia as indicated.

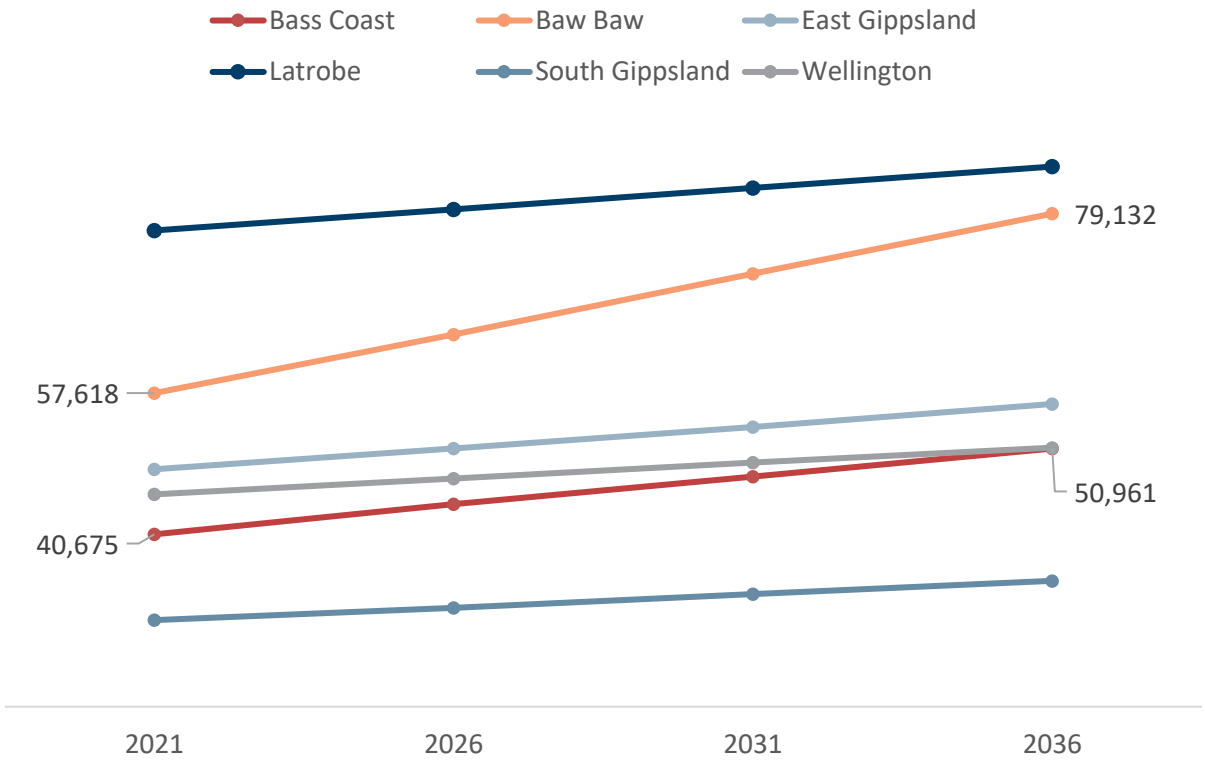
Population projections

Population projections are estimates of the future size, distribution, and composition of the population and can be useful for future planning and service allocation. The total population in regional Victoria is estimated to increase from 1.7 million in 2023 to 2.3 million by 2051; this trend is lower than the projected population increase in metropolitan Melbourne (Department of Transport and Planning, DTP 2023).

Victorian-level data also suggests that there will be a greater increase in lone person households than couples without children, while families with children will continue to be the most common household type (DTP 2023). Social isolation can be an issue for individuals living alone, so greater resourcing of mental health services and support programs, along with a greater need for age-related services such as home care may be required.

The Gippsland population is projected to increase to 357,340 by 2036 and to 413,000 by 2051 (DTP 2023). The highest growth rates (**Figure 4**) are predicted in Baw Baw (37.3% increase) and Bass Coast (25.3% increase), with Baw Baw being identified as the fourth highest LGA of growth in regional Victoria (DTP 2023).

Figure 4. Population projections by Gippsland LGA (2021-2036) (DTP 2023).

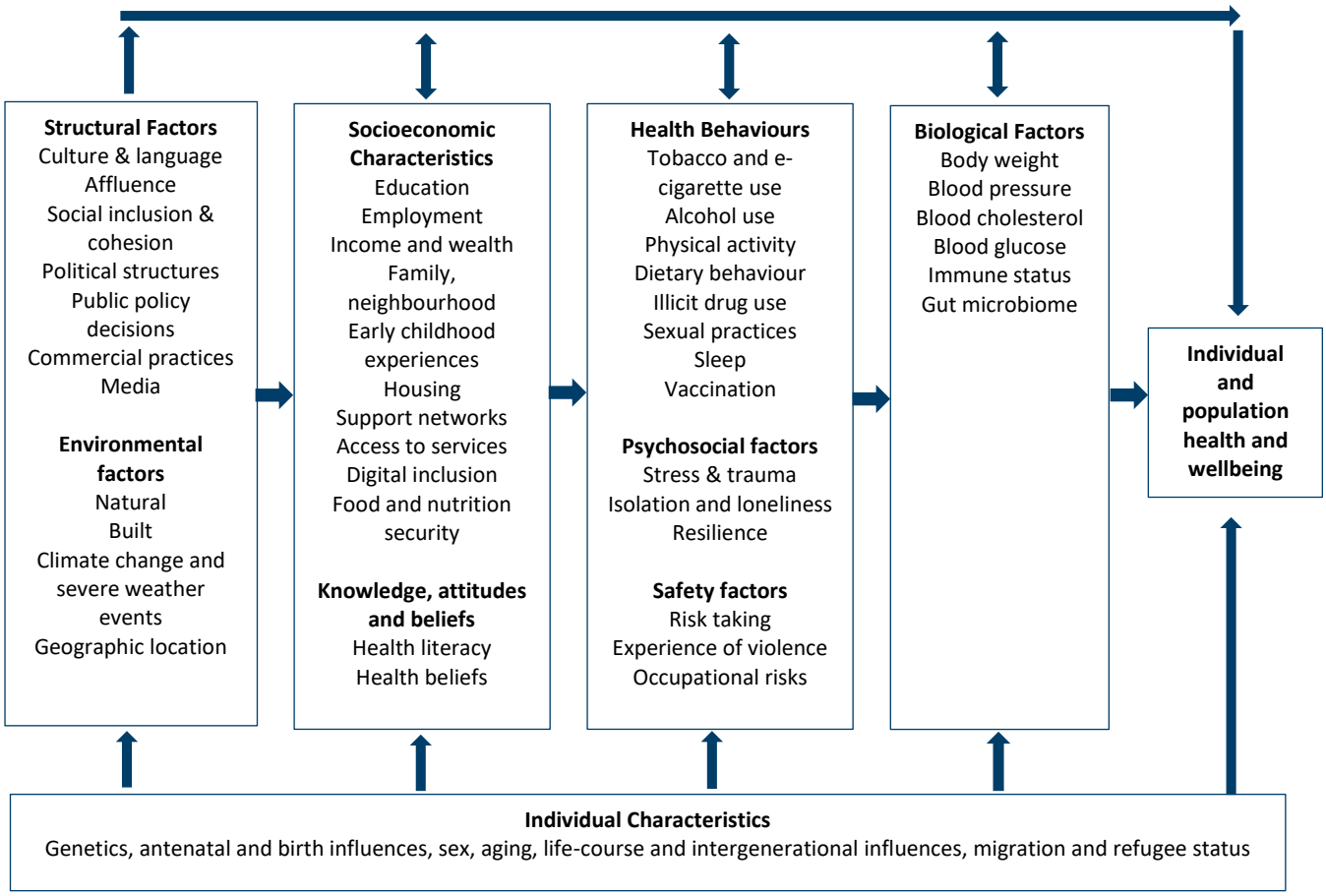


Population composition is also expected to shift Victoria wide with individuals aged 65 and older comprising 16.6% of the total population in 2023 and increasing to 19.2% of the total population by 2051 (DTP 2023).

Social Determinants of Health

It is well recognised that an individual's health is related to many factors, termed the determinants of health (**Figure 5**). The determinants of health include some modifiable health behaviours, however many determinants of health, including environmental and societal context in which people live, as well as physiological factors such as gender and genetics, are not modifiable (AHHA 2024).

Figure 5. A conceptual framework for the determinants of health (AIHW 2024x).



More specifically, the social determinants of health are defined as *"the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems"* (WHO 2024a).

According to the World Health Organisation, the social determinants of health account for between 30-55% of health outcomes (WHO 2024a). Understanding the social determinants of health allows for a whole-of-

system approach to be applied when looking to overcome complex health challenges and improve equity. Many of the relationships between social determinants have been well documented and researched, however health and social services must coordinate their assessment and response to the social determinants of health at a regional and personal level.

Gippsland perspective

The Gippsland region is diverse, socially, culturally and economically and as such people in Gippsland may be impacted by few or several social determinants of health. Health equity can be influenced in both positive and negative ways by social determinants of health (AHHA 2024). The key social determinants of health in Gippsland, obtained from quantitative and qualitative analysis, are detailed in **Table 3**.

Table 3. Summary of the key social determinants of health in Gippsland.

Key Social Determinants	Gippsland Perspective
Income	• **23.3% of people have less than $650 in weekly household income** (higher than the Victorian average 16.4%). • **52.2% of households have low income** (in bottom 40% of income distribution) (higher than the Victorian average 40.9%).
Employment, working conditions and job security	• **4.8% unemployment rate in Gippsland; highest in Latrobe (5.9%) and East Gippsland (4.8%)**, (higher than the Victorian average of 4%). • In recent years, employment in some industries has been impacted by the transition away from fossil fuels and native timber harvesting.
Childhood experiences and family relationships	• **15.4% of children under 16 years live in low income, welfare dependent families** (higher than the Victorian average of 9.3%)
Education and literacy	• **23.0 of 100 people participate in vocational education and training** (age-standardised rate), (higher than the Victorian average of 15.7) • **13.7% of people have a Bachelor degree or higher** (lower than the Victorian average of 29.2%)
Social support and coping skills	• **Social isolation** is strongly associated with poor mental and physical health in Gippsland and across Australia. • **Social exclusion** is commonly experienced due to gender, sexual orientation, culture, race, disability and long-term health conditions in Gippsland and across Australia.
Structural barriers – distribution of power, money and resources	• **52.0% of adults believe multiculturalism makes life better** (lower than the Victorian average of 63.5%) • **Access, affordability and ability to use digital tools is low across Gippsland** compared to Victoria; lowest in East Gippsland and Bass Coast.

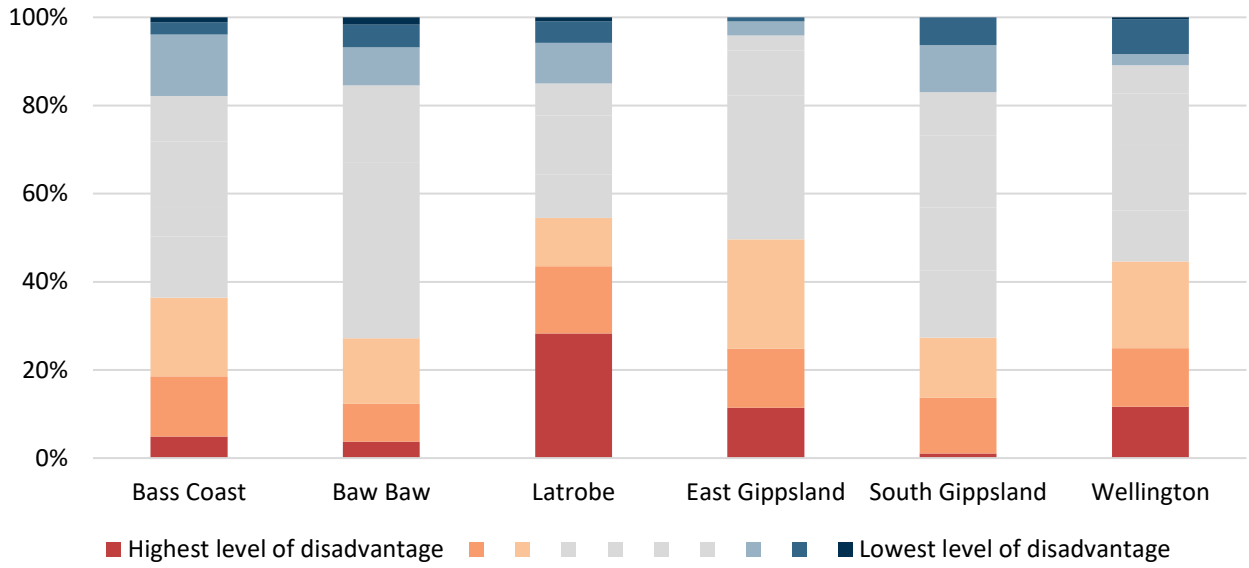
Safety	• **Family violence rates are high across Gippsland;**
	  • Latrobe (3,361 family incidents per 100,000 people)
	  • East Gippsland (3,162 incidents per 100,000 people)
	  • Wellington (2,892 incidents per 100,000 people),
	compared to the Victorian average (1,378 incidents per 100,000 people).

Food security	• **7.9% of adults did not have enough money to buy food in the past year** (higher than the Victorian average of 5.9%)
Physical environment	• **1.5% of people travelled to work by public transport** (lower than the Victorian average of 12.6%) • **Climate change**, as a social determinant of health, continues to impact the health and wellbeing of the Gippsland community, who have experienced multiple climate related disasters in recent years including fire, flood and storm events. Some communities are particularly vulnerable to repeated disaster exposure, which has been shown to be associated with worsening mental health outcomes. • See also **Spotlight on Climate Change and Emergency Management.**
Housing – affordability and security	• **7,312 people in Gippsland accessed homelessness services in 2021-22.** • Consultation participants indicated that, in Gippsland, homeless individuals often mistrust mainstream services due to past negative experiences.
Access to affordable healthcare of decent quality (WHO 2024a)	• **7.1% of people accessed a GP after hours** (lower than the Australia average of 16.6%). • People are increasingly impacted by cost-of-living pressures and increased healthcare costs.

Disadvantage

The Index of Relative Socio-economic Disadvantage (IRSD)[3] summarises information about disadvantage for a particular geographic area (ABS 2023b). **Figure 6** shows that the LGA with highest level of disadvantage is Latrobe, followed by East Gippsland and Wellington. It can be noted that each LGA includes substantial levels of disadvantage. Note that IRSD is based on geography and cannot show how many individuals experience a certain level of disadvantage, but rather how many people live in an area with a level of disadvantage.

Figure 6. Proportion of LGA populations in Gippsland by Socio-economic Disadvantage Decile, 2021 (ABS 2021b)



[3] The indicators used in this measure include percent of people on low income, percent of people aged 15 years and over who have no educational attainment, and percent of occupied private dwellings with no car, and per cent of people who do not speak English well (ABS 2023c).

Spotlight on Climate Change and Emergency Management

The World Health Organisation (WHO) describes climate change as the most significant threat to public health in the 21st Century (WHO 2023a). Climate change, as a social determinant of health, disproportionately affects the health outcomes of vulnerable communities and exacerbates the effects of the other social determinants of health for those who are already at risk. Rural and regional areas are at greater risk of escalating individual, social and economic costs of future natural disasters due to the higher levels of social disadvantage, fewer services and supports, geographical barriers and health workforce challenges (Romanello et al. 2024).

The health impacts of climate change are already being felt internationally, in Australia and in Gippsland. The '2024 report of the Lancet Countdown on health and climate change' reports that in the past year, ten of the 15 indicators used to monitor global climate change-related health hazards, exposures and impacts have reached concerning new records (Romanello et al. 2024). Globally, heat-related mortality of people older than 65 years has increased by 167% in comparison to data from the 1990s (Romanello et al. 2024). In Australia, excess heat has increased by 35% from 1973-74 to 2022-23 (Beggs et al. 2023). Australian data suggests heatwaves have already overwhelmed ambulance services and resulted in increased hospitalisations and mortality (Beggs et al. 2023).

Repeated exposure to disasters has been shown to be associated with worsening mental health outcomes in Australia (Mitchell, Maheen & Bowen 2024), a concern for the Gippsland region which is at extreme risk of floods, bushfires and heatwaves and high risk of earthquakes, storms and infectious disease outbreaks (EMV 2024). Furthermore, anxiety, post-traumatic stress disorder and depression are commonly reported mental health problems following bushfires (Beggs et al. 2023), noting that bushfires significantly impacted the Gippsland region in 2019-20. Since 2019-20, Gippsland has also endured storms and floods in 2021, floods in 2022, floods in 2023-24 and bushfires and storms in 2024.

The direct, indirect, compounding and cascading impacts of climate change on human health are complex and require coordinated, systemic action from multiple organisations and governments departments. Primary healthcare services have a vital role to play prior to, during and after climate related disasters. Primary care providers often share the disaster experience with their local community, providing them with deep understanding of the health care needs and real-time effects of the disaster in community. Although Federal and State agencies have the overall responsibility for on-the-ground disaster management, Gippsland PHN has a role in coordinating a strong and effective local primary health care response to deliver care where and when it is needed.

In 2023, Gippsland PHN released the Gippsland PHN Climate Change Adaptation Strategy which details a Climate Change Action Plan contextualised by objectives relating to leadership, mitigation and resilience. In addition, Gippsland PHN continues to support primary healthcare providers in our region in planning for, responding to, and recovering from emergencies, working alongside State, Federal and local emergency management agencies.

Gippsland Main Health Issues

Gippsland Main Health Issues Snapshot

- The leading cause of mortality in Gippsland between 2018-22 was coronary heart disease.
- Other leading causes of mortality in Gippsland during this period were lung cancer, dementia including Alzheimer's disease, cerebrovascular disease and chronic obstructive pulmonary disease.
- Gippsland has the highest rates nationally of accidental falls, colorectal cancer and heart failure.
- The top presentations to General Practice in 2023-24 were for hypertension, gastroesophageal reflux disease and asthma.

Source: AIHW (2024s), GPHN (2024f)

Burden of Disease

Burden of Disease is measured using the summary metric of disability-adjusted life years (DALY), which includes both years of healthy life lost due to death (fatal burden) and due to disease and injury (non-fatal burden).

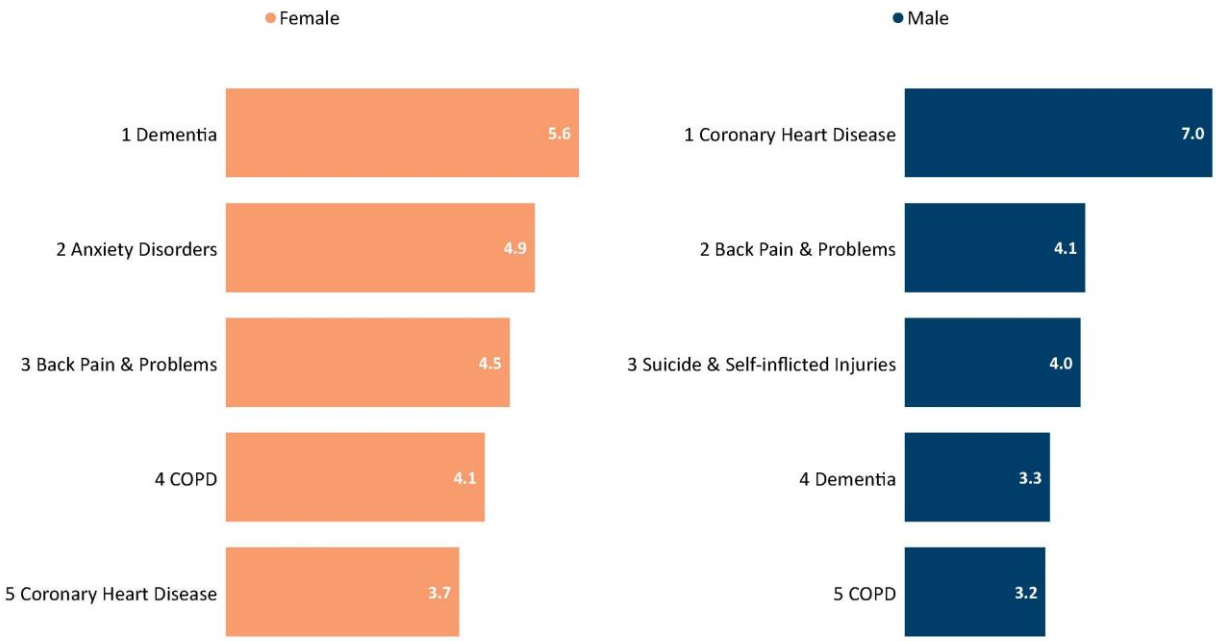
The Australian Burden of Disease Study, updated in 2023, indicates that living with illness or injury causes more disease burden than dying prematurely (AIHW 2023a). Between 2003 and 2023, nationally, due to fewer premature deaths, there has been a moderate shift from fatal burden to non-fatal burden, with non-fatal burden of disease being the greatest contributor to total burden (AIHW 2023a).

In Australia, the conditions which caused the greatest burden of disease in 2023 were (AIHW 2023a):

- Cancer (17% of total DALY, 91% of total DALY that was fatal)
- Mental health conditions and substance use disorders (15% of total DALY, 2% of total DALY that was fatal)
- Musculoskeletal conditions (13% of total DALY, 3% of total DALY that was fatal)
- Cardiovascular diseases (12% of total DALY, 74% of total DALY that was fatal)
- Neurological conditions (8% of total DALY, 49% of total DALY that was fatal)

The leading cause of total burden of disease for males and females is shown in **Figure 7** (AIHW 2023a). It should also be noted that males have higher rates of fatal burden compared to females nationally (AIHW 2023a).

Figure 7. Top five leading causes of total burden of disease nationally by gender (AIHW 2023a).



Mortality

In Gippsland, life expectancy between 2020-22 was 78.7 years for males and 83.2 years for females (ABS 2023a). Trends in life expectancy at birth in Gippsland have remained mostly steady between the periods of 2015-2022 (**Figure 8**) (ABS 2023a).

Over the period 2018-22, Gippsland's age-standardised mortality rate has grown by 1.6% per year, 33% higher than the national growth rate (**Figure 9**) (AIHW 2024s).

For both males and females, Gippsland's age-standardised premature death rate has grown by 2.2% per year from 2018-22, and in 2022 was 28% higher than the 5-year national average (ABS 2024a).

Figure 8. Trends in life expectancy at birth in Gippsland from 2015-22 (ABS 2023a).

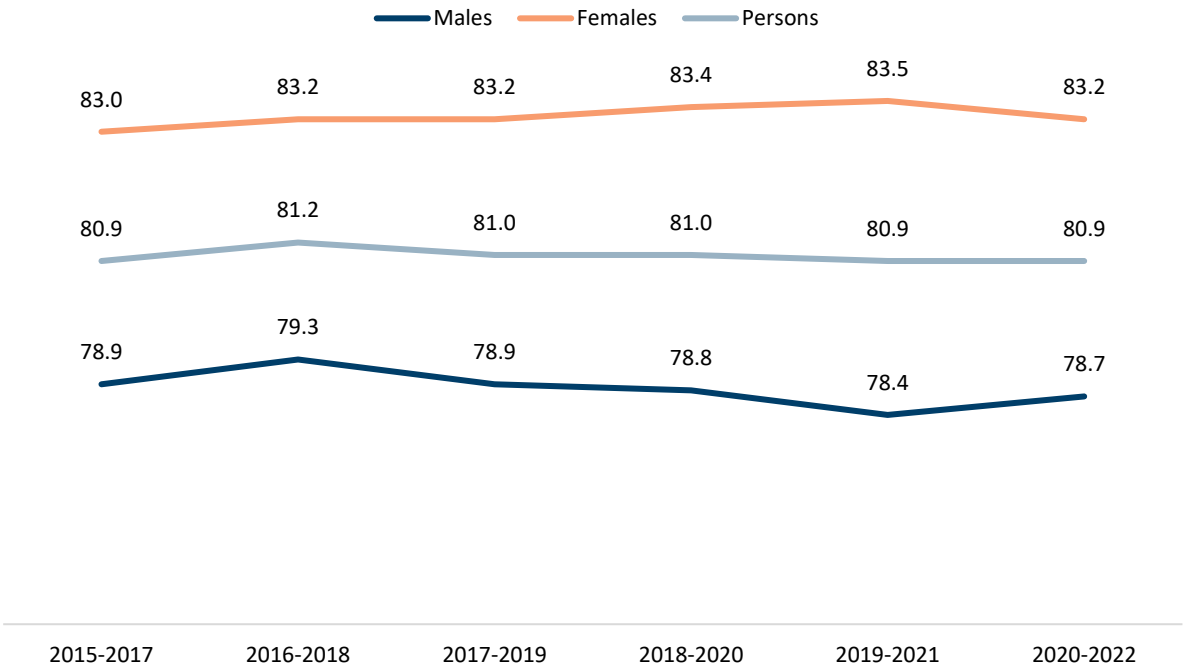
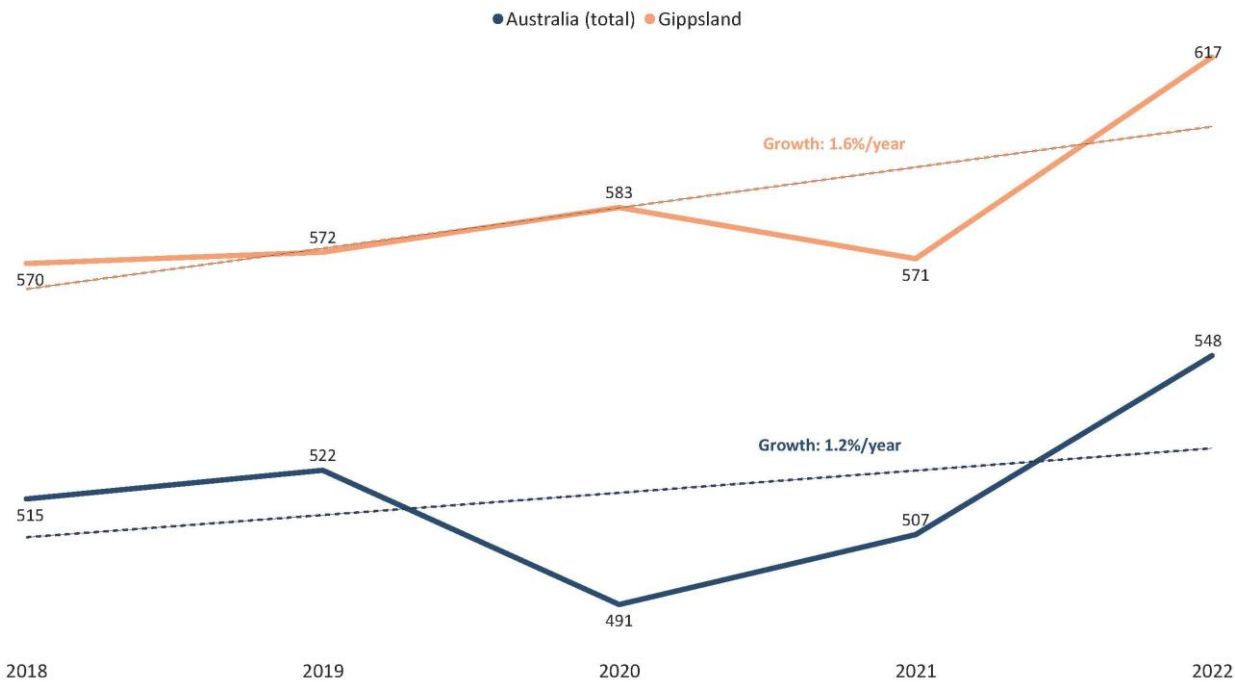


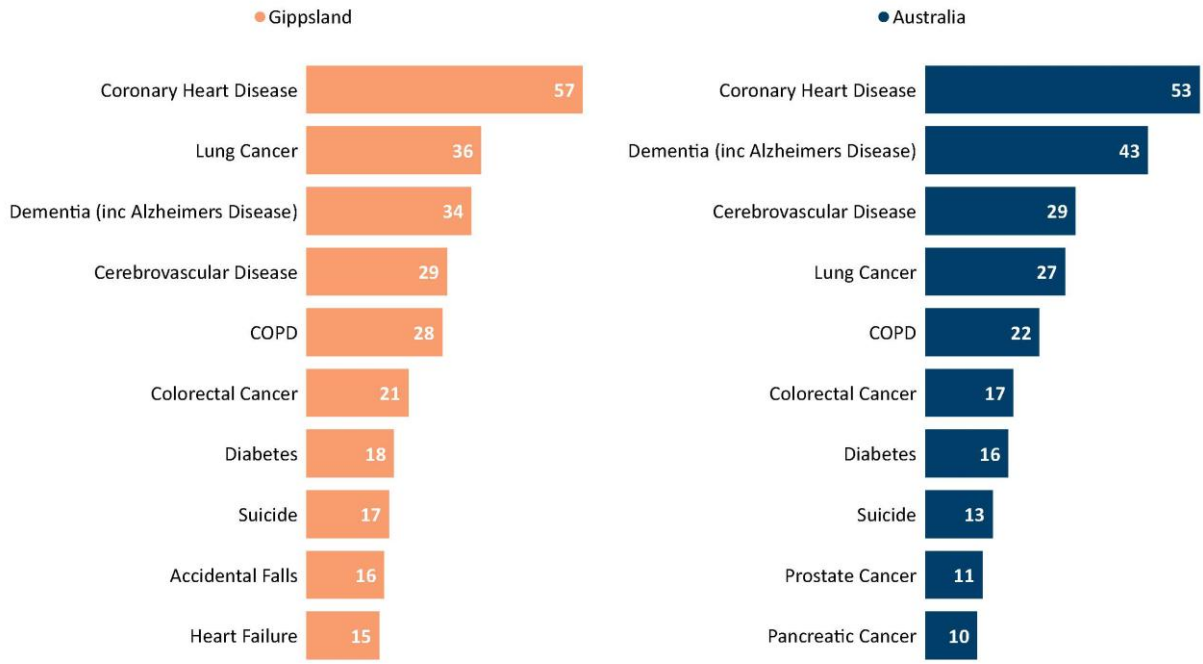
Figure 9. Age-standardised mortality rate per 100,000, all persons (AIHW 2024s).



The leading causes of mortality by aged-standardised rate per 100,000 between 2018-22 are shown in **Figure 10**. In summary (AIHW 2024s):

- For all people, Gippsland has the highest rates nationally of accidental falls, colorectal cancer and heart failure.
- For males, Gippsland has the fourth highest rates nationally of suicide and lung cancer and the fifth highest rates of prostate cancer.
- For females, Gippsland has the highest rates nationally of accidental falls, breast cancer, colorectal cancer and heart failure, with the third highest rates of lung cancer.

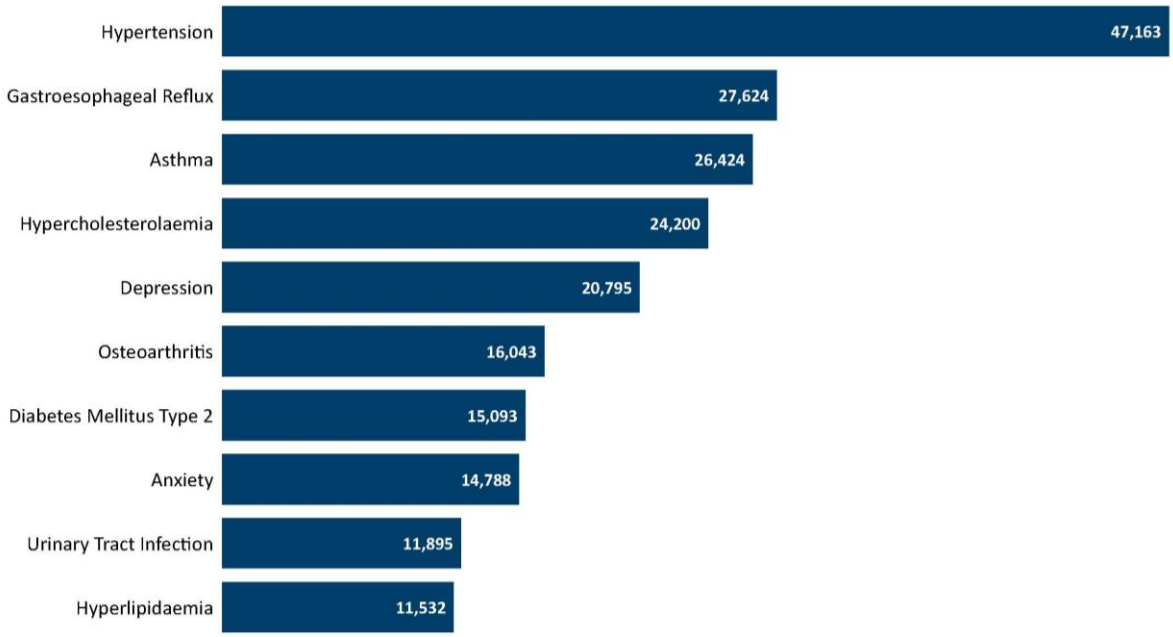
Figure 10. Comparison of Gippsland and Australia leading causes of mortality for all persons by age-standardised rate per 100,000, 2018-2022 (AIHW 2024s).



Presentations to General Practice

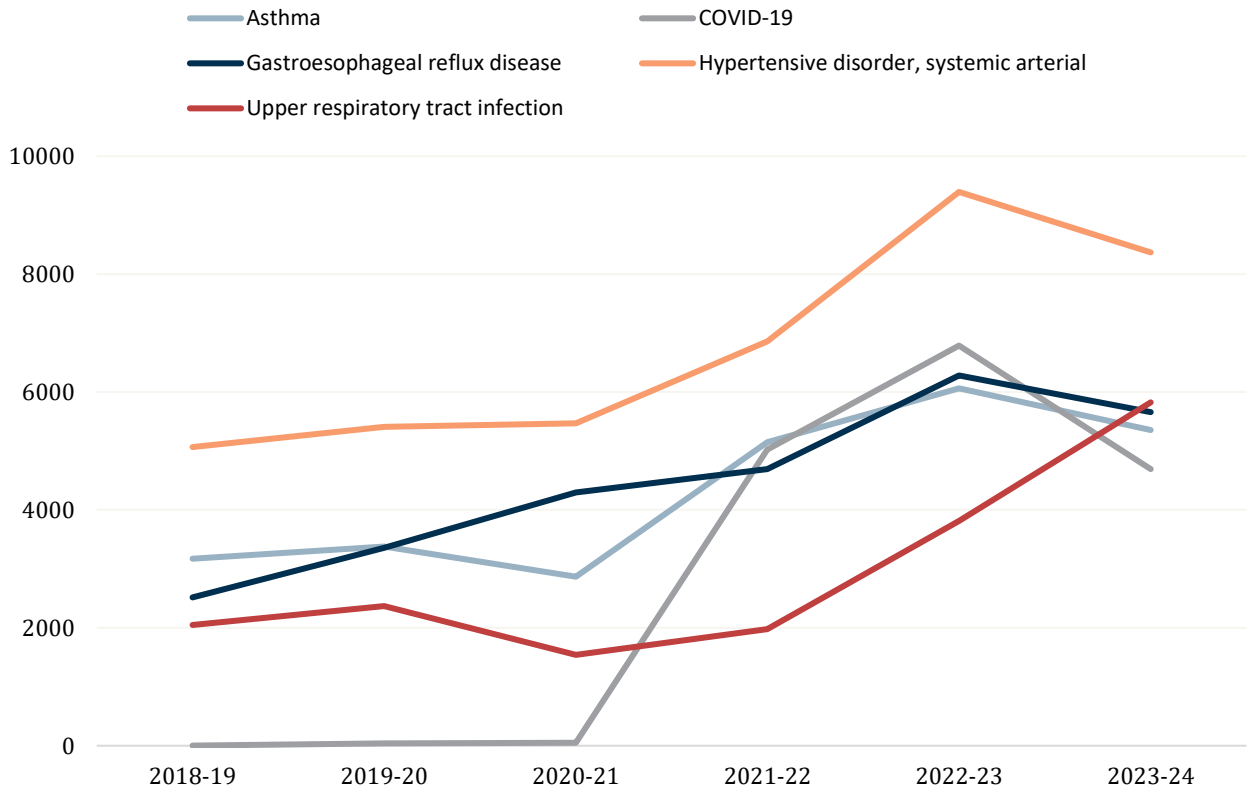
The top active diagnoses among general practice patients in Gippsland in 2023-24 were hypertension, gastroesophageal reflux disease, and asthma (**Figure 11**) (GPHN 2024f).

Figure 11. Top 10 active diagnoses among patients in Gippsland general practices, 2023-24 (GPHN 2024f).



In 2023-24, the greatest number of new diagnoses were related to hypertension, increasing 10.6% per year during the period (**Figure 12**) (GPHN 2024f). Of the top 5, upper respiratory tract infections grew at the largest rate of 23.2% per year, excluding COVID-19 (GPHN 2024f).

Figure 12. Top 5 new diagnoses for patients in Gippsland general practices (GPHN 2024f).



Gippsland Health Services

Health Service Providers

Gippsland Health Service Snapshot

- General practice clinics: 98
- Aboriginal Community Controlled Organisations: 6
- Residential Aged Care Homes: 53
- Public hospitals: 12 (five of which have an Emergency Department)
- Private hospitals: 3
- State-funded Urgent Care Clinics: 2 (Baw Baw and Latrobe)
- Bush nursing centres: 6
- Community pharmacies: 74
- Approximately 222 private and community allied health clinics (inclusive of physiotherapy, dentistry, prosthetics & orthotics, optometry, art therapy, audiology, chiropractic, dietetics, occupational therapy, psychology social work, podiatry, exercise physiology, music therapy and speech pathology)

Source: (GPHN 2024g)

The distribution of general practices across Gippsland LGAs is shown in **Figure 13**, while the distribution of Aboriginal Community Controlled Organisations (ACCOs) is shown in **Figure 14.**

Further service provider maps, including allied health, hospitals and Urgent Care Clinics can be found in **Appendix 2.**

For further details, including workforce and service breakdown by LGA, see **Chapter 5. Health Workforce.**

Figure 13. Distribution of general practices across Gippsland LGAs (Healthdirect Australia 2024).

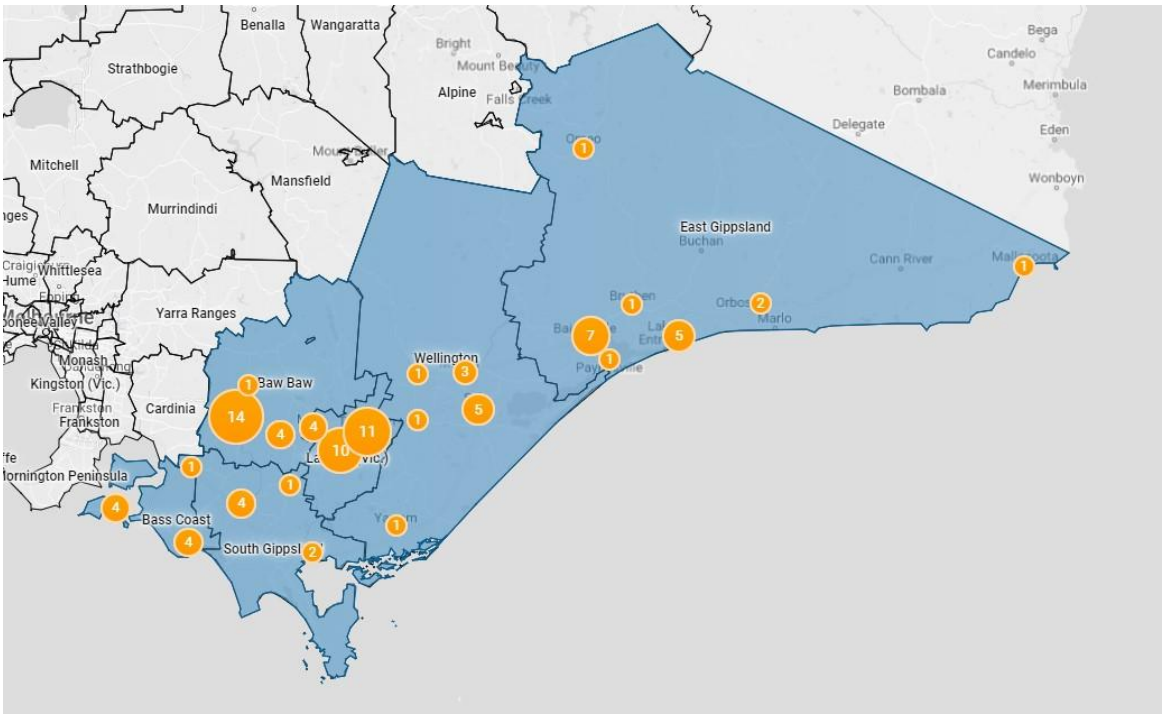
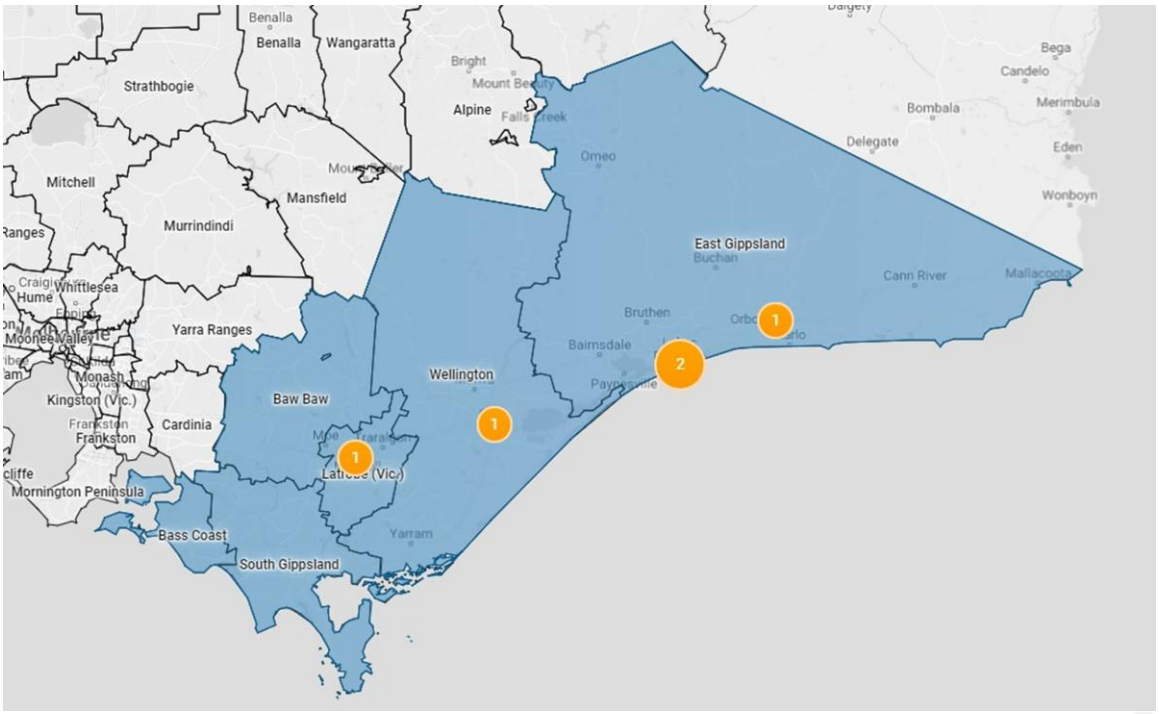


Figure 14. Distribution of ACCOs across Gippsland LGAs (Healthdirect Australia 2024).



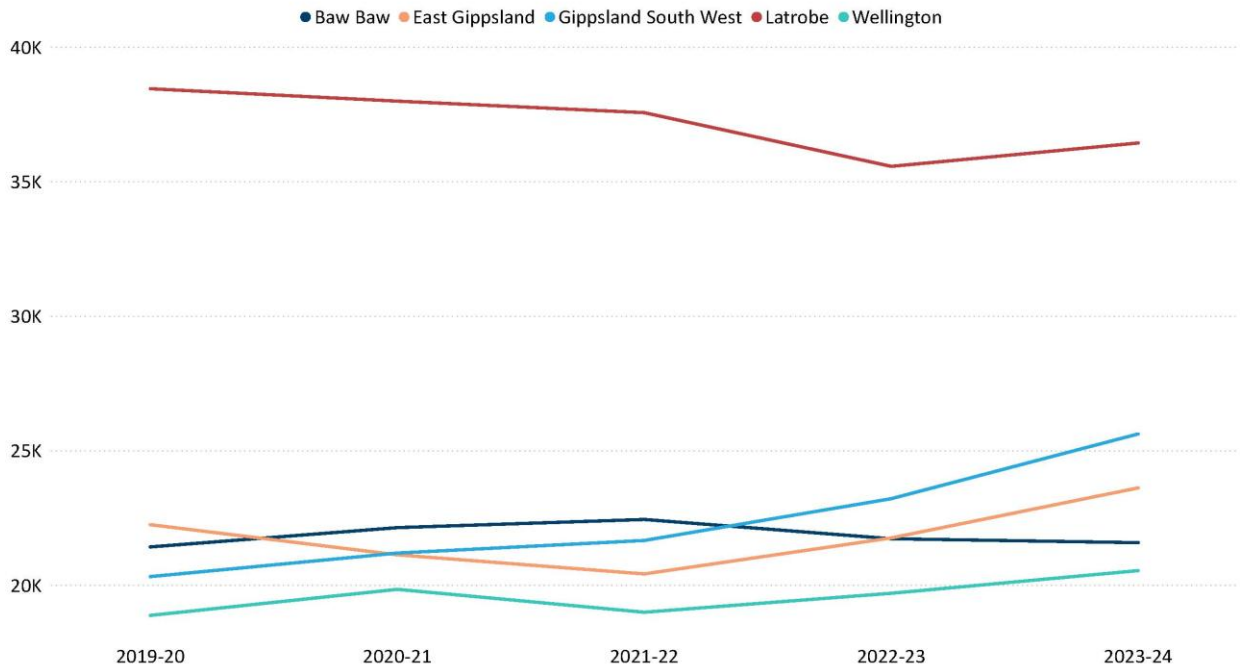
Service Utilisation

Gippsland Emergency Department Presentations

There was a total of 127,750 Emergency Department (ED) presentations to Victorian public hospitals by Gippsland residents in 2023-24, up from 121,270 in 2019-20 (DH 2024b). This is equivalent to a 1.0% increase per year over the past five years. Admission trends by Gippsland SA3 sub-regions can be seen in **Figure 15**, noting a reduction of 1.1% in Latrobe and an increase of 4.8% in Gippsland South West per year over the past five years.

See also **Chapter 1: Aboriginal and/or Torres Strait Islander health and wellbeing.**

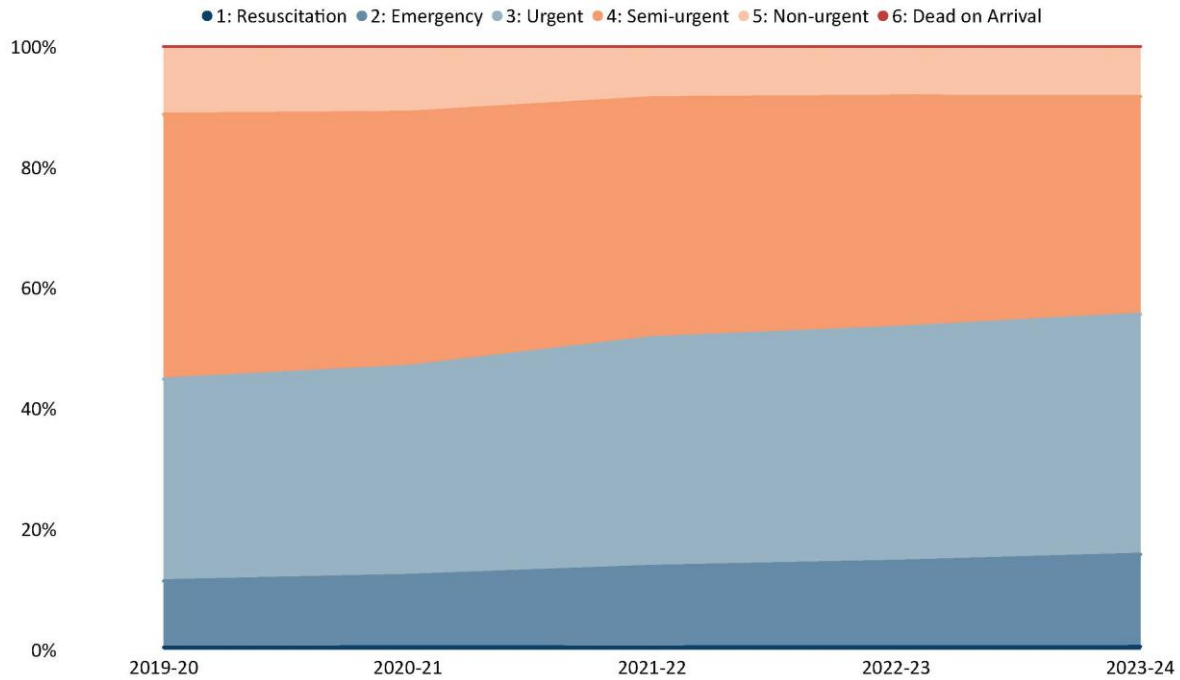
Figure 15. ED presentations by Gippsland residents by SA3 sub-region, 2019-20 to 2023-24 (DH 2024b).



There has been a steady increase of 1.3% per year over the past five years (2019-20 to 2023-24) in the total number of ED presentations by Gippsland residents; however, there has been a progressive change in the triage category types over this period (DH 2024b).

Between 2019-20 and 2023-24, non-urgent (triage category 5) presentations have reduced by 6.2% per year, semi-urgent (triage category 4) presentations have reduced by 3.5% per year, however resuscitations, emergency and urgent presentations have increased by 8.6%, 10% and 5.8% per year respectively (**Figure 16**) (DH 2024b).

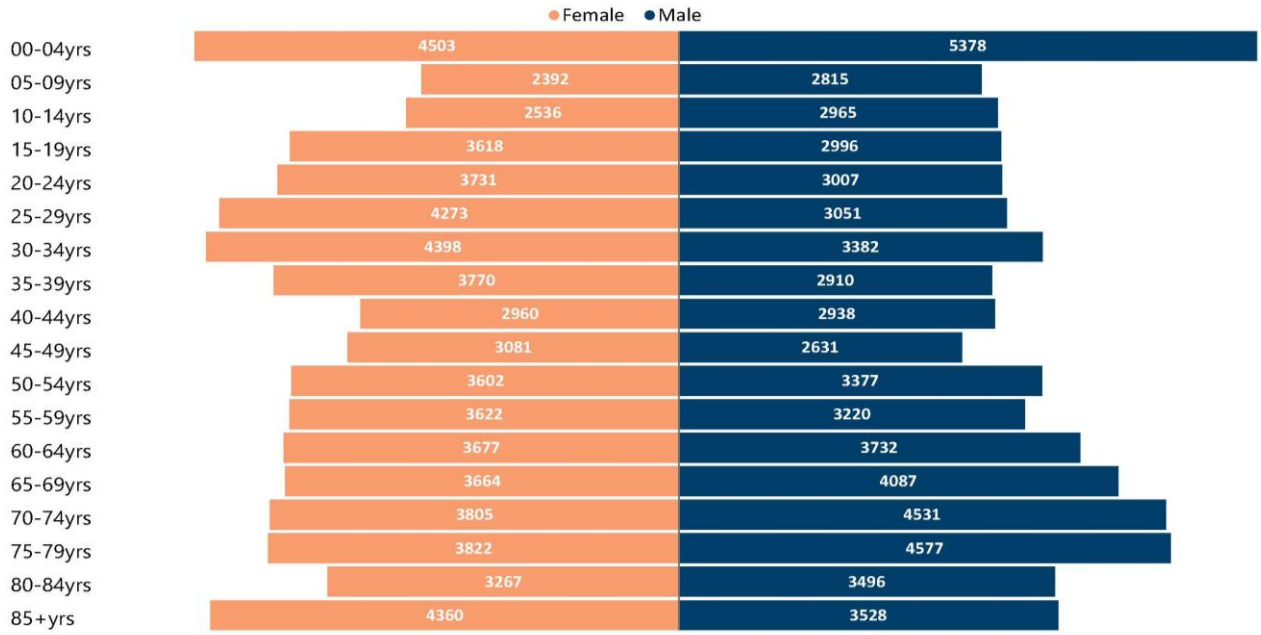
Figure 16. ED presentations for Gippsland residents by triage category, 2019-20 to 2023-24 (DH 2024b).



The age and sex distribution for Gippsland residents presenting to ED in 2023-24 is shown in **Figure 17**. In summary:

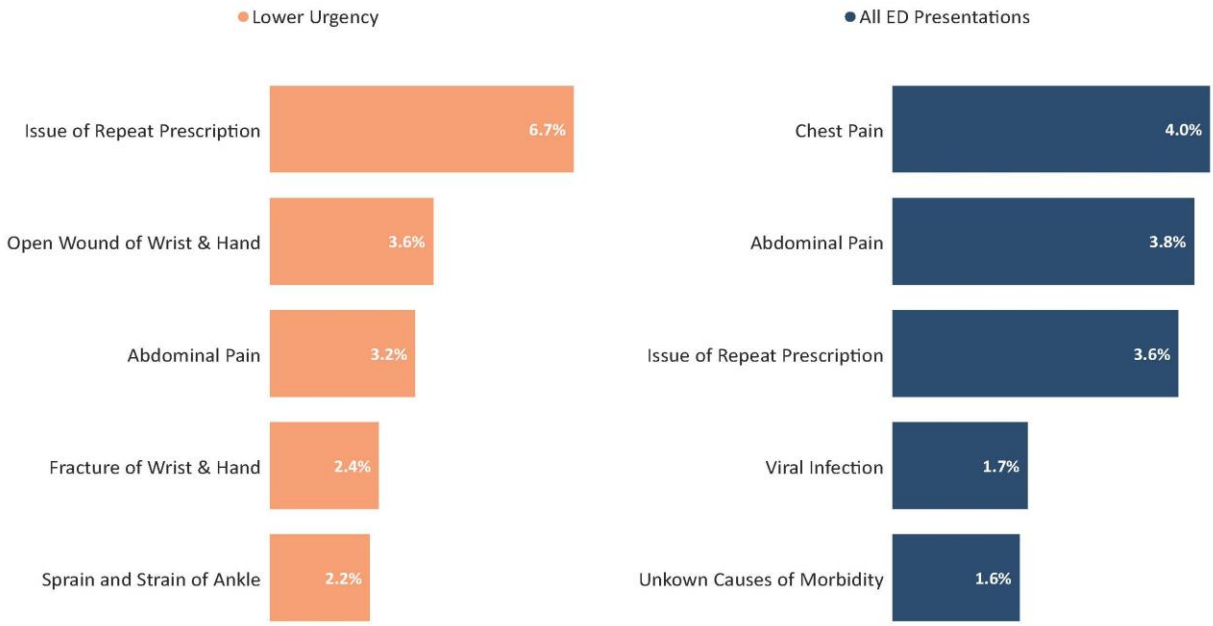
- Females under 60 presented slightly more often,
- Males 60 and over tend to present more often,
- 16.1% were aged 0-14 years,
- 10.5% were aged 15-24 years, and;
- 30.6% were aged 65 or older.

Figure 17. ED presentations for Gippsland residents by age group and sex, 2023-24, n=127,702 (DH 2024b).



Comparison of top five lower urgency ED presentations with top five ED presentations (all triage categories) in Gippsland in 2023-24 is shown in **Figure 18** (DH 2024b). For a detailed list of the top diagnoses among ED presentations for Gippsland residents, including the number of presentations, see **Appendix 5.**

Figure 18. Comparison of top five lower urgency ED presentations with top five ED presentations (all triage categories) in Gippsland, 2023-24 (DH 2024b).



Additional insights from ED data for Gippsland residents in 2023-24:

- After-hours ED presentations[4]: made up 53% of all presentations in 2023-24, slightly reduced from 54% in 2019-20, with a high of 55% in 2021-22. All Gippsland SA3 sub-regions recorded 53-54% of ED activity after hours.

- For Gippsland residents, 89% of ED presentations were at a Gippsland hospital in 2023-24, down from 92% in 2019-20. There was some variation between SA3 subregions (2023-24):
    - 86% in Baw Baw.
    - 90% in East Gippsland.
    - 83% in Gippsland South-West.
    - 93% in Latrobe.
    - 94% in Wellington.

- In 2023-24, 69% of presentations were treated in time and this is an improvement from a low of 64% in 2021-22, but less than 71% in 2019-20.
- Departures from ED (in 2023-24):

[4] **After-hours** includes Sundays, public holidays, weekdays from 8pm to 8am, and Saturdays from 1pm to 8am.

- Returned home: 55%
- Were admitted (at same hospital or elsewhere): 35%
- Left at own risk without treatment: 5%
- Left at own risk after treatment started: 3%

- Arrived via road ambulance: 25% of patients

- Usual accommodation for people presenting to ED:
  - Lived in a private residence with other people: 86%
  - Lived in a private residence alone: 10%
  - Lived in a residential aged care home: 2.9% (3,659 presentations)
  - Experienced homelessness: 0.3% (383 presentations)

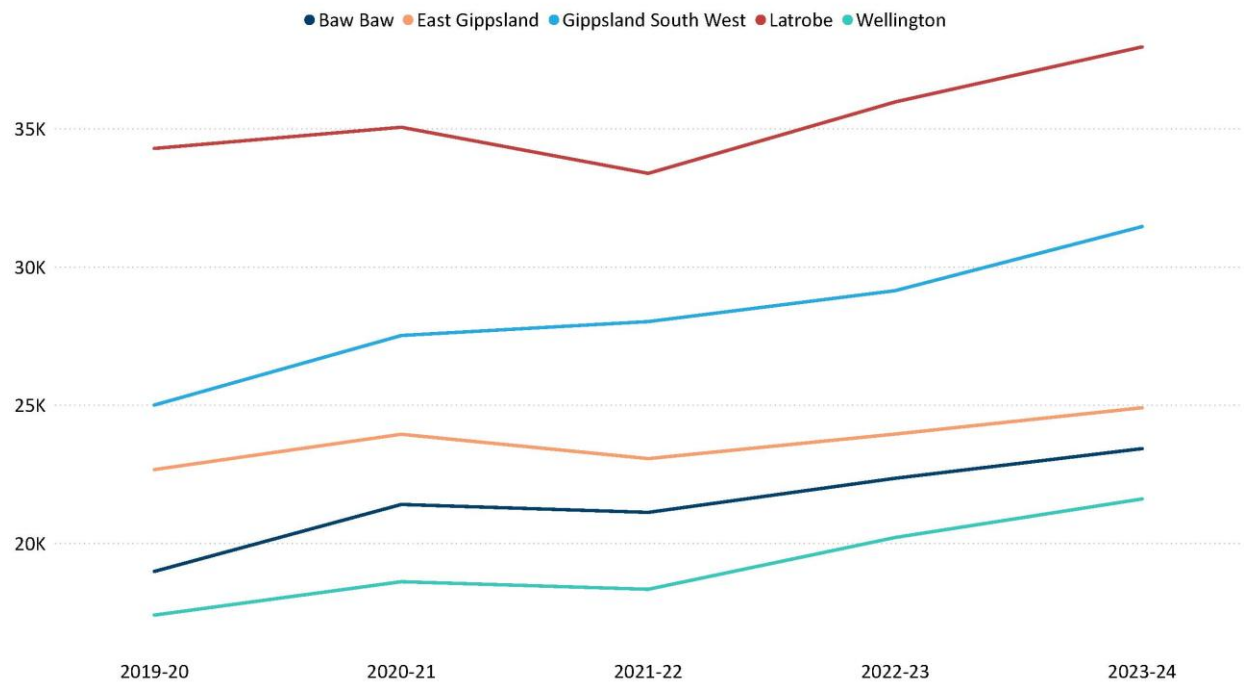
- The top injury cause was 'Falls <1 metre or no height information':
  - 8% of presentations (10,222 presentations)
  - 25% of falls were among 0–14-year-olds (2,526 presentations)
  - 39% were among people aged 65 years or older (3,998 presentations)

- English was the preferred language for 99.6% of presentations

Hospital Admissions – Gippsland residents

There was a total of 139,308 admissions to Victorian public hospitals by Gippsland residents in 2023-24, up from 118,284 in 2019-20 (DH 2024a) (**Figure 19**). This is equivalent to an increase of 4.2% per year over the past five years across the Gippsland region. The highest rate of growth in hospital admissions over the past five years was seen in Gippsland South West (5.9% per year), Wellington (5.6% per year) and Baw Baw (5.4% per year), while admissions in Latrobe and East Gippsland increased at a lower rate (2.6% and 2.4% per year respectively).

Figure 19. Hospital admissions for Gippsland residents by SA3 sub-region, 2019-20 to 2023-24 (DH 2024a).

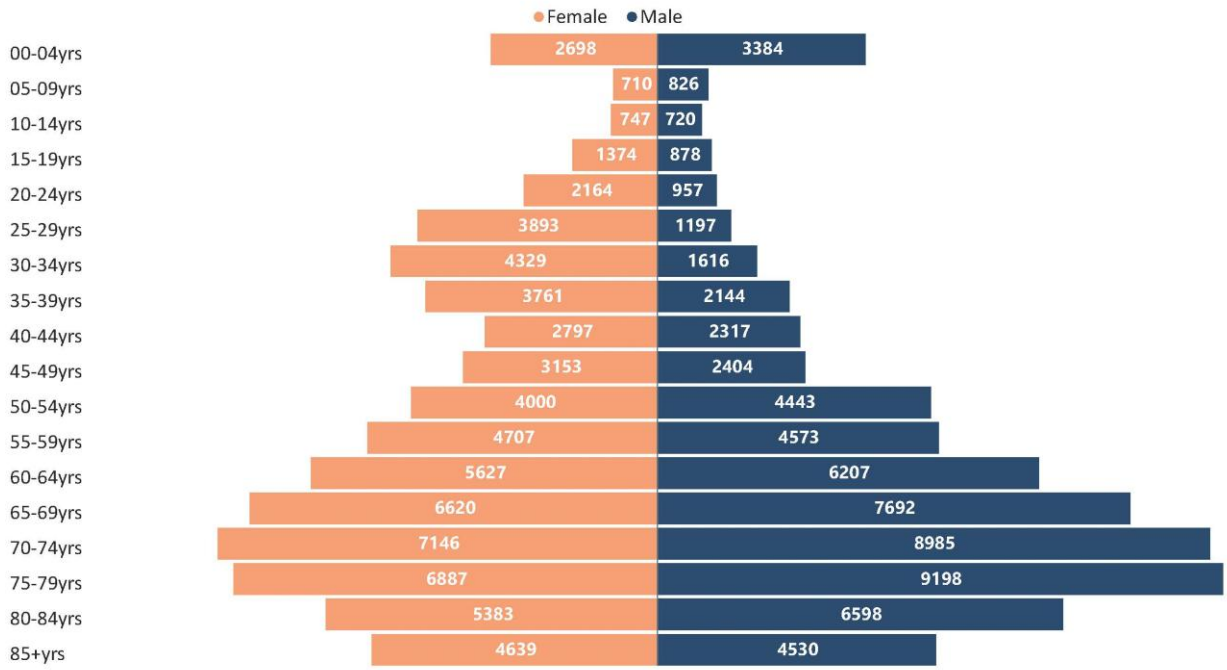


The age and sex distribution for Gippsland residents with a hospital admission in 2023-24 is shown in **Figure 20**. In summary:

- No sex distribution differences were noted,
- 6.5% were aged 0-14 years,
- 3.9% were aged 15-24 years, and;
- 48.6% were aged 65 or older.

It should be noted, as mentioned previously, that 30.6% of all ED presentations were for those aged over 65 years, however 48.6% of admissions were related to this patient cohort. Furthermore, 16.1% of ED presentations were for those aged 0-14 years and 10.5% for those aged 15-24 years, however admission rates among these cohorts were lower, 6.5% and 3.9% respectively.

Figure 20. Hospital admissions for Gippsland residents by age group and sex, 2023-24, n=139,304 (DH 2024a).

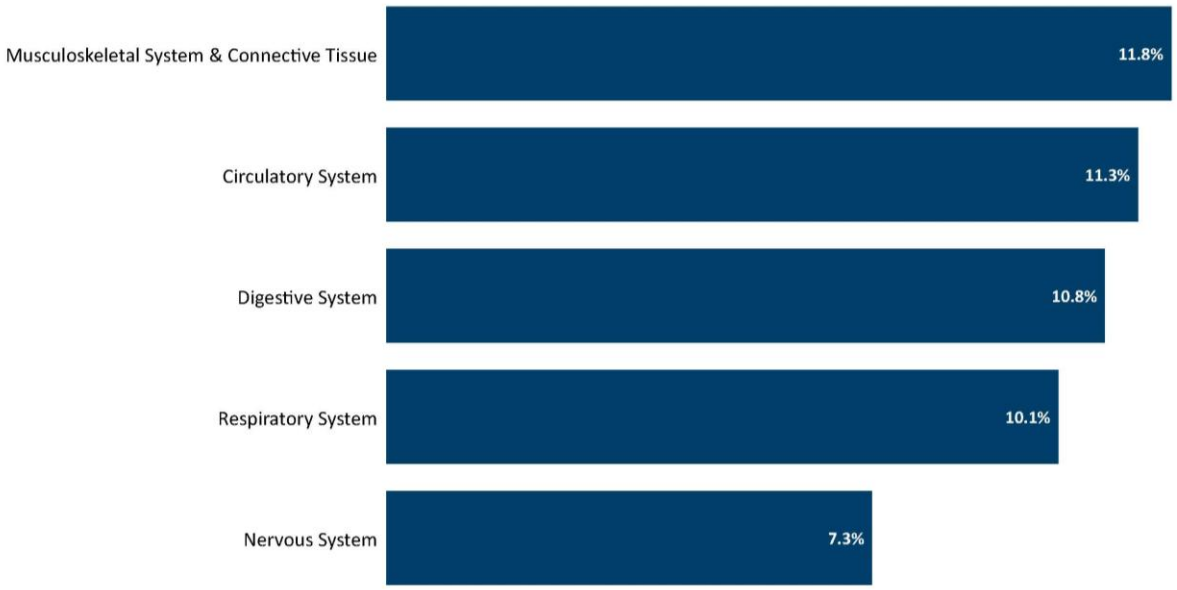


In 2023-2024, there were 53,418 longer admissions (multi-day or overnight), accounting for 38% of total admissions. See **Figure 21** for top five Major Diagnostic Codes (MDC) of longer admissions, noting these made up 51.3% of all overnight & multi-day admissions. For a full list of the major diagnostic codes related to longer admissions, see **Appendix 3.**

The remaining 62% of admissions were same day admissions (85,890 admissions in total). The top reasons for same day admissions were:

1. Haemodialysis: 26% (22,655 admissions)
2. Chemotherapy: 12% (10,393 admissions)
3. Endoscopy (includes colonoscopy and gastroscopy): 12% (10,110 admissions)

Figure 21. Top Major Diagnostic Codes (MDC) for multi-day and overnight admissions for Gippsland residents, percent and number of admissions, 2023-24 (DH 2024a).



Additional insights from admitted hospital data for Gippsland residents in 2023-24 (DH 2024a):

- Of all hospital admissions, 81% were at a Gippsland hospital; the same as 2019-20 and down from 83% in 2021-22. There was variation between SA3 sub-region:
    - Latrobe: 86%
    - Wellington: 84%
    - East Gippsland: 83%
    - Baw Baw: 75%
    - Gippsland South West: 74%

- Discharge destination from hospital was to:
    - Returned to private accommodation or home: 90%
    - Transferred to acute hospital/ extended care: 4.6%
    - Transferred to an aged care residential home: 1.4% (1,193 as usual residence and 802 as not usual residence)
    - Death: 0.9% (1,208 admissions)
    - Left against medical advice: 0.9% (1,193 admissions)

- Discharge referrals were to:

- No referral or support service arranged before discharge: 49%
- Referred to a general practitioner, arranged before discharge: 41%
- Had other clinical care and/or support services, arranged before discharge: 14%

- English was the preferred language for 99.4% of admissions.

The top Potentially Preventable Hospitalisations (PPHs) in 2022-23 in Gippsland varied between genders (DH 2024a). In males, the top three PPHs were related to diabetes complications, Chronic Obstructive Pulmonary Disease (COPD) and congestive cardiac failure; while in females, the top three PPHs were related to iron deficiency anaemia, urinary tract infections and COPD (DH 2024a).

PPHs for diabetes complications were approximately twice as frequent in males compared to females, while PPHs for iron deficiency anaemia were approximately 2.4 times as frequent in females compared to males. For further details, including top ten PPHs by sex with admission figures, see **Appendix 3**.

Gippsland primary healthcare context

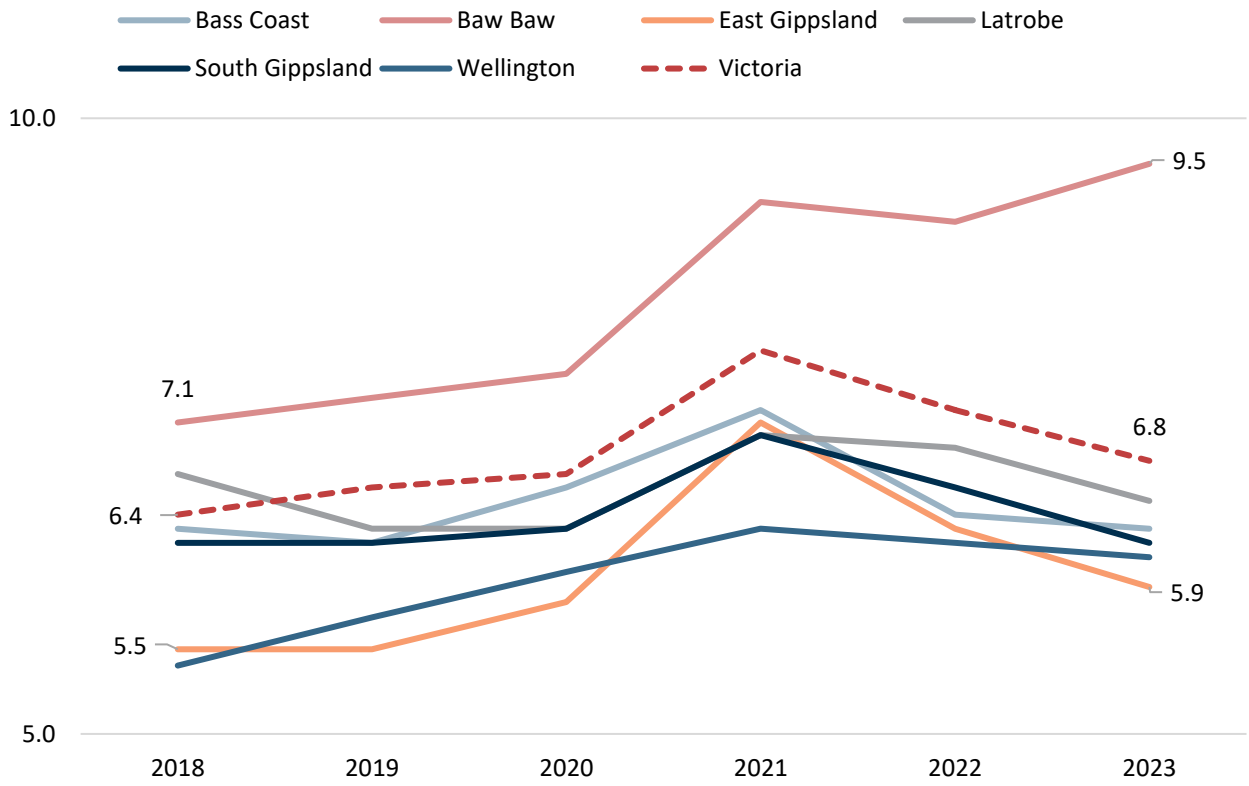
Gippsland-specific general practice data is presented in within the Service Utilisation sections of **Chapters 1-10**. This data contextualises the primary healthcare context in the region, in relation to the respective health priorities identified in this report. Workforce specific data can also be found in **Chapter 5. Health Workforce.**

General Practice Service utilisation

Gippsland residents had an average of 6.9 GP services per person in 2023, similar to 6.8 in Victoria (DoHAC 2024a). There was substantial variation by LGA, see **Figure 22**. It can be noted that:

- Baw Baw had the highest number of services per person at 9.5, up from 7.1 in 2018.
- East Gippsland had the lowest number of services per person at 5.9, up 5.5 since 2018
- All Gippsland LGAs other than Baw Baw had a lower number of services per person compared to Victoria in 2023.
- There was a peak in the number of services per person in 2021 (except in Baw Baw), likely due to improved accessibility of services via telehealth during the COVID-19 pandemic.

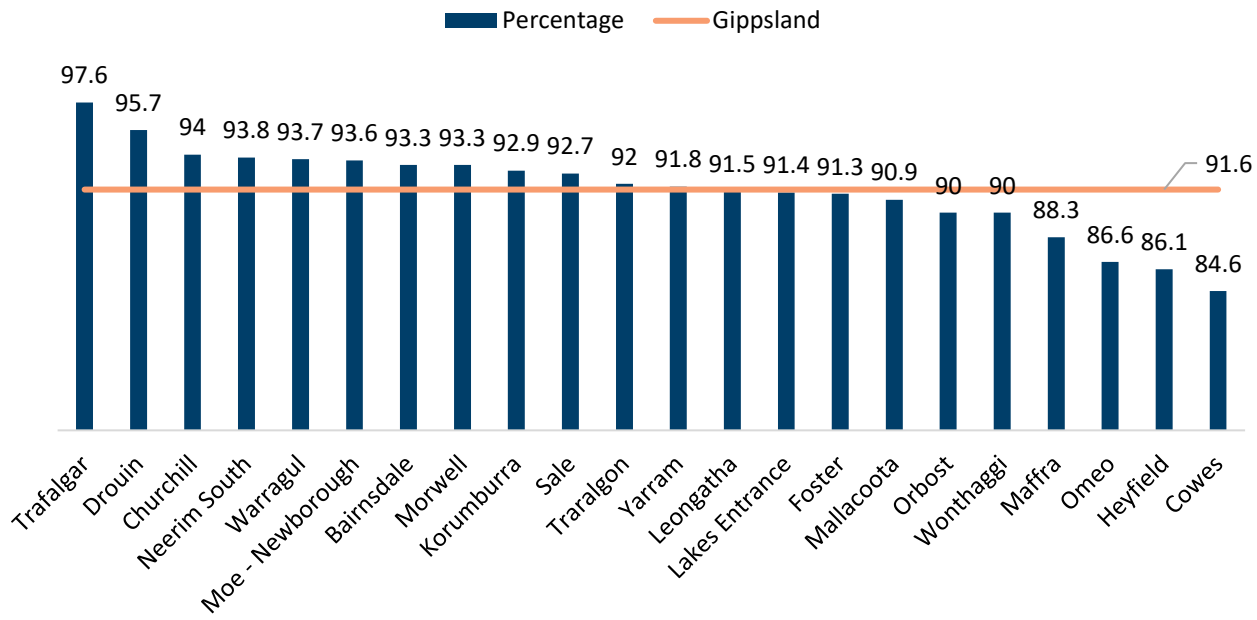
Figure 22. GP services per person, Gippsland LGAs and Victoria, 2018-23 (DoHAC 2024a).



Source: Department of Health, Disability and Ageing (2024a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on 8/10/2024.*
Not for further distribution or publication.

The proportion of residents by GP catchment who used a general practice service during 2023 ranged from a high of 98% in Trafalgar to a low of 85% in Cowes in 2023 (**Figure 23**). A high proportion of residents also used a GP service in Neerim South (94%), Warragul (94%), Moe – Newborough (94%) and Morwell (93%), while low rates were noted in Heyfield (86%), Maffra (88%) and Omeo (87%).

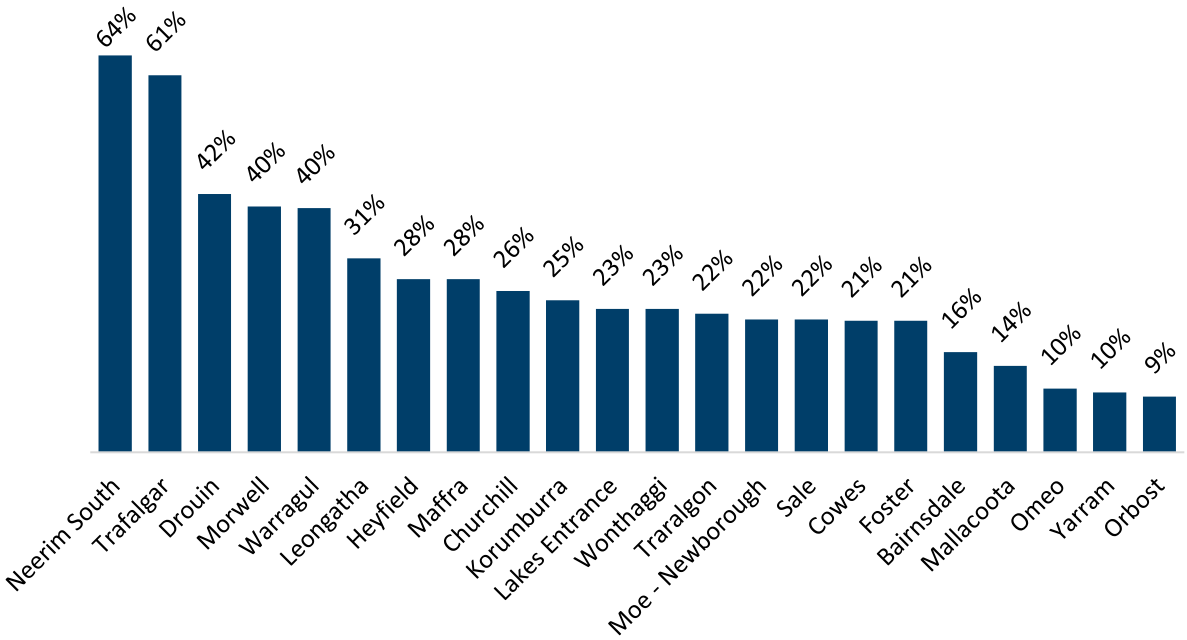
Figure 23. Percentage of GP catchment residents who used a GP service anywhere (in their own catchment or elsewhere) in 2023 (DoHAC 2024a).



Source: Department of Health, Disability and Ageing (2024a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on 8/10/2024.*
Not for further distribution or publication.

- A high proportion of services in Neerim South (64%) and Trafalgar (61%) were delivered to patients residing outside the local catchment. (**Figure 24**).
- The proportion of services delivered to patients residing outside of Victoria is low, ranging between a high of 2.3% in Orbost to a low of 0.6% in Heyfield (no data for Korumburra, Lakes Entrance, Mallacoota, Neerim South, Omeo and Yarram).

Figure 24. Percentage of GP services delivered to patients residing in Victoria but outside the local catchment, 2023 (DoHAC 2024a).



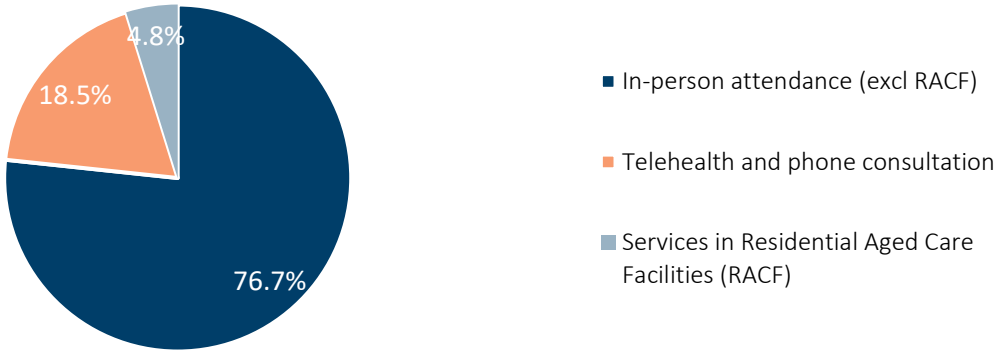
Source: Department of Health, Disability and Ageing (2024a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 8/10/2024*.*
Not for further distribution or publication.

General Practice service delivery type

There was a total of over two million GP services delivered to Gippsland residents in 2023 (DoHAC 2024a). GP service type is displayed in **Figure 25**.

- 76.7% of GP services were provided face to face
- 18.5% were via telehealth and/or phone; ranging from a low of 12% in East Gippsland to 22% in Baw Baw; 21% in Latrobe and 21% in Bass Coast (**Figure 26**)
- 4.8% were provided in Residential Aged Care with a low of 2.9% in Latrobe, 3.0% in East Gippsland, and up to 7.4% in Bass Coast (3.9% in Victoria).
- 1.6% of GP services in Gippsland were provided after hours in 2023; lower than Victoria (5.3%) and similar to 2019 (1.9% in Gippsland and 8.9% Victoria).

Figure 25. GP services by delivery type in Gippsland, 2023 (DoHAC 2024a).



Source: Department of Health, Disability and Ageing (2024a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on 8/10/2024.*
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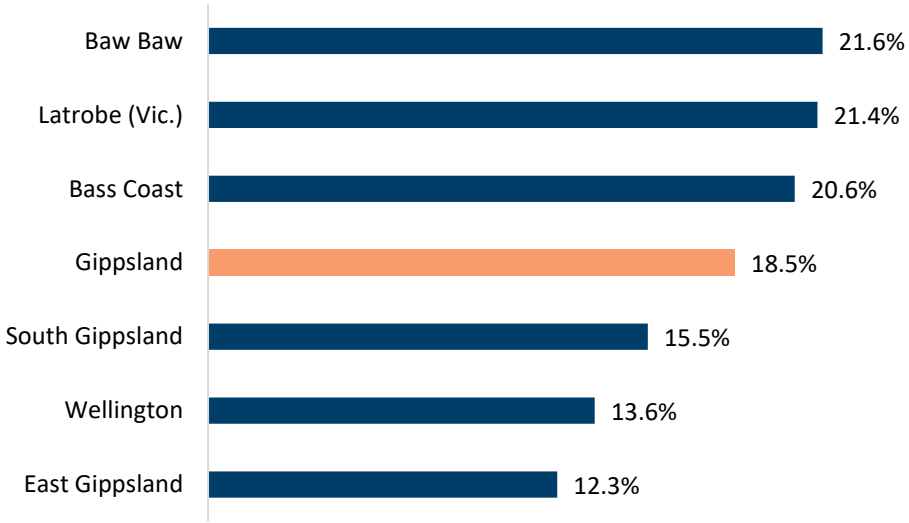
Figure 26. Services by GPs delivered to residents of Gippsland LGAs via telehealth / phone, 2023 (DoHAC 2024a).

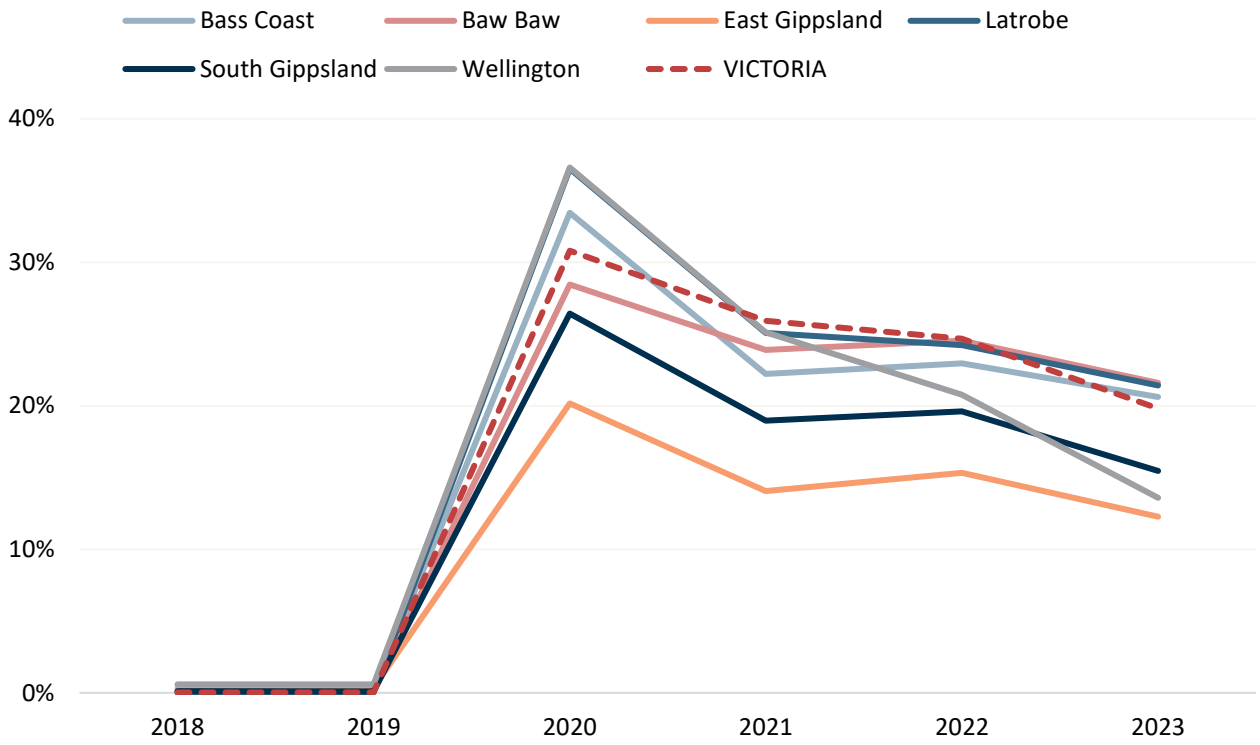


Source: Department of Health, Disability and Ageing (2024a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on 8/10/2024.*
Not for further distribution or publication.

Great variation over time was noted for telehealth and/or phone services by GPs (**Figure 27**).

- In 2023, 18.5% of Gippsland services were provided via telehealth, increasing from 0.2% in 2018 and 2019, rising to 31% in 2020, followed by a gradual decline.
- The proportion of telehealth and/or phone services by GPs was consistently lowest in East Gippsland.

Figure 27. Services by GPs delivered to residents of Gippsland LGAs via telehealth / phone, 2018-2023 (DoHAC 2024a).



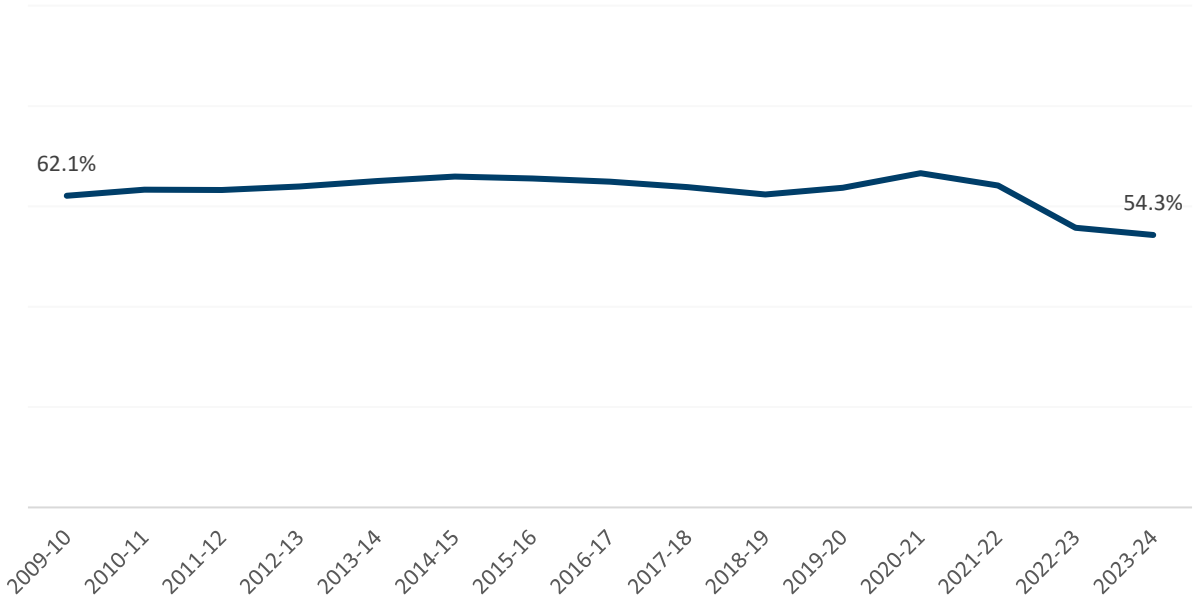
Source: Department of Health, Disability and Ageing (2024a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 8/10/2024.
Not for further distribution or publication.

The sharp increase in Gippsland residents accessing GP telehealth phone and/or video services noted at the beginning of the pandemic in 2020 has not been sustained in recent years. While telehealth funding and policy settings have changed through the pandemic, they are now a permanent part of Medicare, with a range of MBS items still available for telehealth video and telephone consultations for specialists, GPs, mental health practitioners, midwives, allied health providers and nurse practitioners. Despite the gradual decline, with the introduction of Strengthening Medicare initiatives, such as the recently implemented General Practice in Aged Care Incentive (GP ACI) in 2024, telehealth in regional areas is expected to increase as the GP ACI supports telehealth consults for follow-up appointments with aged care residents. In future, the use of telehealth is a care model that is expected to evolve and expand to improve access, especially in regions such as Gippsland with health professional workforce shortages.

Bulk billing

To further contextualise the local primary healthcare landscape, **Figure 28** below presents data on the General Practitioner (GP) Non-Referred attendance bulk billing rates in Gippsland between 2009-10 and 2023-24. It can be noted that there has been a reduction in the percentage of 'always bulk billed' consultations[5] of 0.9% per year over the past 15 years (DoHAC 2024f). Information of Medicare-subsided allied health consultations can be found in **Chapter 8. Chronic Conditions.**

Figure 28. GP Non-Referred Attendance Patient Bulk Billing Rates (excluding temporary COVID-19 vaccine items), 2009-10 to 2023-24 (DoHAC 2024f).



[5] 'Always' refers to being bulk billed 100% of the time.

Professional Stakeholder Perspective

Gippsland PHN stakeholder consultations have noted the following key themes (GPHN 2024e):

Healthcare system challenges

- There is concern about the lack of information sharing and coordination of care between the primary care setting and the acute setting, especially for persons with complex needs that require the involvement of numerous providers.
- There is a lack of understanding of healthcare reform among professionals, including MyMedicare and mental health reform.

> *"Greater linkages between services to ensure clients either don't fall through the cracks or end up linked in with multiple agencies addressing the same things and requiring the client to re tell their stories multiple times."* (Health professional)

> *"…the people at the table when talking happens don't seem to be the people who actually understand what is happening and how things work*." (Health professional and carer)

Pressure on emergency departments

- Pressure on emergency departments seen in in many parts of Gippsland. This leads to long wait times and sometimes delays in the ability to attend to people arriving by ambulance in a timely way. The Urgent Care Centres (UCCs, formerly Priority Primary Care Centres or PPCCs), operating in Baw Baw and Latrobe provide an important alternative and there is strong support for additional sites in Wellington, East Gippsland, Bass Coast and South Gippsland.
- Many factors contribute to the ED pressures, including lack of affordable care options, lack of transport and lack of local after-hours in primary care, including access to pharmacy. Local feedback has also identified a lack of access to aged care beds as a source of delay in discharging patients. However, while these factors are reported by stakeholders, it should be noted that often there may be services in place but knowledge of them can limited.

Ongoing impact of COVID-19

- COVID-19 pandemic impacts linger and there is confusion about where to access care and vaccinations after the closure of specific clinics.

Community, Consumer and Carer Perspective

Insights from the ***Tell Gippsland PHN why you don't access healthcare even if you need it*** engagement project (GPHN 2024c) informed the 2024 Health Needs Assessment. See also **What we did** section. Results are included in relevant sections below and some general themes are included here along with other general insights from Gippsland PHN community, consumer and carer consultation findings.

Some barriers and enablers have been consistently identified as key themes by the Gippsland community and they continue to be relevant based on consultations during 2023-24 (GPHN 2024c & GPHN 2024d). They are presented here in summary form with additional information relevant for identified priority areas included within those sections.

Cost of accessing healthcare

- The cost of accessing healthcare is a key barrier to accessing care. This has been the case since our first major community engagement in 2016; however, it is becoming an even more significant issue as more GP services reduce or stop bulk billing. Additionally, cost of living pressures leads to consumers facing choices between healthcare or essentials like food, shelter and bills. Flow on effects include:
    - Not going or delaying seeing a GP or other healthcare provider, leading to people being more unwell when they do seek care.
    - Not taking medications.
    - Unable to afford relevant referrals for medical specialists, allied health, dental care and diagnostic services due to high gap fees.
    - Unable to access transport due to the added cost, limiting ability to access relevant referral options and also social supports.

      "…many of our families can't get access or don't have the means to pay for services upfront when or if they are available." (Community member)

      "*I leave it as long as I can, then go to get it investigated*." (Community member)

      "People cannot afford to go to GP… should be community service not business enterprise… when people avoid the GP they end up in ED and [it] costs more" (Community member)

Lack of local public referral options

- Lack of local public referral options leads to significant costs. This was described when people were referred to a specialist or allied health provider and often realised they cannot afford to see a private provider who might be available sooner while a public free option can involve a wait of years.

Long wait times

- Long wait times are an ongoing issue impacting many health services and providers. This has flow on effects as health conditions worsen while the patient is waiting for access.

Lack of information about existing services

- A lack of information about existing services and how to access them continues to be raised as an issue across the system. They can be particularly challenging for alcohol and other drug treatment services, mental health services, aged care and after-hours medical services.

Difficulties in accessing a general practitioner

- Difficulties in accessing a GP, and especially a preferred GP in a timely manner, continues to be a commonly reported concern. 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.

  "Society hasn't come to terms with having the general practice as the home rather than a single GP" (Community member)

Poor communication

- People continue to report not feeling heard by their doctor or other health professional, leading to un-helpful consultations (including inappropriate prescribing and referrals) and sometimes a reluctance to continue seeking help.

Lack of equity of access across the region

- The further away from the regional centres you are, the harder it gets to access healthcare. Many services seem to be funded for the whole region but are only available in Latrobe. There are also pockets of disadvantage that are also impacted by service gaps, including the waterline areas of Bass Coast, coastal areas of Wellington and small, remote communities in east Gippsland.

Person-centred care

- People want person-centred, holistic and trauma informed care that is safe and high-quality. This leads to trust and connection.

  "Look at me, listen to me, respect me as a person" (Community member)

Summary

Data presented above provides a high-level snapshot of the health status of the Gippsland community. Key insights from qualitative and quantitative data analysis in relation to the identified priority areas (Chapters 1-10) further contextualises this summary, particularly informed by primary healthcare data. Gippsland PHN acknowledges the complexity of health issues faced by the Gippsland community, and the value of all data in informing Gippsland PHN's core functions and activities as per the National PHN Strategy (2023-24): coordinate, commission, and capacity build (DoHAC 2024g).

Chapter 1: Aboriginal and/or Torres Strait Islander Health and Wellbeing

"Aboriginal health" means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their Community. It is a whole of life view and includes the cyclical concept of life-death-life." - National Aboriginal Community Controlled Health Organisation (NACCHO)

Summary

Gippsland health insights

- There are 5,819 Aboriginal and/or Torres Strait Islander peoples living in Gippsland (ABS 2021a), across East Gippsland (29%), Latrobe (29%), Wellington (16%), and Baw Baw, Bass Coast and South Gippsland (27%).
- Aboriginal and/or Torres Strait Islander Health Checks were recieved by 14.1% of the population in 2023.
- In 2023-2024, 24.7% of Aboriginal and/or Torres Strait Islander patients with activity in a general practice in Gippsland had an active mental health diagnosis.
- Chronic conditions comprised up to 59% of potentially preventable hospitalisations in 2017-2018 to 2020-2021, with diabetes being the leading condition.
- There are five Aboriginal Community-Controlled Organisations (ACCOs) which deliver health and social care services in six locations across Gippsland.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Community-led and owned services and supports for Aboriginal and/or Torres Strait Islander peoples, based on self-determination and data sovereignty.
- Improved access to holistic and trauma informed care for Aboriginal and/or Torres Strait Islander peoples across the Gippsland region.
- Improved support and coordination for Aboriginal and/or Torres Strait Islander peoples accessing mainstream services.
- Improved access to care for Aboriginal and/or Torres Strait Islander children.
- Increased culturally safe practices.
- Improved data quality, including about cultural identification.
- Increased Aboriginal and/or Torres Strait Islander Health Checks and follow up services.
- Increased childhood immunisation rates to meet the 95% target.

Community voices

"I am respected for who I am and for the cultural values I bring with me."

"I want a safe place to go where I'm not judged."

"I want to see and use First Peoples health and wellbeing services."

Introduction and Background

Gippsland PHN is located on the lands of the Gunaikurnai 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. Gippsland PHN also covers the region between Orbost and the Victorian/New South Wales border; this land is currently unceded and research on traditional custodianship is ongoing.

Gippsland PHN acknowledges the past and present trauma and injustices that Aboriginal and/or Torres Strait Islander peoples have endured, and continue to endure, due to colonisation. The historical and ongoing effects of colonisation and racism have a significant negative impact on health and wellbeing (AIHW 2024a). However, cultural factors such as connection to Country, language, self-determination, family and kinship, and cultural expression can be protective and positively influence Aboriginal and/or Torres Strait Islander peoples' health and wellbeing.

Gippsland PHN's vision for reconciliation, as articulated in our Reconciliation Action Plan, is to address Aboriginal and/or Torres Strait Islander people's right to equity of access to culturally safe and inclusive primary health care in Gippsland (GPHN 2023a).

In achieving this vision, we continue to work collaboratively with Aboriginal and/or Torres Strait Islander people, using a strengths-based approach. We aim to share data and information that are relevant and empower sustainable self-determination in accordance with Indigenous Data Sovereignty principles (Lowitja Institute 2024). The contents of this chapter have been informed by ACCO leaders who have guided Gippsland PHN to focus on current strengths in the data as we aim towards building a healthier future for Aboriginal and/or Torres Strait Islander people in Gippsland. We thank them for their time and guidance and look forward to supporting this journey.

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/or Torres Strait Islander people.
- Is a representative body of Aboriginal and/or Torres Strait Islander community controlled peak organisations and members.
- Is built around what Aboriginal and/or Torres Strait Islander peoples have said is important to improve their lives.

- Identifies Four Priority Reforms to change the way governments work, new government accountability measures and shared monitoring and implementation arrangements:
    1. Shared decision-making: Aboriginal and/or Torres Strait Islander peoples are empowered to share decision-making authority with governments to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements.
    2. Building the community-controlled sector: There is a strong and sustainable Aboriginal and/or Torres Strait Islander community-controlled sector delivering high quality services to meet the needs of Aboriginal and/or Torres Strait Islander peoples across the country.
    3. 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/or Torres Strait Islander peoples, including through the services they fund.
    4. Aboriginal and/or Torres Strait Islander peoples 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.

The Aboriginal Health and Wellbeing Partnership Agreement and Action Plan (VACCHO 2024) identifies agreed outcomes and an action plan, developed in strategic collaboration between the Aboriginal Community-controlled health sector, the mainstream health sector and the Victorian Department of Health. The domains are:

- Prevention and early intervention are central to health,
- Culturally safe healthcare,
- A self-determined health system,
- Working from a shared evidence base,
- Building a sustainable health sector.

All data in this section are for Aboriginal and/or Torres Strait Islander peoples in Gippsland where available, with comparisons to Aboriginal and/or Torres Strait Islander peoples in Victoria and/or Australia as indicated. There have been improvements to both demographic and health related data. However, limitations persist across sources of Aboriginal and/or Torres Strait Islander health information (Australian Indigenous HealthInfoNet 2024a). This can make it difficult to estimate the true size of the Aboriginal and/or Torres Strait Islander population, as well as quantify the occurrence of certain health conditions and life events.

Demographics

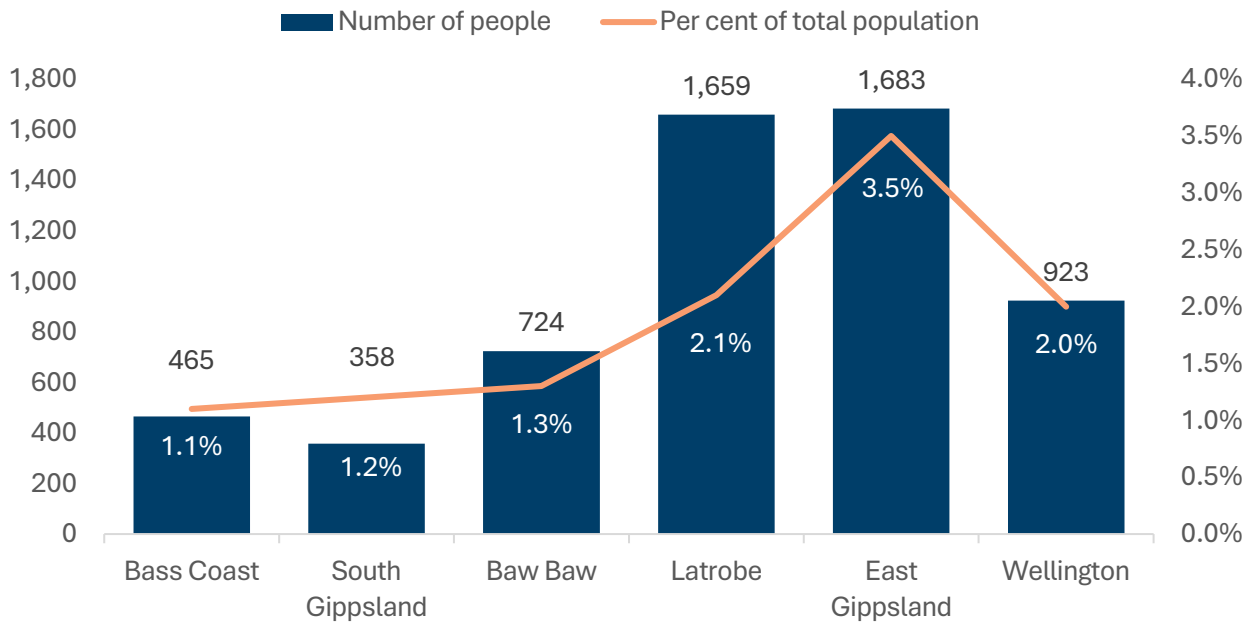
According to the 2021 census, there were a total of 5,819 Aboriginal and/or Torres Strait Islander people living in Gippsland (ABS 2021a), see **Figure 29**. In summary (ABS 2021a):

- Gippsland is home to 8.9% of Victoria's Aboriginal and/or Torres Strait Islander population.
- The median age is 23 years and there are 3.0 people in the average household.
- Population breakdown is as follows:
    - 28% (1,626) aged 0-11 years
    - 24% (1,392) aged 12-24 years
    - 27% (1,599) aged 25-49 years
    - 21% (1,195) aged 50 years or over

It can also be noted that:

- A similar number of Indigenous people live in Latrobe (1,659) and East Gippsland (1,683).
- Of the total population, 3.5% identify as Aboriginal and/or Torres Strait Islander in East Gippsland.
- Of the Aboriginal and/or Torres Strait Islander population, 29% live in Gippsland live in East Gippsland; 29% in Latrobe, 16% in Wellington and 27% live in Baw Baw, Bass Coast or South Gippsland
- Of the total population in Gippsland, 6.5% of individuals did not state their Aboriginal and/or Torres Strait Islander status in the census, so these are considered minimum numbers.

Figure 29. Aboriginal and/or Torres Strait Islander population by LGA in Gippsland, number and percentage of total population, 2021 (PHIDU 2024a)



Factors Affecting Health

Compared to other PHNs, Gippsland had high rates of participation in education and training among Aboriginal and/or Torres Strait Islander peoples, including participation in vocational education and training, where Gippsland had the second highest rate of PHNs (**Table 4**).

In Gippsland, rates of workforce participation were similar to the Australian average for Aboriginal and/or Torres Strait Islander people, but lower than the Victorian average for Aboriginal and/or Torres Strait Islander people (ABS 2021a). Rates of unemployment were similar to the Australian average, but higher than the Victorian average (ABS 2021a).

The median weekly income among Aboriginal and/or Torres Strait Islander peoples in Gippsland was $551 in 2021, ranging from a low of $497 per week in South Gippsland to $662 per week in Baw Baw (ABS 2021a). The rate of low-income households was higher than both Victoria and Australia and in the top 25% of PHNs in Australia (PHIDU 2024a).

Table 4. Education and employment indicators for Aboriginal and/or Torres Strait Islander peoples in Gippsland compared to Victoria and Australia, 2021 (PHIDU 2024a).

	Gippsland	Victoria	Australia
Full-time participation in full-time secondary school education at age 16	79.3%	77.9%	71.4%
Participation in vocational education and training, age standardised rate per 100 (2022)	18.5	17.7	16.4
Labour force participation	54.0%	58.5%	54.1%
Unemployment rate	12.0%	9.6%	12.3%
Low-income households (households in bottom 40% of income distribution)	59.6%	50.1%	53.3%

Health Status

Overview

In Australia, Aboriginal and/or Torres Strait Islander males were expected to live to 71.9 years in 2020-2022, and females were expected to live to 75.6 years (Australian Indigenous HealthInfoNet 2024b). This is slightly higher in inner and outer regional areas (**Table 5**). Gippsland-specific data are not available and comparisons over time are not recommended due to data limitations.

Table 5. Life expectancy of Aboriginal and/or Torres Strait Islander peoples in Australia, 2020-22 (Australian Indigenous HealthInfoNet 2024).

Remoteness	Males	Females
Major Cities	72.5	76.5
Inner and Outer Regional	72.8	76.7
Remote and Very Remote	67.3	71.3

A 2018 Australian Burden of Disease Study outlines the latest national data on the impact and causes of illness and death among Aboriginal and/or Torres Strait Islander people (AIHW 2021a). It was found that 53% of total burden was due to living with illness or injury (non-fatal); while 47% was due to dying prematurely (fatal) (AIHW 2021a).

The top five disease groups causing total burden of disease were (AIHW 2021a):

1. Mental and substance use disorder (23%) – increasing burden due to anxiety disorders, alcohol use disorder and depressive disorders were seen since 2003
2. Injuries (12%) – increase in suicide and self-inflicted injury
3. Cardiovascular disease (11%) – decrease in coronary heart disease, COPD and type 2 diabetes
4. Cancer (9.9%) – slight decrease in lung cancer
5. Musculoskeletal conditions (8.0%) – decrease in rheumatoid arthritis

Of the total burden of disease impacting Aboriginal and/or Torres Strait Islander people, 49% was potentially preventable (AIHW 2021a). The risk factors contributing the most preventable burden in 2018 were (AIHW 2021a):

- Tobacco use (12%),
- Alcohol use (10%),
- Overweight (including obesity) (9.7%),
- Illicit drug use (6.9%), and
- Dietary factors (6.2%).

Chronic conditions

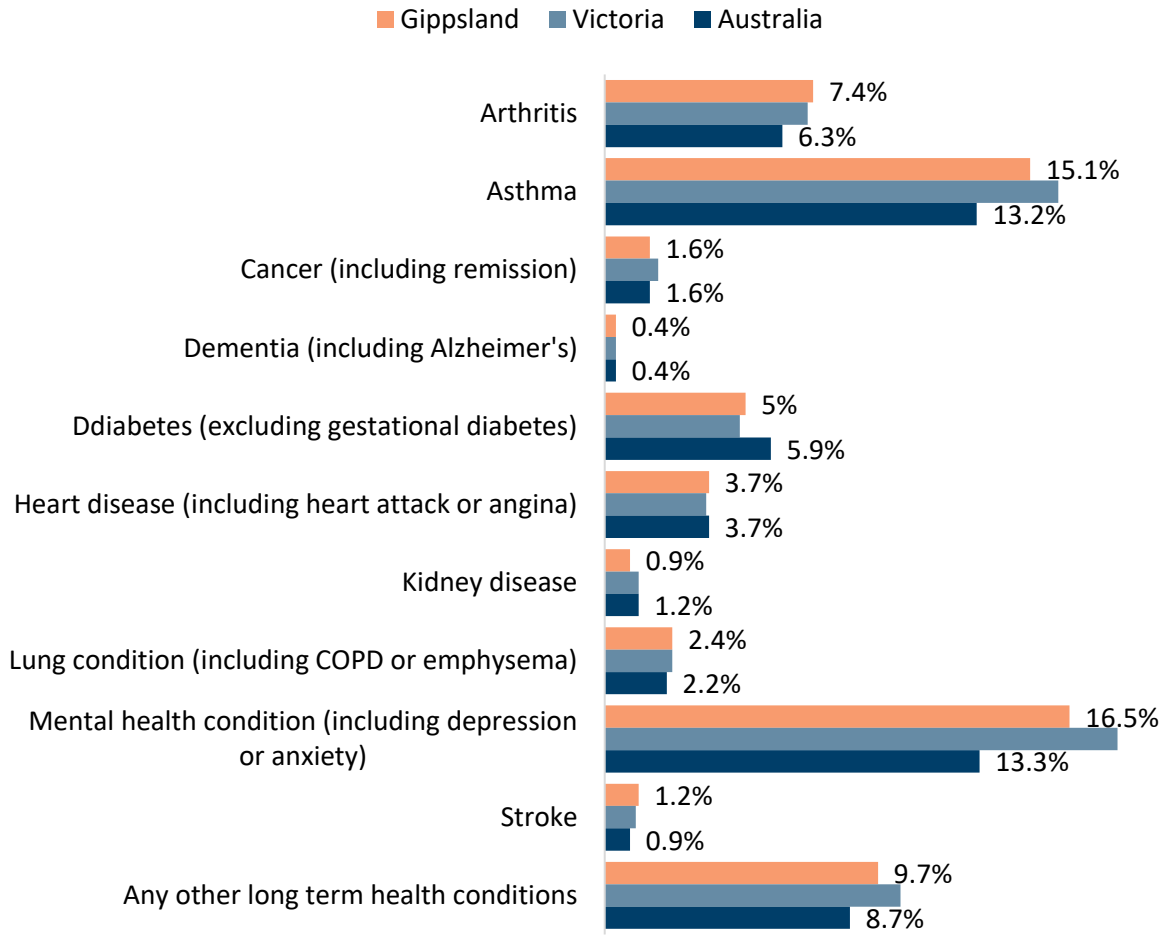
The majority (3,096 people) of Aboriginal and/or Torres Strait Islander peoples in Gippsland self-reported having no long-term health conditions in 2021 (PHIDU 2024a). However, an estimated 1,994 people in Gippsland reported one or more long-term health conditions (**Table 6**).

The most common chronic conditions reported in Gippsland were a mental health condition (16.5%) and asthma (15.1%) (**Figure 30**).

Table 6. Self-reported long-term health conditions of Aboriginal and/or Torres Strait Islander peoples in Gippsland, 2021 (PHIDU 2024a).

	Number	Age Standardised Rate per 100 people
No long-term health condition	3,096	53.4
One long-term health condition	1,267	22.0
Two long-term health conditions	453	7.7
Three or more long-term health conditions	282	4.6
One or more long-term health conditions	1,997	34.2

Figure 30. Self-reported long-term health conditions of Aboriginal and/or Torres Strait Islander peoples in Gippsland compared to Victoria and Australia, 2021 (PHIDU 2024a).



Disability

Based on 2021 census data, 10.7% of Aboriginal and/or Torres Strait Islander people in Gippsland (617 people) had a severe or profound disability, which was the second highest rate compared to other PHNs nationally (**Table 7**). Additionally, Gippsland had the highest rates of Aboriginal and/or Torres Strait Islander people aged 0 to 64 with a profound disability (10%), and persons aged 15-years and over providing assistance to a person with a disability (17.5%). However, Gippsland has the second lowest rates of people aged 65 and over with a profound or severe disability (21.1%).

Table 7. Percentage of Aboriginal and/or Torres Strait Islander peoples in Gippsland with a profound or severe disability, 2021 (PHIDU 2024a).

	Gippsland	Victoria	Australia
People with a profound or severe disability	10.7%	10%	8.2%
People aged 0 to 64 years with a profound or severe disability	10%	9%	7%
People aged 65 years and over with a profound or severe disability	21.1%	24.9%	27.9%
Persons aged 15 years and over providing assistance to persons with a disability	17.5%	16.4%	14%

Children and young people

There were 390 babies born to Aboriginal and/or Torres Strait Islander mothers in Gippsland between 2019 to 2021 (an average of 130 babies per year). This is up from 310 between 2016 to 2018 (an average of 103 babies per year) (PHIDU 2024a).

In Gippsland, 41% of Aboriginal and/or Torres Strait Islander mothers smoked during the first 20 weeks of pregnancy in 2019-2021; a reduction from 51% in 2016-2018.

Aboriginal and/or Torres Strait Islander children in Gippsland, aged 0-14 years, self-reported data suggests (PHIDU 2024a):

- Asthma affects 218 individuals (10.5%, compared to 12.0% in Victoria and 10.4% in Australia)
- A mental health condition affects 99 individuals (4.8%, compared to 5.4% in Victoria and 4.0% in Australia)

Service System

Gippsland has five Aboriginal Community-Controlled Organisations (ACCOs) which deliver health and social care services in six locations. Some services are also delivered through outreach in East Gippsland. These services are:

- Ramahyuck (Sale and Morwell),
- Gippsland and East Gippsland Aboriginal Cooperative (GEGAC, Bairnsdale),
- Lakes Entrance Aboriginal Health Association (LEAHA, Lakes Entrance),
- Lake Tyers Aboriginal Health and Children's Services (Lake Tyers), and
- Moogji Aboriginal Council (Orbost).

Each ACCO works with Gippsland PHN on quality improvement programs and commissioning of services targeted at the Aboriginal and/or Torres Strait Islander population. All also contribute data to the national Key Performance Indicators (nKPIs) and in addition, some Gippsland ACCOs share de-identified data through the PHN-GP data system. One Gippsland ACCO was the second in Victoria to receive Rainbow Tick accreditation.

Services commissioned specifically for Gippsland's Aboriginal and/or Torres Strait Islander population, include:

- The Integrated Team Care (ITC) program is provided across four ACCOs. It aims to assist Aboriginal and/or Torres Strait Islander peoples to access primary health care, assisting eligible Aboriginal and/or Torres Strait Islander peoples with chronic disease/s who require coordinated, multidisciplinary care. It also aims to improve access for Aboriginal and/or Torres Strait Islander people to culturally appropriate mainstream primary care.
- The Indigenous Dual Diagnosis Service (IDDS) supporting Aboriginal and/or Torres Strait Islander people experiencing both mental health and alcohol and drug problems, delivered by ACCOs.
- Cultural awareness training for commissioned services, delivered by Gunaikurnai and Bunurong Elders in consultation with Gunaikurnai Lands and Waters Aboriginal Corporation (GLaWAC) and Bunurong Land Council supported by Gippsland PHN.

The Gippsland LGAs of Baw Baw, Bass Coast and South Gippsland are not serviced by an ACCO. Aboriginal and/or Torres Strait Islander people/s who reside in these areas or visit the area rely on mainstream services for their healthcare. An overview of general practices can be found in **Chapter 5: Health Workforce.**

Service Utilisation

Children and young people

Between 2019 and 2021, 40.2% of Aboriginal and/or Torres Strait Islander mothers in Gippsland had an antenatal visit in the first 10 weeks of pregnancy, compared to 42.3% of Aboriginal and/or Torres Strait Islander Peoples in Victoria (PHIDU 2024a). This is a substantial decrease from 53.5% in Gippsland and 61.5% in Victoria between 2016 and 2018.

Rates of full immunisation for Aboriginal and/or Torres Strait Islander children aged 2 and 5 years decreased in Gippsland[6] between 2018-19 and 2023-24 (**Figure 31**) (DoHAC 2023). For 1 year old children, rates increased (DoHAC 2023) In 2023-24, Aboriginal and/or Torres Strait Islander children in Gippsland were slightly less likely to be fully immunised than in Victoria and Australia, with rates among the lowest 25% of regions nationally for 2-year-old and 5-year-old children (**Table 8**) (DoHAC 2023).

Figure 31. Immunisation rates (fully immunised) for Aboriginal and/or Torres Strait Islander children at 1, 2 and 5 years of age, Gippsland, 2018-19 until 2023-24 (DoHAC 2023).

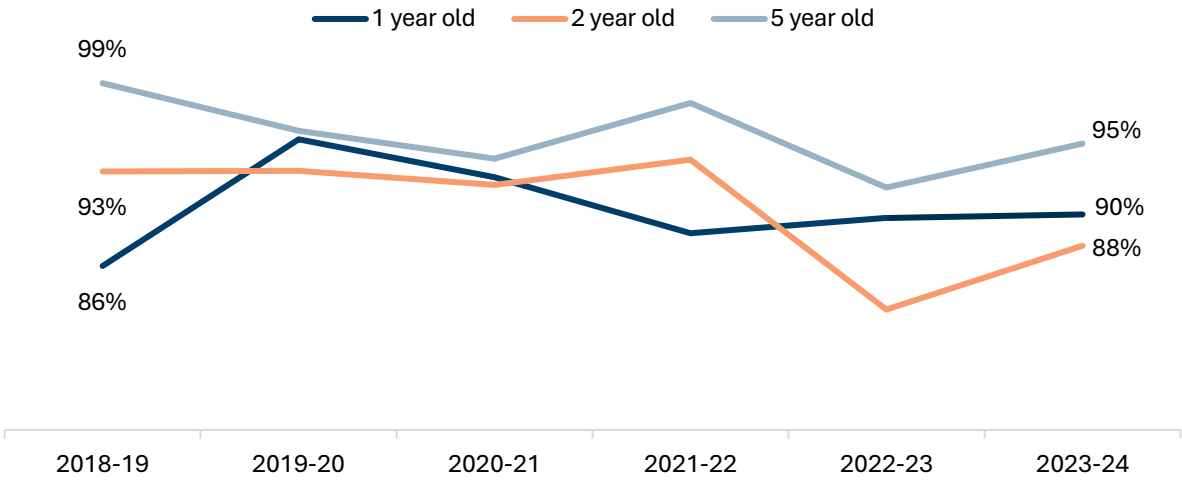


Table 8. Immunisation rates (fully immunised) for Aboriginal and/or Torres Strait Islander children at 1, 2 and 5 years of age, 2023-24 (DoHAC 2023).

Age Group	Gippsland	Victoria	Australia
1 year old children	90.1%	92.4%	90.4%
2 year old children	87.9%	88.4%	88.8%
5 year old children	95.0%	95.7%	95.4%

[6] Gippsland PHN acknowledges feedback from Gippsland and East Gippsland Aboriginal Cooperative (GEGAC) regarding their focus on immunisation and acknowledge the figures reported by Department of Health, Disability and Ageing are likely an underrepresentation of the true rates of immunisation in Gippsland due to issues with data fields used for reporting. Gippsland PHN recognises the continued commitment of all Gippsland Aboriginal Community Controlled Health Organisations to increasing immunisation rates.

General practice

There were 5,709 Aboriginal and/or Torres Strait Islander patients, or 2.4% of all patients that had activities (including in person consultations, phone and online) at Gippsland general practices in 2023-24, with an average of 10.7 activities per patient (GPHN 2024f). Note that these data have limitations, especially since de-identified data were not available for analysis from all general practices in Gippsland[7].

This is up from a total of 5,301 patients with an average of 7.1 activities per person in 2019-20 (noting that direct comparisons are not possible due to changes in how the data were analysed, but improved capture of activity for Indigenous patients is evident).

Of the total 238,071 patients who had activities in 2023-24 across Gippsland, 27% did not have Aboriginal and/or Torres Strait Islander status recorded. This is similar to data quality recorded in 2019-2020. In practice software, Aboriginal and/or Torres Strait Islander status includes 'Non-Aboriginal/Torres Strait Islander', 'Aboriginal', 'Aboriginal and Torres Strait Islander' etc. When this data is not recorded, it can mean that clinics are not aware of Aboriginal and/or Torres Strait Islander status of patients and therefore may not offer services they are entitled to. Distribution by LGA is shown in **Table 9**.

Table 9. Number of Aboriginal and/or Torres Strait Islander patients with activities by LGA, 2023-24 (GPHN 2024f).

LGA	Number of Indigenous patients*	Proportion of patients with Indigenous status not recorded
Bass Coast	260	22.8%
Baw Baw	874	33.5%
East Gippsland	1,436	31.7%
Latrobe	1,919	26.6%
South Gippsland	307	21.6%
Wellington	1,041	16.1%
Gippsland	5,709	27.0%

In 2023-24, 24.7% of Aboriginal and/or Torres Strait Islander patients had an active mental health diagnosis (**Figure 32**) (GPHN 2024f). The next most common chronic diseases were respiratory and cardiovascular with 17.8% and 13.5% of patients respectively (GPHN 2024f).

In 2023-24, the most common current diagnosis among Aboriginal and/or Torres Strait Islander patients seeing a general practitioner in Gippsland was asthma (affecting 803 people), followed by hypertension (affecting 609 people) and depression (affecting 580 people) (**Figure 33**).

[7] Note: Data from GEGAC and Moogji were not available for analysis.

Figure 32. Percentage of Aboriginal and/or Torres Strait Islander patients with an active chronic disease diagnosis in 2023-2024 (GPHN 2024f).

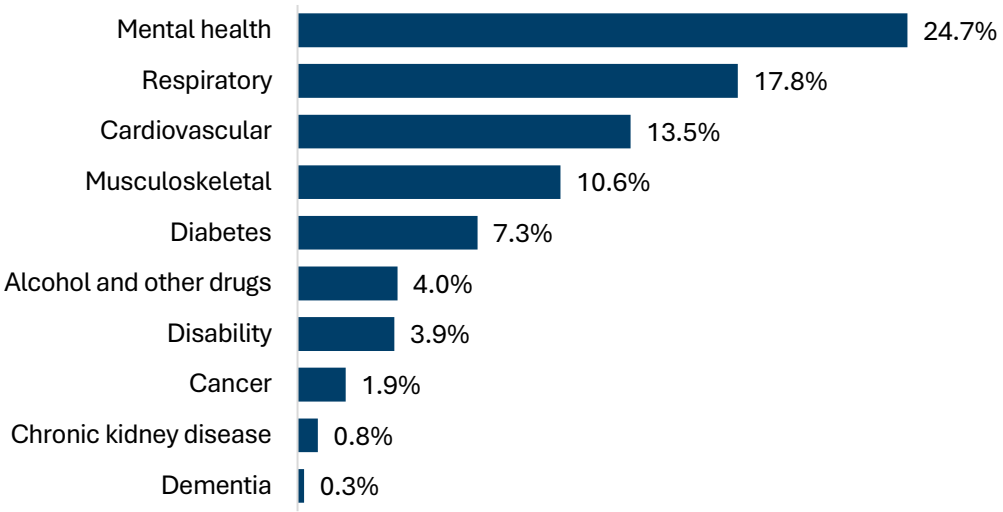
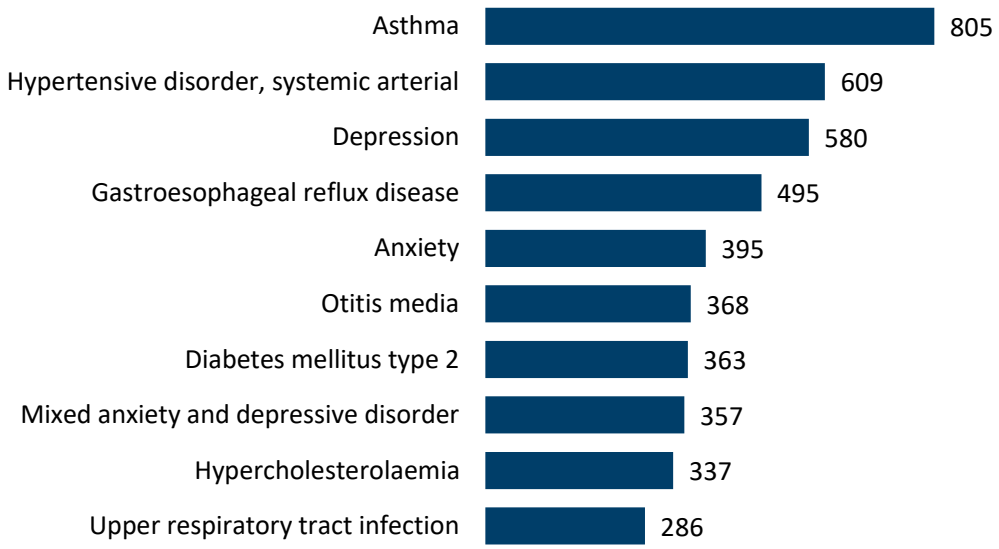
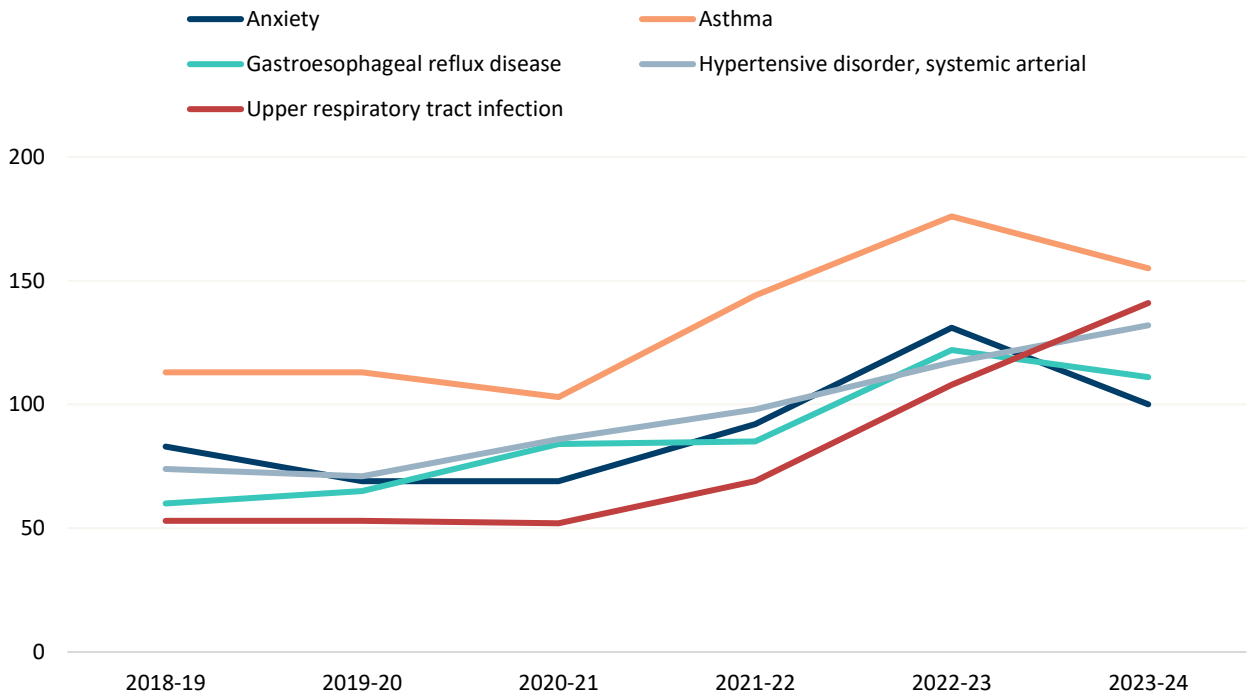


Figure 33. Number of Aboriginal and/or Torres Strait Islander patients with an active top 10 diagnosis, 2023-24 (GPHN 2024f).



The top five conditions have collectively increased by 10.8% per year over the past six years. Asthma has consistently been the most frequent new diagnosis, while Upper Respiratory Tract Infections have grown the fastest, at 21.6% per year (**Figure 34**).

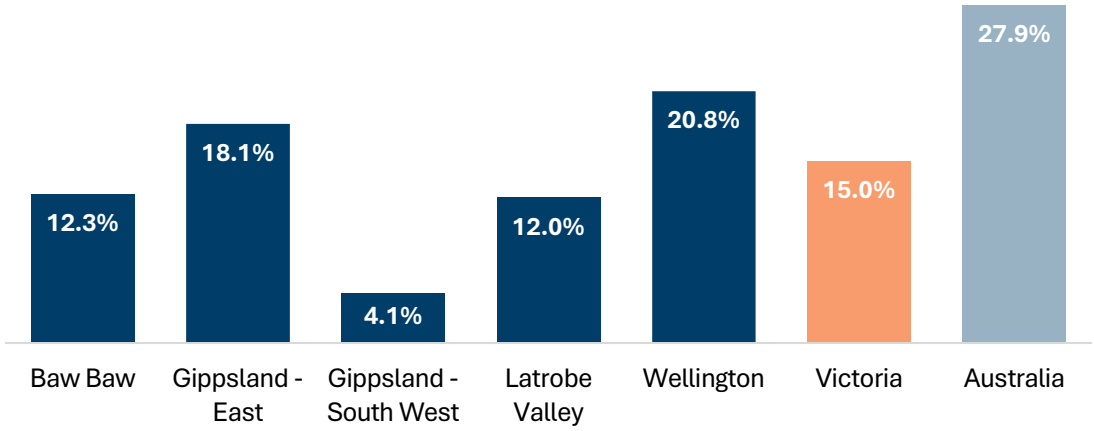
Figure 34. Number of new diagnoses for Aboriginal and/or Torres Strait Islander patients for selected illnesses, 2018-19 to 2023-24 (GPHN 2024f).



All Aboriginal and/or Torres Strait Islander people, regardless of age, are eligible for an Aboriginal and/or Torres Strait Islander health assessment each year using specific MBS items (715 - General Practitioner (GP) or 228 - Other Medical Practitioner (OMP)), including a health assessment provided via videoconference or teleconference (MBS item 92004, 92011, 92016, 92023).

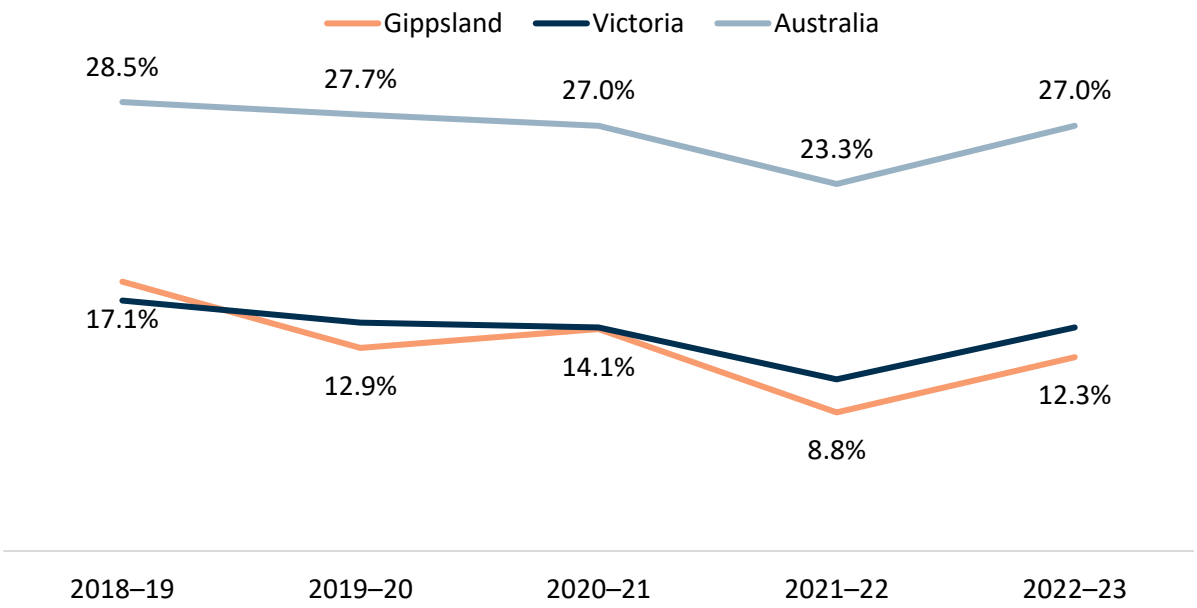
In Gippsland in 2023, 14.1% of Aboriginal and/or Torres Strait Islander peoples received an Aboriginal and/or Torres Strait Islander health assessment, with uptake varying from 20.8% in Wellington to 4.1% in Gippsland South West (**Figure 35**). Wellington and Gippsland – East had higher proportions of Aboriginal and/or Torres Strait Islander health checks than both Gippsland overall and Victoria. Baw Baw, Latrobe Valley and Gippsland – South West were in the lowest quarter of uptake Australia wide, noting that Baw Baw and Gippsland – South West do not have an Aboriginal Community Controlled Organisation.

Figure 35. Aboriginal and/or Torres Strait Islander health checks, percentage of the Aboriginal and/or Torres Strait Islander population, Gippsland SA3 sub-regions and comparison to Victoria and Australia, 2023 (AIHW 2024c).



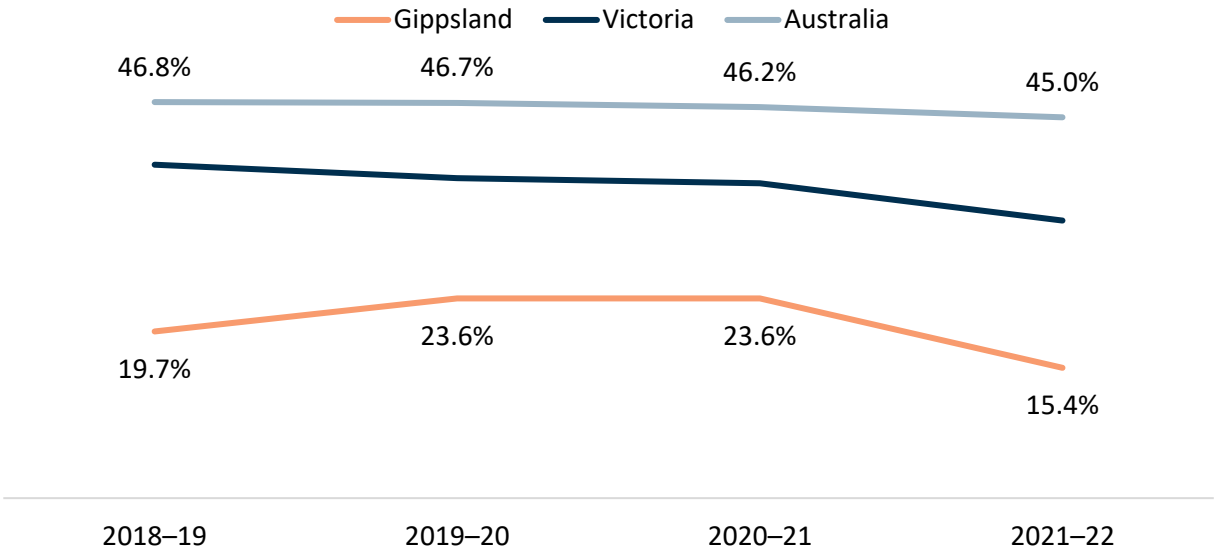
Between 2018-19 and 2022-23, there was a decrease in the proportion of Aboriginal and/or Torres Strait Islander peoples receiving Aboriginal and/or Torres Strait Islander health checks in Gippsland. This has reduced from 17.1% in 2018-19 to 12.3% in 2022-2023 (**Figure 36**). The was also a decrease during this time in Victoria and Australia.

Figure 36. Aboriginal and/or Torres Strait Islander health checks in Gippsland, 2018-19 to 2022-23, with comparison to Victoria and Australia (AIHW 2024c).



In 2021-22, 15.4% of Aboriginal and/or Torres Strait Islander patients who had received a health check in Gippsland received a follow-up service. This has declined from 19.7% in 2018-19 (**Figure 37**) and is substantially lower than both Victoria and Australia.

Figure 37. Use of follow-up services among Aboriginal and/or Torres Strait Islander health check patients, 2018-19 to 2021-22 (AIHW 2024c).



Commissioned services

Integrated Team Care (ITC) Program

- A total of 4,630 ITC services were delivered during 2023-24 including:
  - 2,949 care coordination services for 244 people
  - 1,681 outreach services for 157 people, with pharmacy prescriptions and support to attend appointments the most frequent services utilised.
  - 751 supplementary services, with transport and medical aids most often requested under this funding stream
- Cost of ITC service was approximately $101 per session.
- Service provision over the past 2 years has been relatively consistent, increasing almost 2-fold from 2021-22, however low service provision during that period may have been partially related to COVID-19, and the introduction of a new data management system for providers.

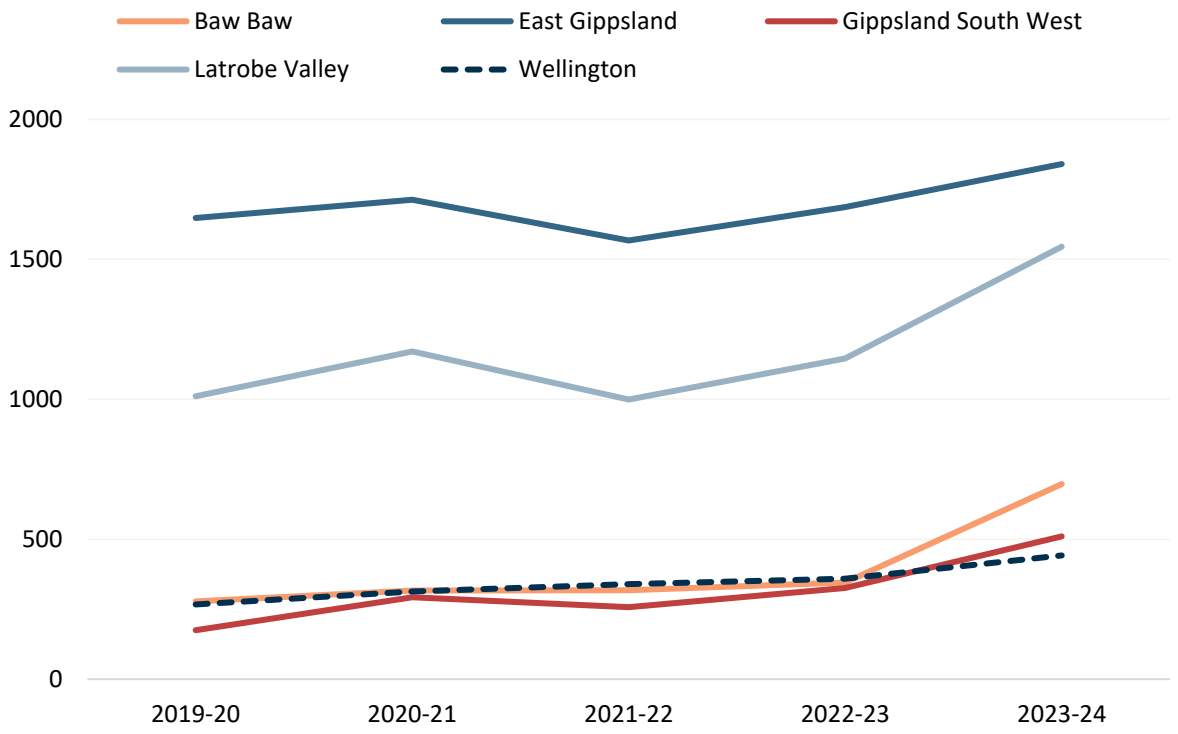
Indigenous Dual Diagnosis (IDDS) program

There were 1,245 hours of service delivery in total provided to participants in the IDDS program in 2023-2024. See also **Chapter 4: Mental health and wellbeing, including suicide prevention** for Primary Mental Health services.

Hospital admissions

There was a total of 5,034 hospital admissions (to public hospitals) for Aboriginal and/or Torres Strait Islander people in 2023-2024, an increase from 3,378 in 2019-2020 (DH 2024a). This is equivalent to an increase of 10.5% per year over five years across Gippsland. Each SA3 sub-region in Gippsland has seen an increase (**Figure 38**). The largest increase over this time period was in Gippsland South West (30.7% per year), Baw Baw (25.8% per year) and Wellington (13.4% per year), with Latrobe and East Gippsland increasing by 11.2% and 2.8% per year respectively. It should also be noted that Baw Baw had a 102% increase in hospital admissions for Aboriginal and/or Torres Strait Islander people between 2022-23 and 2023-24.

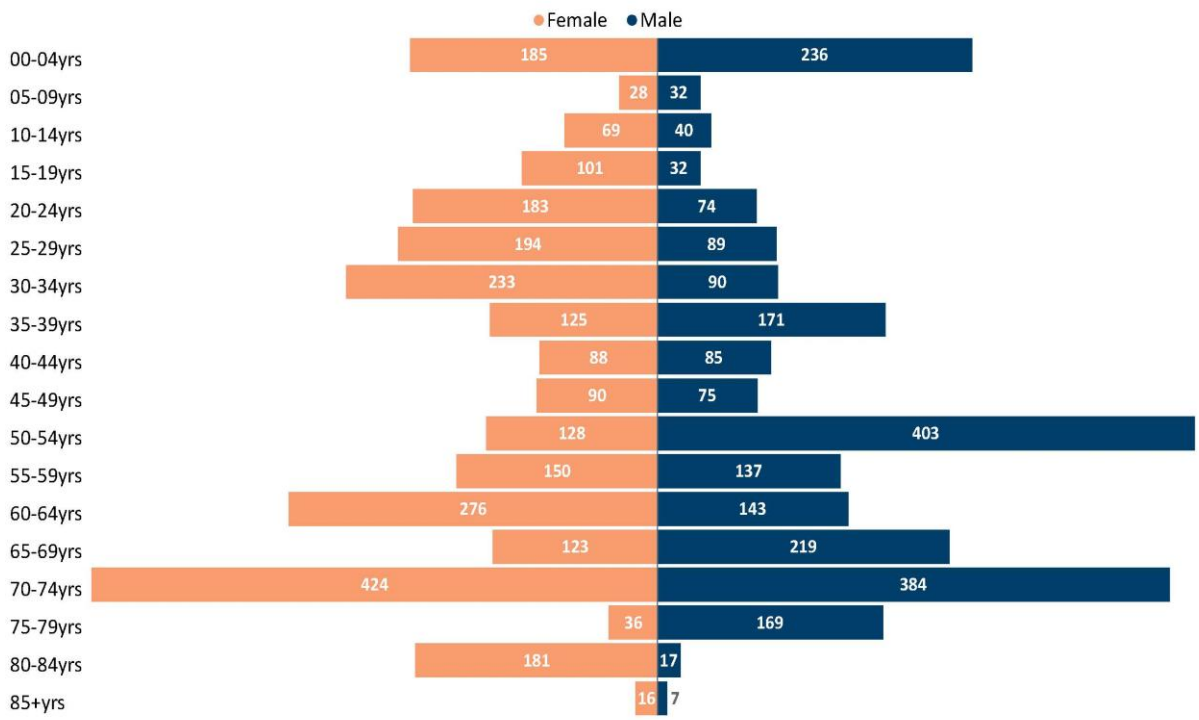
Figure 38. Hospital admissions for Aboriginal and/or Torres Strait Islander peoples in Gippsland by Statistical Area 3, 2019-20 until 2023-24 (DH 2024a).



The age and sex distribution of Aboriginal and /or Torres Strait Islander people admitted in 2023-2024 is shown in **Figure 39.** In summary:

- 50.4% were female
- 11.7% were aged 0-14 years
- 7.7% were aged 15-24 years
- 55.9% were aged 50 years or older (31.3% were aged 65 or older)

Figure 39. Hospital admissions for Aboriginal and/or Torres Strait Islander peoples in Gippsland by age group and sex, 2023-24, n=5,034 (DH 2024a).



In 2023-2024, 63% of admissions were same day admissions (total of 3,150); this is up slightly over time from 62% in 2019-2020, with a low of 58% in 2022-2023. The top reasons for same day admissions were:

1. Haemodialysis: 49% (1,544 admissions)
2. Chemotherapy: 5% (170 admissions)
3. Endoscopy (includes colonoscopy and gastroscopy): 4% (127 admissions)

There were 1,884 longer admissions (multi-day or overnight), accounting for 37% of total admissions. The top Major Diagnostic Codes (MDC) for Aboriginal and/or Torres Strait Islander peoples in 2023-2024 are shown in **Table 10**. All categories saw an increase in the number of admissions over time.

Table 10. Top Major Diagnostic Codes (MDC) for admissions for Aboriginal and/or Torres Strait Islander peoples, percentage and number of presentations in Gippsland, 2023-24, n = 1,884 (DH 2024a).

Major Diagnostic Codes	Percentage	Number
Newborns & Other Neonates	10.6%	199
Diseases & Disorders of the Digestive System	10.2%	193
Pregnancy, Childbirth & the Puerperium	10.0%	188
Diseases & Disorders of the Respiratory System	8.8%	166
Diseases & Disorders of the Musculoskeletal System & Connective Tissue	8.0%	150
Diseases & Disorders of the Circulatory System	7.7%	145
Mental Diseases & Disorders	5.3%	100
Diseases & Disorders of the Nervous System	5.2%	98
Factors Influencing Health Status & Other Contacts with Health Services	4.6%	87
Diseases & Disorders of the Skin, Subcutaneous Tissue & Breast	4.4%	82
Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders	3.9%	73

Additional insights based on hospital data in 2023-2024 (DH 2024a):

- **Proportion of Admissions:** 3.6% of total hospital admissions in Gippsland were for people who identified as Aboriginal and/or Torres Strait Islander.
- **Local Hospital Admissions:** In 2023-2024, 86% of admissions for Aboriginal and /or Torres Strait Islander people were at a Gippsland hospital, down from 89% in 2019-2020, but higher than 84% in 2022-2023
- **Emergency Cases:** Emergency admissions comprised 32% of total admissions; down from 33% in 2019-20 and peaked at 38% in 2021-22
- **RACH Admissions:** 22 admissions originating from Residential Aged Care Homes over five years (2019-2020 to 2023-2024)
- **Discharge Referrals and Support:**
    - No Referral or Support: 51% had no referral or support services arranged at discharge;
    - General Practice Referrals: 38% had a referral in place to general practice
    - Domiciliary Postnatal Care Referrals: 3% had a referral for domiciliary postnatal care
    - Mental Health Services: 2% had a referral for mental health community services
    - Other Referrals: 9% had another referral or support arranged before discharge.

Potentially Preventable Hospitalisations (PPH): The PPH rate for Aboriginal and/or Torres Strait Islander peoples in Gippsland decreased from 5,133 admissions per 100,000 people (age-standardised rate) in 2016-2017 to 2018-2019 (PHIDU 2021) to 4,720 in 2017-2018 to 2020-2021 (PHIDU 2024a).

- **Comparison to Victoria:** Despite the reduction, the PPH rate in Gippsland remains higher than Victoria's rate of 3,557 admissions per 100,000 people in 2017-2018 to 2020-2021)
- **Regional variation:** Bass Coast and South Gippsland rates (per 100,000) were low (2,030), while Baw Baw rates were high (8,349)
- **Chronic conditions leading to PPH:** 59% of PPH were due to chronic conditions, with the top 3:
    - Diabetes: 22%, up from 18%
    - Chronic Obstructive Pulmonary Disease: 15%, down from 17%
    - Iron deficiency anaemia: 9%, steady

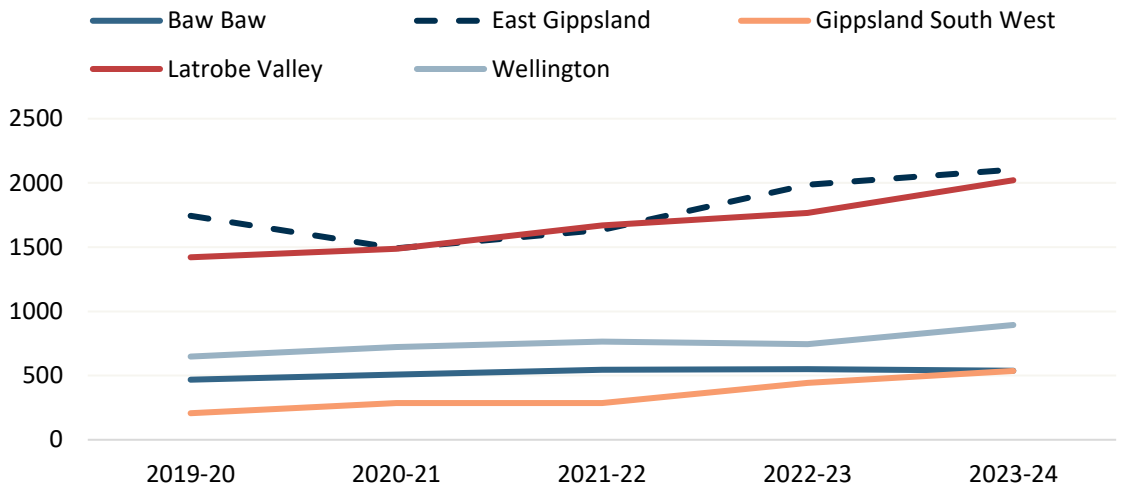
Emergency Department presentations

There were 6,094 total Emergency Department (ED) presentations (to public hospitals) for Aboriginal and/or Torres Strait Islander peoples in Gippsland in 2023-2024, up from 4,487 in 2019-2020, (DH 2024b). All SA3 sub-regions in Gippsland have seen an increase (**Figure 40**).

Over the past 5 years, Gippsland presentations have grown at an annual growth rate of 8%. Within the region, the LGAs individually are growing at:

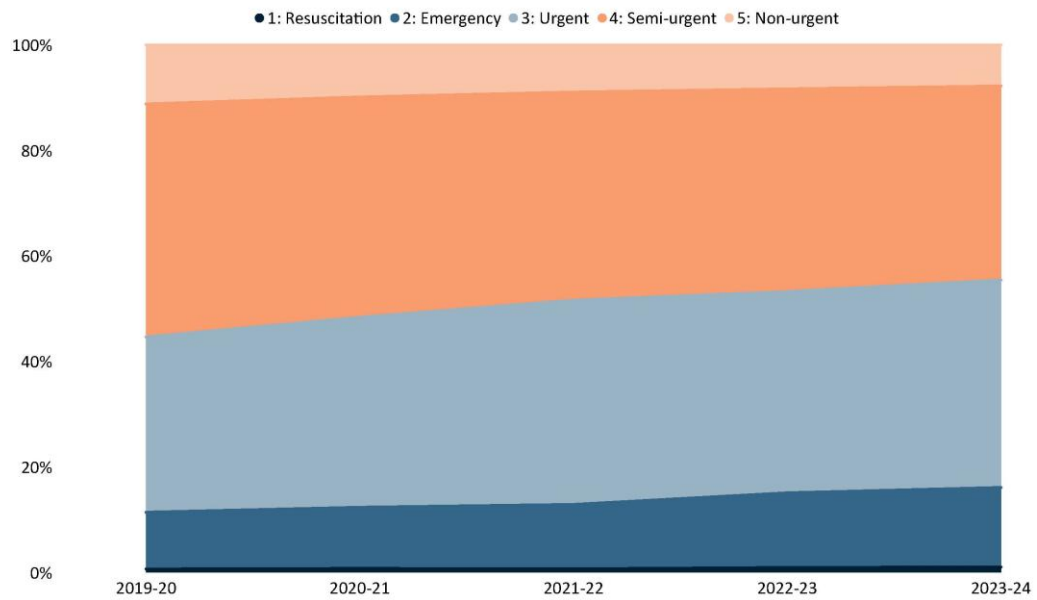
- Baw Baw: +3.6% per year
- East Gippsland: +4.8% per year
- Gippsland South West: +26.9% per year
- Latrobe: +9.2% per year
- Wellington: +8.4% per year

Figure 40. ED presentations by Aboriginal and/or Torres Strait Islander peoples in Gippsland by Statistical Area 3, 2019-2020 until 2023-2024 (DH 2024b).



ED presentation for Aboriginal and /or Torres Strait Islander people have increased 8% per year over the past 5 years, with Emergency and Urgent presentations increasing 17.4% and 12.6% per year, respectively (**Figure 41**). By contrast there was a decrease in semi-urgent and non-urgent presentations, collectively reducing from 55% to 45% of total ED presentations between 2019-20 and 2023-2024.

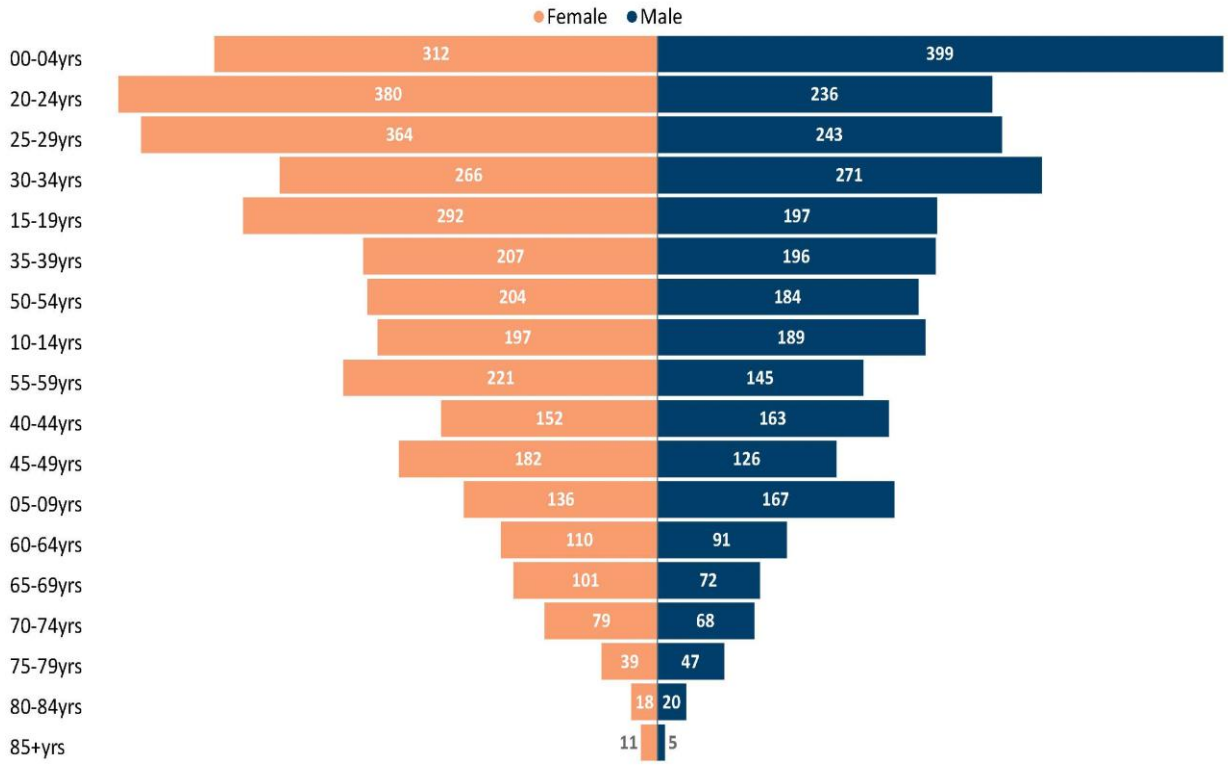
Figure 41. ED presentations by Aboriginal and/or Torres Strait Islander peoples in Gippsland by triage category, 2019-2020 until 2023-2024 (DH 2024b).



The age and sex distribution of Aboriginal and /or Torres Strait Islander peoples presenting to ED in 2023-2024 is shown in **Figure 42**. In summary:

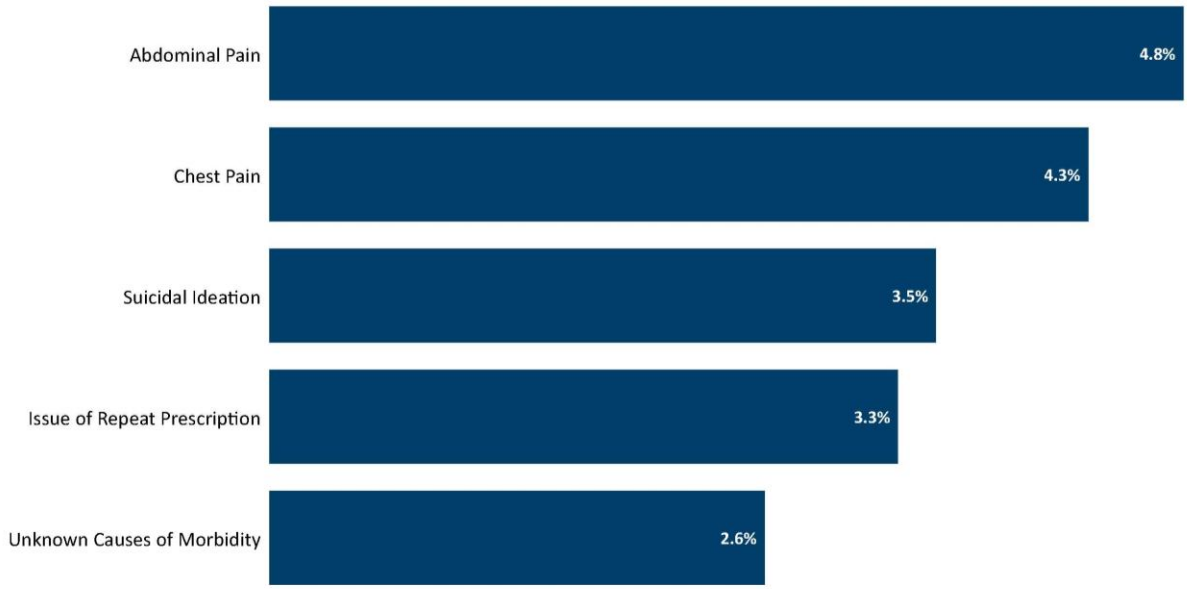
- 53.7% were female
- 23.0% were aged 0-14 years
- 18.1% were aged 15-24 years
- 23.2% were aged 50 years or older (7.6% were aged 65 or older)

Figure 42. Hospital admissions for Aboriginal and/or Torres Strait Islander people in Gippsland by age group and sex, 2023-24, n=6,090 (DH 2024b).



The top five diagnoses among ED presentations are shown in **Figure 43** (DH 2024b). For a complete list of top diagnoses among ED presentations for Aboriginal and/or Torres Strait Islander peoples, see **Appendix 6**. Among lower urgency presentations[8] the top diagnosis was 'Issue of repeat prescription', accounting for 6.1% of presentations (127 presentations).

Figure 43. Top diagnoses* among ED presentations for Aboriginal and/or Torres Strait Islander peoples (ICD-10 codes), percentage of all presentations and number of presentations in Gippsland, 2023-2024 (DH 2024b).



Additional insights from ED data for people identifying as Aboriginal and/or Torres Strait Islander in 2023-2024 are as follows:

- Of Gippsland resident presentations to ED (127,750), 4.8% of these were for people who identified as Aboriginal and /or Torres Strait Islander (6,094).

- The majority (93%) of ED presentations for Aboriginal and /or Torres Strait Islander peoples were at a Gippsland hospital in 2023-2024, down from 96% in 2019-2020.

[8] Lower urgency ED presentations are defined as presentations at formal public hospital EDs where the person:

- Had a type of visit to the ED of *Emergency presentation*
- Had a triage category of *semi-urgent* (triage category 4: should be seen within 60 minutes) or *non-urgent care* (triage category 5: should be seen within 120 minutes)
- Did not arrive by ambulance, or police or correctional vehicle
- Was not admitted to the hospital, not referred to another hospital, and did not die

- **After-hours ED presentations:** comprised 59% of all presentations in 2023-2024 and this has been consistent since 2019-2020, except for 2021-2020 when it made up 62%.

- **Departures from ED** (in 2023-2024):
    - Returned home: 59%
    - Were admitted (at the same hospital or elsewhere): 26%
    - Left at own risk without treatment: 7%
    - Left at own risk after treatment started: 6%

- **Arrived via road ambulance:** 27% of patients

- **Usual accommodation for people presenting to ED:**
    - Lived in a private residence with other people: 87%
    - Lived in a private residence alone: 9%
    - Experienced homelessness: 1.4%
    - Lived in a residential aged care facility: 0.7%

- The **top injury cause** was 'Falls <1 metre or no height information', mainly seen in children (38% of falls were among 0–14-year-olds).

Professional Stakeholder Perspective

"Holistic / multidisciplinary services are preferred for Aboriginal and Torres Strait Islander people"

Gippsland PHN stakeholder consultations have noted (GPHN 2024e):

- Chronic disease management, mental health and socioeconomic determinants of health such as employment and housing were identified as key issues for Aboriginal and /or Torres Strait Islander peoples.
- Service and workforce gaps including Aboriginal and/or Torres Strait Islander health workers and culturally specific services were identified by stakeholders.

Insights from ACCOs (2024):

- Seeing many people with mental health issues but lacking a diagnosis
- Also seeing alcohol and other drug issues, often related to mental health
- Mental health issues and alcohol and other drug issues often occur together with chronic disease
- Lack of mental health and AOD diagnoses leads to deterioration of other conditions
- Some people don't access healthcare and for some, even outreach services are too structured
- Yarning and doing a BBQ at the park can work well to reach the whole community

Service gaps and barriers have been identified (GPHN 2024e):

- A lack of dental services that are free to access, with one main provider no longer providing this service
- A lack of transport to get to health services
- A lack of access to affordable medical specialists.
- Workforce challenges experienced by providers, especially for mental health and alcohol and other drug services.
- Long wait times are an ongoing issue.

Services commissioned providers of Integrated Team Care and other services for Aboriginal and/or Torres Strait Islander clients in Gippsland have reported some barriers and opportunities for improvements:

- There are workforce challenges.
- It is recognised continuity of care is important for building relationships.
- Ongoing professional development in evidence based chronic disease management is considered important.
- Employment of Aboriginal and /or Torres Strait Islander Liaison officers / health workers may support improved care coordination:

"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."

- Appropriate support for people who are unable to read and write is an identified need

  "…clients aren't at the stage of self-managing due to inability or unable to read or write."

- Additional resources for health promotion and prevention would benefit young people's health checks.

Community, Consumer and Carer Perspective

Community engagement with Aboriginal and/or Torres Strait Islander peoples has noted the following (GPHN 2024c and GPHN 2024d):

Social determinants

- Many health issues are related to childhood experiences, including:
    - Police/jail interactions for children and/or family
    - Availability of a caring family member
    - Uncertainty about ancestry and family connections
- Several social factors affect health in important ways and make it harder to access support and to trust people; key factors highlighted were:
    - Racism experiences
    - Homelessness
    - Family violence

    "You know, there's a lot of homeless people I see in town. They've got no help, no support, no nothing."

    "Orange Door [family violence service entry point] *… I didn't know what to say properly with them when I rang up, so I kind of just kind of let that go a little bit too, because I don't know what I'm meant to say..."*
- Work and study opportunities are important for people's health and wellbeing.
- Some communities feel like people are not listening to them.

Health issues

- Reported health issues included:
    - Mental health issues, often related to childhood and/or ongoing trauma and family violence

      "I need a new health plan because, my depression is really bad…"
    - Heart and lung health were described as main health issues
    - Alcohol and other drug issues are often happening alongside mental health issues
- Learning coping mechanisms to manage own mental health

  "My doctor that I'm talking to has been able to help me formulate approaches to help keep myself calm and bursting out such as square breathing."

Accessing services

- Some people prefer to go to mainstream service providers

  "I like to go through mainstream stuff."

- Poor experiences, but also good ones.

  "And especially if you happen to be a woman and a person with a disability, you're not going to get the help you need. They're going to put everything down to the fact that you have an intellectual disability, or a … traumatic brain injury. And they won't actually look into your mental health."

  "…my last doctor has been really good to me."

Ideas for improving health

Aboriginal and/or Torres Strait Islander respondents shared ideas about what would improve their health (GPHN 2024c and GPHN 2024e):

- Community:
  - Consult the elders

    "There's a lot of people overlook the elders. There's a broad range of knowledge that they have … this touches on what we should be doing for everyone's health."

  - Local educational opportunities that are culturally appropriate

    "… there's a Koori support worker, which I'm able to go to with any situations…"

    "Koori or Indigenous program … generally everyone just … has the chat and everyone has fun. But at times we also do activities …that help like boost our knowledge of our background."

  - Community activities where people can come together in a non-formal way
- Health professionals
  - Trusted doctor who listens to patient issues and concerns

    "I don't trust anyone. They need to listen to the patient who knows their body. Number one and foremost. And I need to be heard when I'm going to a doctor. Listen to me. Listen to me."

  - Support workers for people with complex issues.

    "I need a worker. I just need a worker… please don't think I'm lazy because I'm not. … like I really need this help do you know what I mean?"

  - Access to female doctors can be important

- Support from allied health professionals can be a real help

  "… so I think I talk more to my pharmacist …he's lovely, than the actual doctor."

- Access to services
  - Drop in or same day appointments locally and free services
  - Outreach services for marginalised people

    "More outgoing community support programs would be nice."
  - Support for young people

    "I want what's best for these communities today, like the youth program and stuff like that. Because there's nothing out there for these kids."

Other research

Findings related to health and wellbeing from engagement with Aboriginal and/or Torres Strait Islander peoples in Latrobe (LHA, 2020) 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 are required.
- Cultural connection and mental health comes first; Aboriginal and /or Torres Strait Islander peoples 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 and /or Torres Strait Islander peoples 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.

Chapter 2: Healthy Ageing (People Aged 65+)

Healthy ageing, also termed positive ageing, is where persons 65+ years are supported to maintain their health and independence with various levels of care required to achieve this. Empowering the ageing community to plan for this stage of life to enable some control over decision making is important. Activities to support positive and healthy ageing include engaging in preventative healthcare, maintaining adequate levels of physical activity and exercise, consuming a healthy diet, caring for mental health needs, engaging with social networks, whilst managing any chronic health issues. Over time ageing needs can change from independence to requiring the involvement of a variety of supportive care environments to assist.

Summary

Gippsland health insights

- Gippsland has a higher proportion of residents aged 65 years or older (24.8%), compared to Victoria (16.8%) and Australia (16.2%).
- Bass Coast and East Gippsland have a notably high prevalence of people living with Dementia
- Approximately 66% of Gippsland residents receive the aged care pension.
- The age-standardised rate of deaths from accidental falls in Gippsland was 15.4 per 100,000 population, substantially higher than the Australia average of 8.3 per 100,000 people.
- Gippsland has 53 residential aged care homes and one multi-purpose service including residential.
- The growing demand for workers coupled with constraints on workforce availability is resulting in strong competition for workers and occupational shortages across many industries, including aged care.
- These impacts are more acute in regional areas like Gippsland and industries that have historically relied heavily on migrants to meet demand.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Improved support for people living with dementia, their family and carers.
- Improved access to services and supports promoting healthy ageing.
- Improved communication between clinicians, consumers and carers about treatment choices, including palliative care.
- Improved care coordination, including addressing elder abuse and alcohol and other drug misuse.
- Improved social support for older people.
- Reduced avoidable deaths and hospital activity due to falls.
- Increased access to GP services in aged care.

Community voices

"I can work out how the health system works and how to get the health care I need."

"I want to be heard and respected."

"I want to be able to access a doctor with knowledge of working with dementia."

"I would like to receive care and die in my community and not have to move away."

Health Status

Demographic overview

It is estimated that 24.8% of the Gippsland population are aged 65 years or older, compared to 16.8% in Victoria and 16.2% in Australia (ABS 2021a). An even higher proportion is seen in Bass Coast (29.5%) and East Gippsland (30.9%) respectively.

By 2030, 28.1% of the Gippsland population are projected to be aged 65 years or older compared to only 17.1% in Victoria (PHIDU 2021). In Bass Coast and East Gippsland this percentage is expected to increase to 33.5% and 34.9% respectively.

Descriptive statistics for Gippsland people aged 65 years or older are detailed below:

- **Diversity:** Over 6,400 people were born in a non-English speaking country with the most common countries of origin: Netherlands (1,500 people), Italy (1,100 people), Germany (1,075 people), Malta (375 people), Greece (175 people) and Croatia (150 people) (PHIDU 2021).
- **Languages spoken:** Top languages spoken at home among people aged 65 year and older with low English proficiency are Mandarin, Italian, Vietnamese, Greek and Thai (PHIDU 2021).
- **Disability:** People with a profound or severe disability comprise 16.1% (less than the Victorian average of 19.4%) (PHIDU 2021).
- **Income:** People on low income comprise 49.8%, similar to the Victoria average of 47.1% (PHIDU 2021).
- **Living arrangements:** 25.4% live alone, and 9.0% rent, which is similar to Victorian averages of 25.3% and 10.3% respectively (PHIDU 2021).
- **Internet access:** Only 27.5% of older adults accessed the internet from home, far less than the Victorian average of 64.8% (PHIDU 2021).

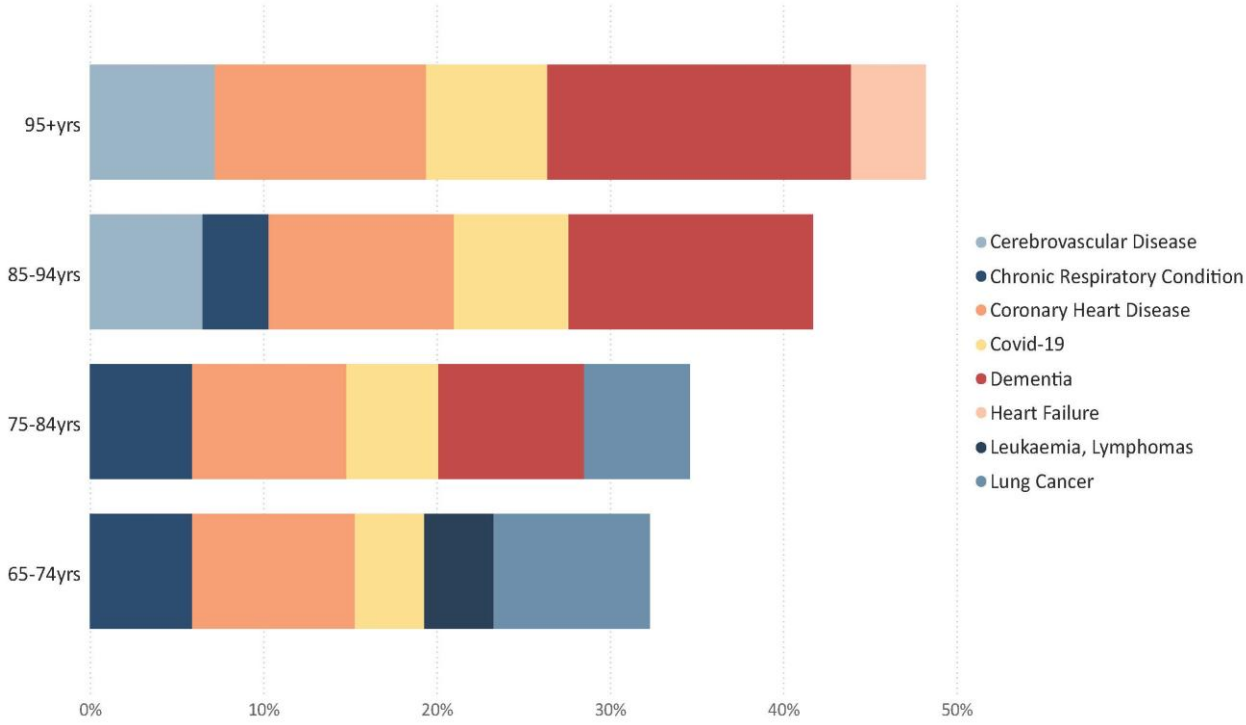
In Gippsland, 66.7% of people 65 years or older receive the aged pension, higher than the Victorian average of 58.3%, with the highest rates in Latrobe (72.2%), Bass Coast (67.4%) and East Gippsland (66.8%) (PHIDU 2021).

Aboriginal and/or Torres Strait Islander specific demographic data can be found in **Chapter 1. Aboriginal and/or Torres Strait Islander Health and Wellbeing.** All data in Chapter 1 are for Aboriginal and/or Torres Strait Islander peoples in Gippsland where available, with comparisons to Aboriginal and/or Torres Strait Islander peoples in Victoria and/or Australia.

National data

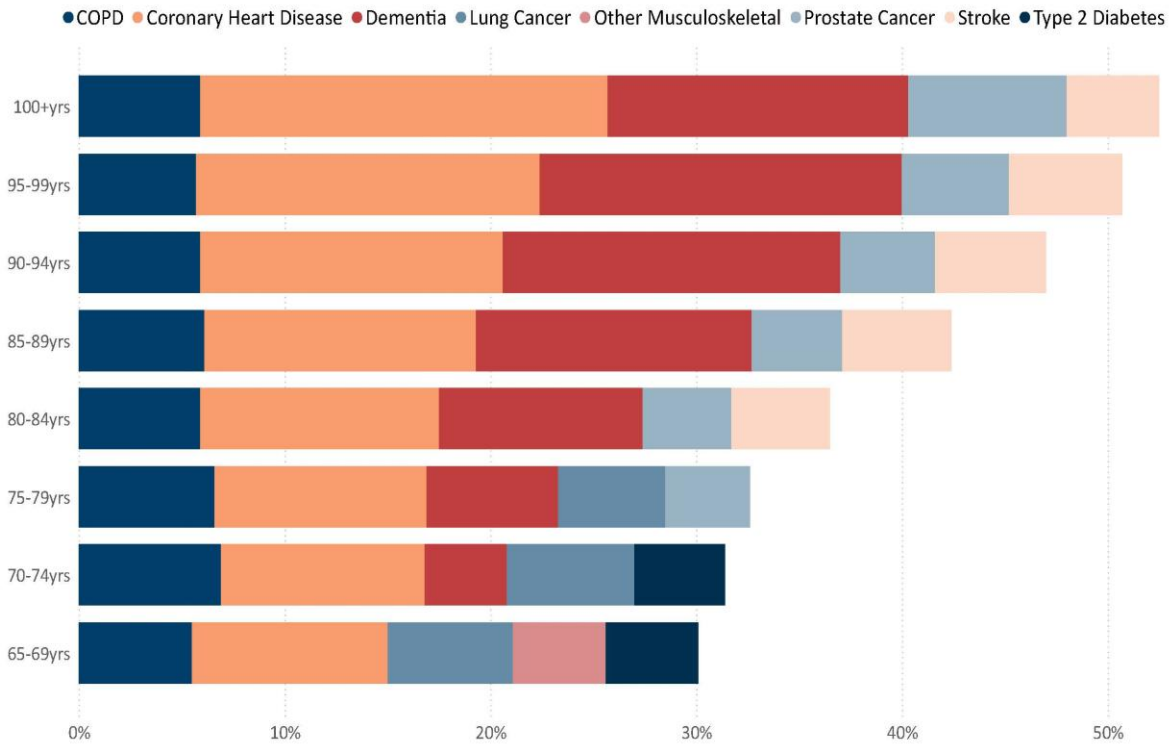
In Australia, 84% of deaths nationally occurred in people aged 65 years and older (AIHW 2024o). The top five leading causes of disease in 2022 among those aged 65 years and older in Australia is shown in **Figure 44** (AIHW 2024o). Overall, dementia (including Alzheimer's disease) is the leading cause of death among people aged 65 and older, followed by coronary heart disease (AIHW 2024o).

Figure 44. Top five leading causes of death in Australia for people aged 65 years and older by age group, 2022 (AIHW 2024o).



The top five leading disease groups causing total burden (fatal and non-fatal combined) for people aged 65 and over in Australia in 2023 are shown in **Figure 45**. See also **Burden of Disease**.

Figure 45. Top five leading causes of total burden (percentage of total DALY) in Australia in 2023 (AIHW 2024o).



Service System

Aged care service types in Gippsland include the following:

- **Residential aged care homes**
  - There are 53 facilities in Gippsland and one multi-purpose service including residential in Orbost (AIHW 2021a).
  - Occupancy rates of residential aged care beds were 81.5% as of June 2023 (GEN Aged Care 2023).
  - There are an estimated 3,417 residential operational places in Gippsland as of 30 September 2024 (PHIDU 2024b). Latrobe and Wellington are among the top 25% of LGAs nationally for aged care residential places per 1,000 people (aged 70 years and over), with 109 and 80, respectively (PHIDU 2021); the other LGA's in the region are all below the Gippsland (75) and Victoria (78) average.
- **Home Care Packages**
  - There are a minimum of 36 providers in Gippsland.
- **Commonwealth Home Support Programs**
  - There were 222,011 people using Commonwealth Home Support Programs in Victoria during 2022-23; of these, 63.4% were for females (GEN Aged Care 2024).
- **Short term restorative care services**
  - There are four short term restorative care services across Gippsland.

Workforce

The key aged care health workforce includes registered nurses, enrolled nurses, personal care workers and allied health professionals. Medical support is generally provided by a general practice.

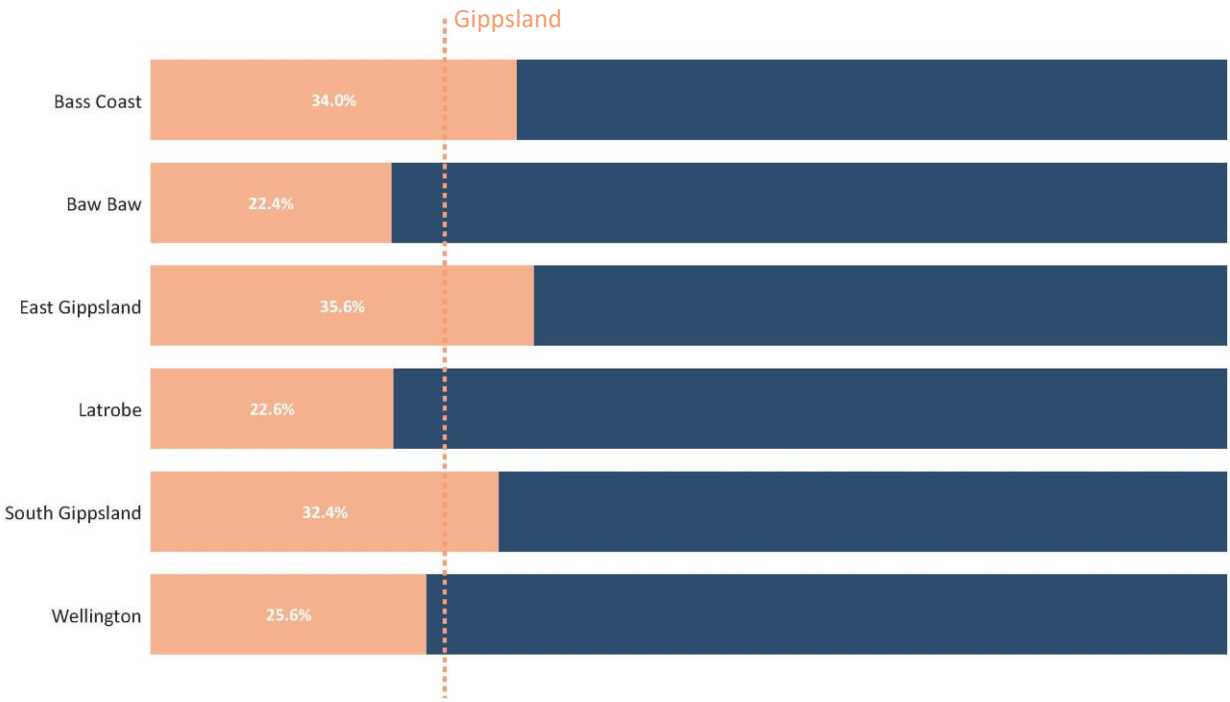
See **Chapter 5. Health workforce** for further workforce data.

Service Utilisation

General practice

In 2023-24, people aged over 65 years accounted for 27% of general practice patients in Gippsland (GPHN 2024f) (**Figure 46**), reflecting population proportions. Furthermore, 43% of the activity[9] at Gippsland general practices in 2023-24 was for people aged 65 years or older with an average of 20 activities per patient (GPHN 2024f).

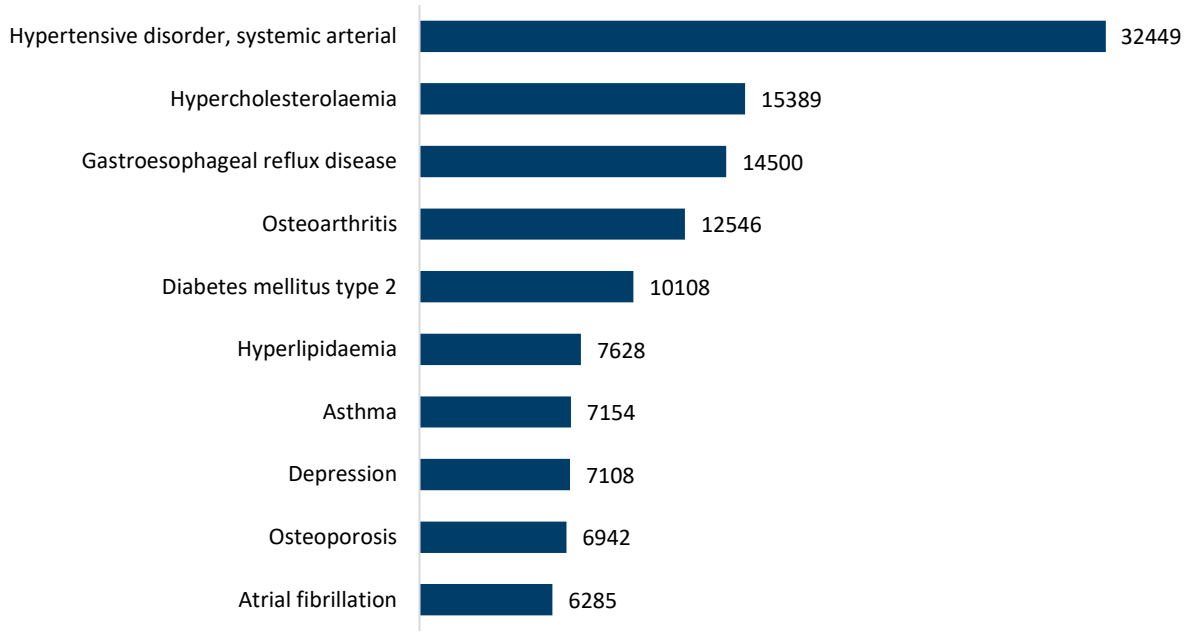
Figure 46. Percentage of people aged 65 and over in Gippsland general practices in 2023-24 (GPHN 2024f).



The top 10 **active diagnoses** for patients in Gippsland general practice in 2023-24 are show in **Figure 47**. In Gippsland, the most common diagnosis in general practice for people aged over 65 in 2023-24 was hypertension (GPHN 2024f). A diagnosis of hypertension was more than twice as common as the next most common diagnosis, hypercholesterolaemia (GPHN 2024f).

[9] An 'Activity' (sometimes referred to as a 'Visit' or 'Encounter') is defined as any professional interchange between a patient and a practice staff member. In the clinical information systems, an activity recorded any time a patient's electronic medical record is accessed regardless of whether or not this was for clinical purposes. This may be either automatically date stamped by the clinical software or entered by the clinician.

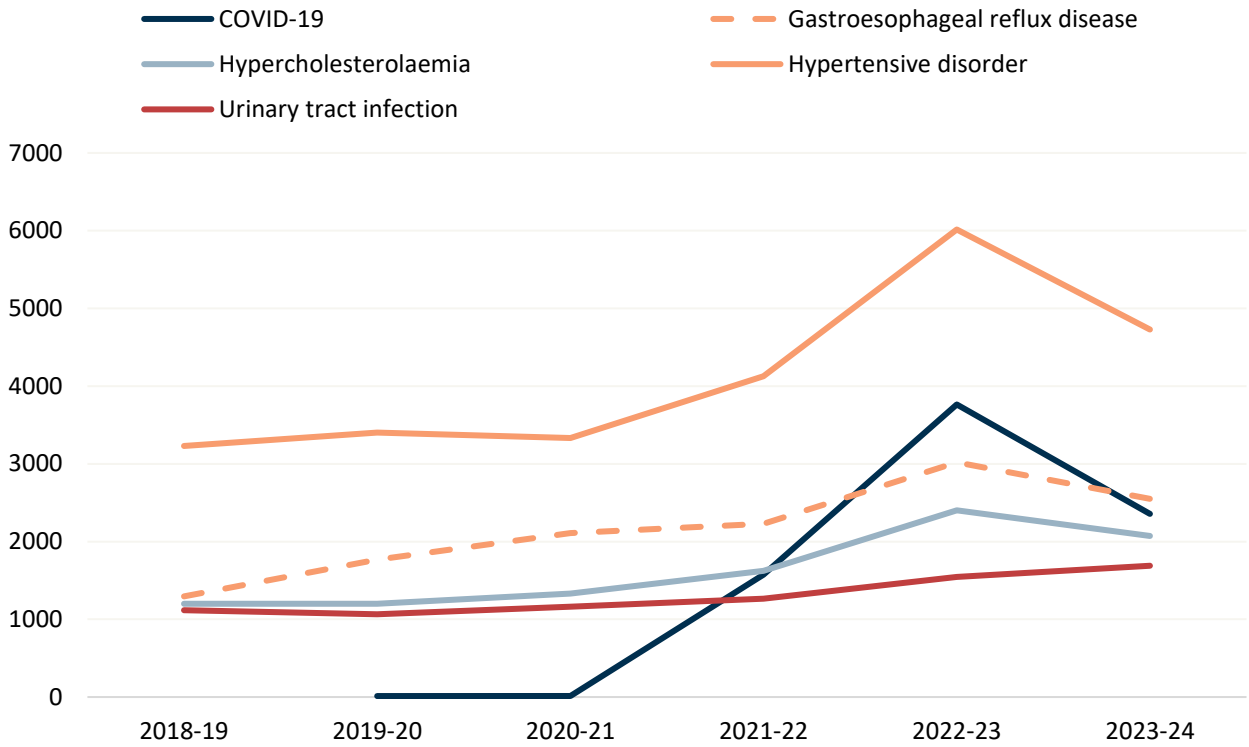
Figure 47. Top ten active diagnoses for active patients aged 65 years and older, 2023-24 (GPHN 2024f).



When considering trends over time relating to new diagnoses among this patient cohort (**Figure 48**), hypertension has remained the most common new diagnosis for people over 65 years between 2018-19 and 2023-24 (GPHN 2024f). When considering the other top new diagnoses, gastroesophageal reflux disease increased by 14.5% per year over the past six years, followed by hypercholesterolaemia (11.6% per year), hypertension (7.9% per year) and urinary tract infection (8.6% per year). Notably the new diagnoses for the top five all reduced from 2022-23 to 2023-24, expect for urinary tract infection which increased 9.2%.

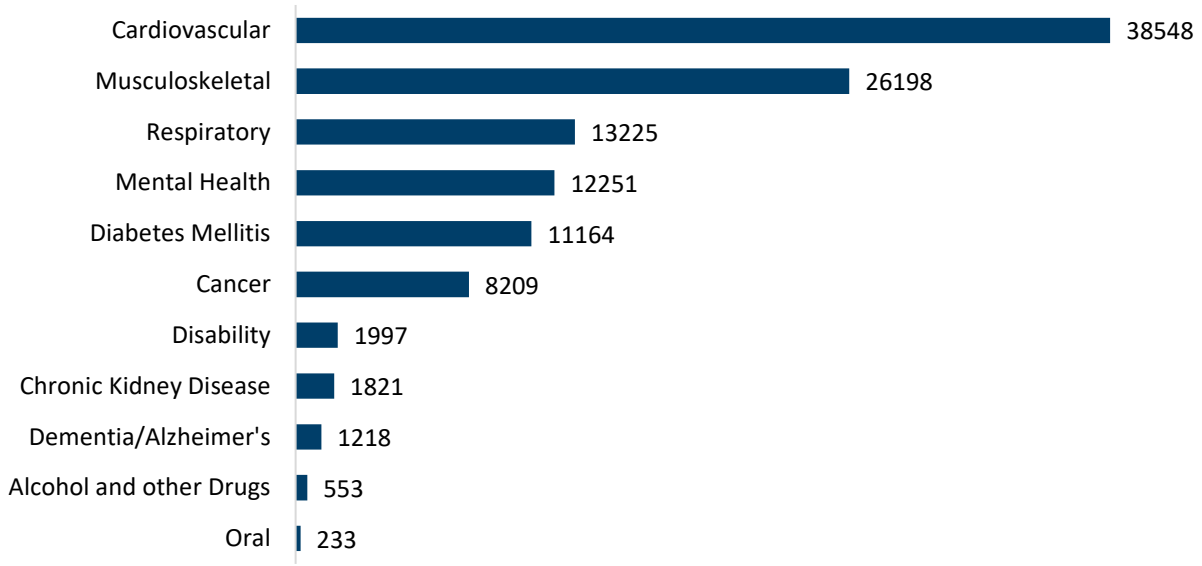
Furthermore, COVID-19 diagnoses surged in 2020-21 to become the second most common new diagnosis in 2022-23 (GPHN 2024f), however new COVID-19 diagnoses reduced in 2023-24, likely due to increased provision of self-administered rapid antigen tests, negating the need to visit a general practice.

Figure 48. Top 5 new diagnoses for patients aged 65 years and older in Gippsland by year (GPHN 2024f).



The number of active chronic disease diagnosis for patients aged 65 years and older in 2023-24 is shown in **Figure 49** (GPHN 2024f). Cardiovascular and musculoskeletal disease make up the majority of chronic disease diagnoses among active patients aged over 65 years in 2023-24 (GPHN 2024f). See also **Chapter 8. Chronic disease**.

Figure 49. Prevalence of active chronic disease category diagnoses for active patients aged 65 years and older, 2023-24 (GPHN 2024f).



Gippsland PHN commissioned services data

As part of the overall Primary Mental Health Care funding, Gippsland PHN commissions a Mental Health in Aged Care program for people living in or transitioning into Residential Aged Care Homes (RACHs). The program is an early intervention program offering low to mild intensity holistic care addressing mental, physical, and social health needs. Individual or group support is provided by mental health and wellbeing support workers, alongside trained peer support workers and local community volunteers. The Mental Health in Aged Care program was delivered in all 53 residential aged care homes (100% of homes) and 477 residents have participated in the program from the start from 1st July 2022 to 30th June 2024 (GPHN 2024g).

Mental Health in Aged Care Program

- In 2023-24, 947 people aged over 65 years accessed Gippsland PHN's Mental Health in Aged Care Program (21.5% of all people accessing program).
- There were 6,980 services delivered to this group, an average of seven services per person.

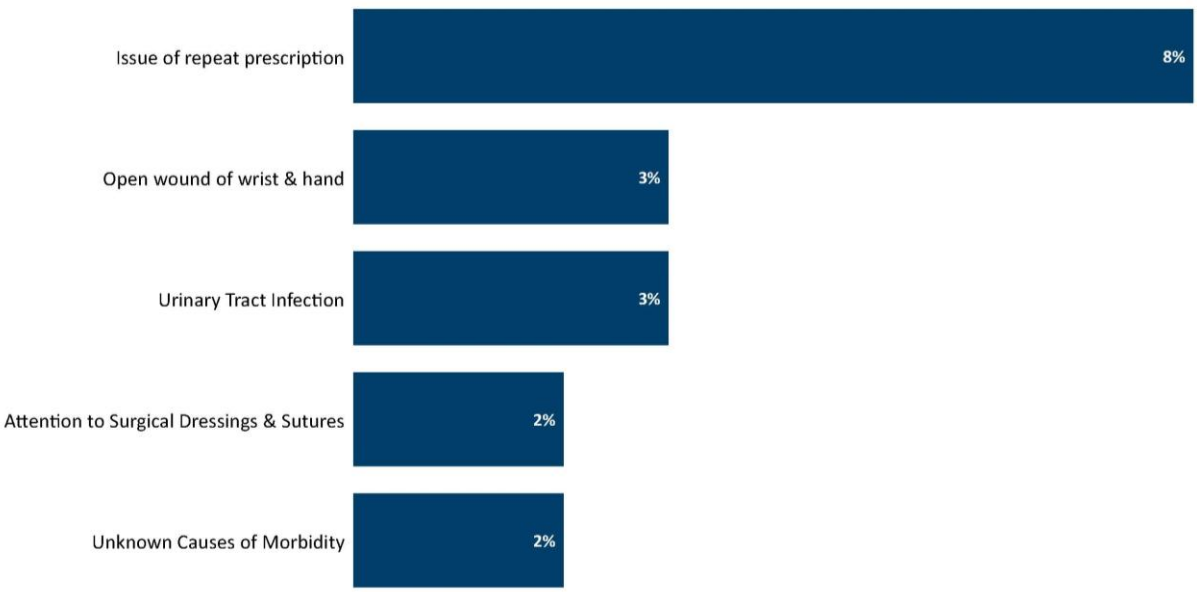
Emergency Department (ED) presentations

There was a total of 39,137 emergency department (ED) presentations for people aged 65 years or older in 2023-24, representing 31% of all ED presentations. For people aged 65 years or older, 17% of ED presentations were related to injuries. The top cause was 'Fall <1 metre or no height information', making up 10% of all presentations for people aged 65 years or older (4,001 presentations in 2023-24).

Additionally, for people aged 65 years or older:

- **Lower urgency presentations:** 18% of ED presentations were lower urgency in 2023-24; a reduction from 23% in 2019-20 (DH 2024b). The top five diagnoses among lower urgency presentations among this cohort is shown in 2023-24 is shown in **Figure 50**. For a full list of all top diagnoses, see **Appendix 7.**
- **Regional variation:** There was variation between SA3 sub-regions in relation to this, with 25% in Wellington, 14% in Baw Baw, 19% each in East Gippsland and Gippsland South West, and 16% in Latrobe (DH 2024b).

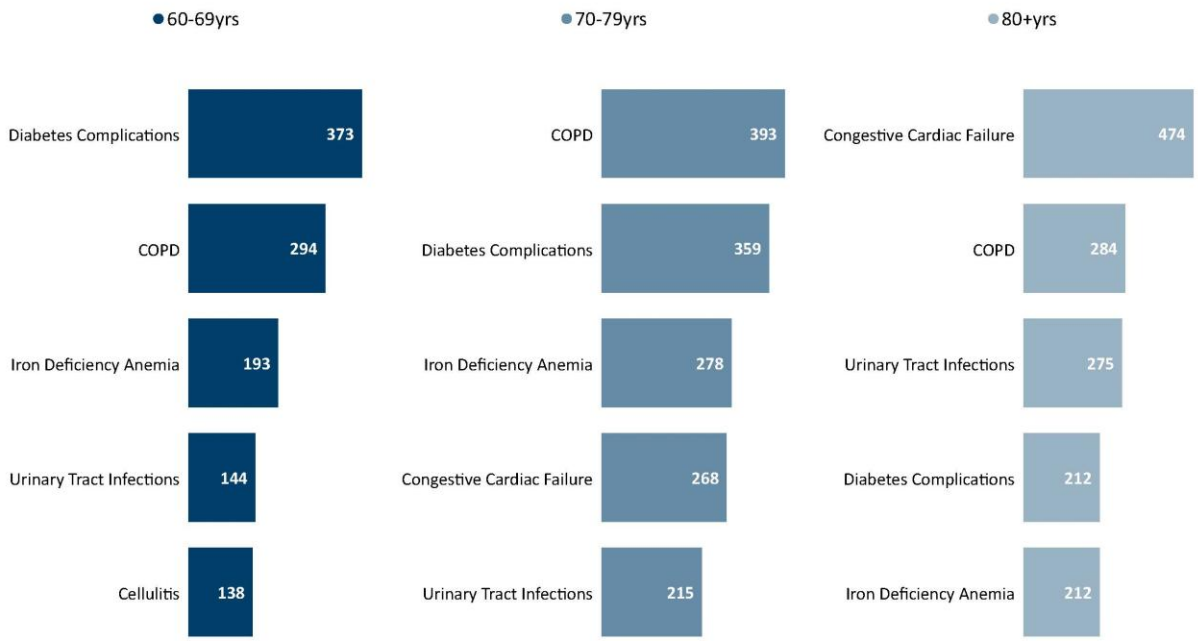
Figure 50. Top five diagnoses among lower urgency presentations for people aged 65 years or older, 2023-24 (DH 2024b).



Hospital admissions

In 2023-24, there were a total of 67,678 hospital admissions for people aged 65 years or older, making up 49% of all admissions (DH 2024a). The top five Potentially Preventable Hospitalisations (PPHs) and number of admissions for Gippsland residents among this cohort is show in **Figure 51**.

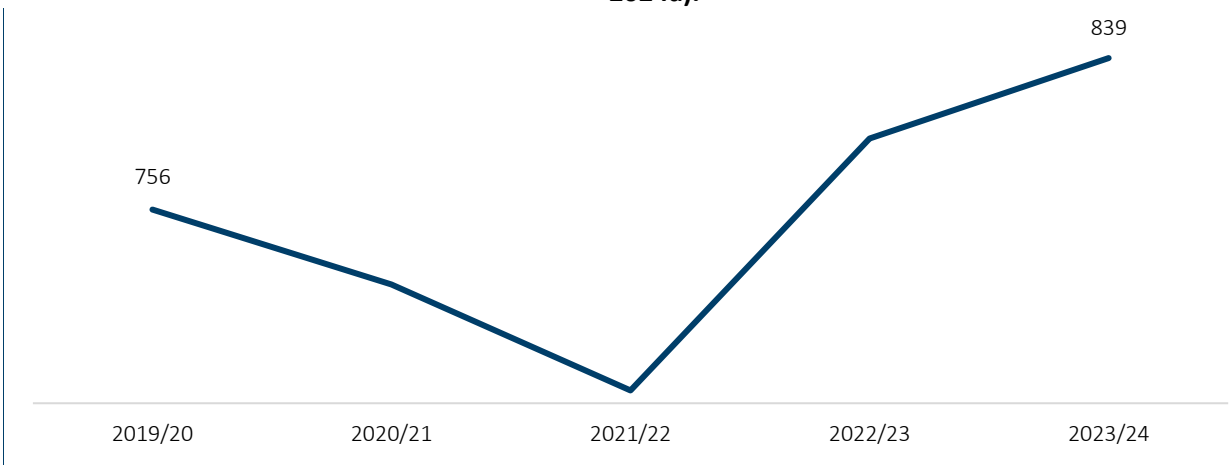
Figure 51. Top five PPHs and number of admissions for Gippsland residents 60 years or older in 2022-23 (DH 2024a):



Palliative care

- **Admissions:** Palliative Care admissions for Gippsland residents increased 2.6% per year from 756 in 2019-20 to 839 in 2023-24 (**Figure 52**) (DH 2024a).
- **Total admissions:** The total number of Palliative Care admissions between 2019-20 to 2022-23 was 3,762 (DH 2024a).
- **LGA breakdown:** Of the total Palliative Care admissions, 32% were for Latrobe residents, 25% for Gippsland South West, 17% each for East Gippsland and Wellington and 9% for Baw Baw residents (DH 2024a).

Figure 52. Hospital admissions by Gippsland residents for Palliative Care, 2019-20 to 2023-24 (DH 2024a).



Professional Stakeholder Perspective

Gippsland PHN stakeholder consultations have noted (GPHN 2024e):

- Advance care planning is important, but there is a great challenge to identify suitable workforce to undertake these tasks.
- Staff shortages result in challenges for aged care facilities. When understaffed, there is more pressure on existing staff to meet the needs of residents. This can result in poor health outcomes and avoidable hospitalisations.
    - Dementia and mental health issues are common, including challenging behaviours, and often require additional resources to be managed effectively. This can be challenging when there are staff shortages.

What works and suggestions to improve care

- Integration of health and social care models to meet the needs of individuals.

  "Gippsland has an ageing population who wants to live and die at home. However, a big impediment to this is the fragmentation of services… Distance compounds this dilemma… we need to leverage telehealth to connect health and social care teams." (Health professional)

- Involving families for ongoing support and reconnection of families
- Early intervention programs have noted improved social connection and improved mental health as a pleasant by-product of the program
- Pre and post surveys for early intervention programs showing overall improved (or at least sustained) health outcomes (GPHN 2024g)
- Exercise classes reducing risk of falls, and therefore hospitalisations. These also provide other social benefits

  "Some clients who attended [early intervention] groups now meet weekly for coffee and exercise" (Professional)

Capacity in aged care system

- There are great services, but they often lack capacity to help everyone.
- If people are not accepted through My Aged Care or are on a wait list some clients are left very vulnerable.
- Care Finder case loads are high, and referrals continue to grow. With lack of services to refer to, it makes closing cases difficult.

  "Care Finder is fantastic but wait list is huge, especially in East Gippsland." (Health professional)

Community, Consumer and Carer Perspective

Insights from Gippsland PHN consultations (2024d and 2024e) related to older people include:

Health issues

- Isolation for older people can lead to severe loneliness, often impacting both mental health and physical health. Isolation can also impact health indirectly, if an older person needs support from others to access transport, services, or health information.
- Elder abuse issues often go unrecognised and, because of a shift in Elder abuse services and supports to the family violence sector in Victoria, there are concerns about access issues.
- Access to palliative care, including medication and bereavement support is often difficult to access and/or a referral is made too late to benefit the consumer.

Perceptions of ageing

- Older people spoke about being very aware of the ageing process. Some people felt anxious about this, while others talked about having a positive approach and keeping themselves well. Independence was a key theme in these discussions.
  "Like I said, you know, normally very, very independent, a lot of my independence and that, but just lately I've noticed myself getting very forgetful, which is starting to get me down."

- The desire to remain in the home for as long as possible was brought up often. These discussions included services that could support people to remain at home longer.

  "Can't use a whipper snipper, they're too heavy, different things like that. There's quite a lot that could be done for elderly people that want to stay at home."

Perceptions of aged care system

- Health professionals were sometimes perceived to have a lack knowledge and understanding about how to work with patients with dementia.
- Difficulty in navigating the aged care system was a common theme for older people. This is often reliant on having a younger carer available to provide support.
- Many older community members were aware of the pressures on the aged care system, and worried about how they would be impacted.

  "And I'm in that bracket now and I worry about what my future looks like in five years time. Am I going to be able to get the services I need?"

  "…and there's so many homes because the population is so much older now. Like, and I don't know how you can fix that, you know? Like, I know, but everyone's just living older and – and, and longer.

Chapter 3: Alcohol and Other Drugs

Alcohol and other drugs (AOD) include both legal and illicit substances that can cause damage to a person's health through misuse and dependency issues. Alcohol, tobacco, and illicit drug use is a leading cause of preventable disease in Australia and is associated with a range of issues that can also impact an individual's financial and personal relationships.

Summary

Gippsland health insights

- Over 65% of adults in Gippsland are estimated to consume alcohol at risky levels (Victoria 60%).
- There is an ongoing lack of local rehabilitation and detoxification services (both community and residential), and often there is a need to travel to access care, especially from East Gippsland.
- 65% of people with an AOD diagnosis also had a mental health diagnosis in GP data.
- Ambulance attendance rates related to alcohol and other drugs remained high, with alcohol intoxication being the most common; East Gippsland, Latrobe and Wellington recorded rates among the top 25% of Victorian LGAs (2022-23).
- The alcohol related death rate remains higher across most Gippsland LGAs compared to the rest of Victoria. Latrobe, East Gippsland and Bass Coast were among the top 25% of LGAs in Victoria for these deaths in 2021.
- Stigma amongst health providers is reported as a barrier to seeking help for drug, alcohol, and gambling issues.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Improved health professional knowledge and understanding about dual diagnosis of AOD misuse and mental health conditions.
- Improved experience for people accessing help anywhere in the system.
- Improved access to services and supports for young people, Aboriginal and/or Torres Strait Islander peoples and males.
- Improved care planning and access to a multidisciplinary team.
- Improved community support and reduced stigma.
- Reduced alcohol and other drug related deaths.

Community voices

"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."

"I want local supports available for AOD without negativity and stigma."

Health Status

National data

Burden of disease

In Australia in 2023, mental and substance use disorders was the fourth highest cause of burden of disease (as DALY) at 12.1% (AIHW 2024g). The burden of disease related to alcohol, tobacco and other drugs in Australia, taken from the Australian Burden of Disease Study 2018 (latest available), is summarised as follows (AIHW 2024g):

- Tobacco, alcohol and illicit drug use collectively accounted for 15.4% of the total burden of disease in Australia in 2018.
- Alcohol use contributed to 4.5% of the total burden of disease in Australia in 2018. For males aged 15-44 it was the leading risk factor (12.3% compared to females 3.9%).
- Alcohol use was responsible for the entire burden due to alcohol use disorders, 40% of liver cancer burden, 25% of road traffic injuries – motor vehicle occupant burden, 19% of chronic liver disease burden and 14% of suicide burden.
- In 2018, illicit drug use contributed to 3.0% of the total burden of disease in Australia, predominantly affecting those aged 15–44. Males in this age group experienced a twice the proportion of total disease burden from illicit drug use than females in this age group (10.6% compared to 4.4%).
- Illicit drug use was responsible for 100% of the burden of drug use disorders (excluding alcohol) and 72% of the poisoning burden. It was also responsible for 74% of the acute Hepatitis C burden, 33% of the acute Hepatitis B burden, and 7.2% of the HIV/AIDS burden.
- Opioid use was the largest contributor to illicit drug use burden (31%), followed by amphetamines (24%), cocaine (10.9%) and cannabis (10.2%). In addition, 17.8% of the burden was from diseases contracted from unsafe injecting practices.

Drug and alcohol-induced deaths

Drug-induced deaths are defined as those that can be directly attributable to drug use and includes both those due to acute toxicity (for example, drug overdose) and chronic use (for example, drug-induced cardiac conditions) as determined by toxicology and pathology reports (AIHW 2024g). Most drug-induced deaths are due to acute causes, whereas the majority of alcohol-induced deaths are due to chronic conditions.

Nationally in 2022, there were (AIHW 2024g):

- **Alcohol-induced deaths:** 1,742 nationally, up from 1,317 in 2019 (this was a 10-year peak)
    - Gender: 71% of alcohol deaths were for males
    - Age distribution: The highest rates were amongst 55–64-year-olds

- **Drug-induced deaths:** 1,693 nationally, down from 1,865 in 2019
    - **Drug classes:** 38% of deaths involved three or more drugs; opioids were the most commonly identified drug class (including heroin and synthetic opioids), and benzodiazepines were the most common antidepressant drugs involved in deaths
    - **Cause:** 69% were accidental and 24% were considered intentional
    - **Gender:** 64% of deaths were males
    - **Age:** The median age was 50 years for males and 45 years for females
    - **Location:** 78% of deaths occurred at home
    - **Sociodemographic gap:** 32% of deaths occurred amongst people living in the most disadvantaged areas
    - **Associated disorders:** 52% had mental and behavioural disorders due to psychoactive substance use as an associated cause of death
    - **Risk factors:** Psychosocial risk factors were recorded for 43% of all drug-induced deaths and in 74% of intentional drug-induced deaths; multiple factors can be relevant in each case and the most common were:
        - Personal history of self-harm was the most commonly identified risk factor (11%)
        - Relationship issues such as disruption of family by separation and divorce (5.3%)
        - Other risk factors included release from prison (especially for heroin deaths) and limitations of activities due to disability.

Priority populations

Priority populations were identified in the National Drug Strategy 2017-2026 (DoHAC 2017) and by AIHW (2024j) and they include:

- **Young people:**
    - 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
    - 42% of young people (aged 18-24 years) report risky drinking
    - 35% of young people (aged 18-24 years) report recent illicit use of drugs with an average initiation of 19.5 years
- **Homelessness**: 8.6% of specialist homelessness service clients aged 10 and over reported problematic alcohol and/or drug use

- **Older adults**: Have unique health circumstances including pain, co-morbidities, and social circumstances such as isolation that are important to consider in the context of alcohol and other drug use;
    - 33% of people in their 60s consumed alcohol at risky levels
    - Recent illicit drug use is becoming more common with 7.8% of people aged 60 years or older reporting recent illicit drug use

- **LGBTQ+ Community:** 47% of lesbian, gay or bisexual people had recent illicit drug use

- **Prisoners:** 73% of people entering prison reported using illicit drugs, most commonly amphetamines and cannabis; illicit drug offences were the 3rd most common principal offence, accounting for 7.7% of defendants who had their offence finalised in a Magistrates' Court

- **Aboriginal and/or Torres Strait Islander Peoples:** see **Chapter 1** for data related to this group.

Gippsland data

The latest available data on the estimated prevalence of alcohol use across Gippsland LGAs is from 2017 (DH 2017) (**Figure 53**). Prevalence of the population consuming alcohol at levels likely to increase lifetime risk (>2 standard drinks per day) is higher in five out of the six Gippsland LGAs, compared to the Victorian average, with Bass Coast the highest (DH 2017). Furthermore, the prevalence of the population consuming alcohol at levels with increased risk of injury (>4 standard drinks on a single occasion at least monthly) is higher in all six Gippsland LGAs compared to the Victorian average, with East Gippsland the highest (DH 2017).

Figure 53. Estimated alcohol consumption[10] (age-standardised) by Gippsland LGA, compared to Victorian average (DH 2017).

Additionally, Latrobe, Bass Coast and East Gippsland were among the top 25% of Victorian LGA's for alcohol-related death rate per 100,000 population (Turning Point 2024). The rates in Latrobe having been growing the fastest in Gippsland, at +3.8% per year (Victoria, +0.9%), whilst Bass Coast and East Gippsland are the only two LGA's in Gippsland to have reducing rates at -1% and -0.8% per year respectively (**Appendix 8.1**). Notably, alcohol-related death rates per 100,000 continue to be higher for females than males in Victoria and most Gippsland LGA's; however, male rates are continuing to increase throughout the region, whilst all LGA's expect Latrobe and South Gippsland are decreasing for females (**Appendix 8.2**). Throughout Gippsland the highest growth rates are observed in Baw Baw and Wellington males (+7.6% & +4.4% per year, respectively) (**Appendix 8.3**).

Unintentional drug-induced death rates are high in Gippsland with 9.2 deaths per 100,000 people, compared to 6.6 in Victoria and Australia. Latrobe has the highest rate in the region at 11.6 deaths per 100,000 people (Penington Institute 2024). According to the Victorian Coroners Court, there were 25 overdose deaths in Gippsland in 2023 (CCOV 2024).

[10] Alcohol consumption definitions:

>2 standard drinks per day is defined as alcohol consumed by adults at levels likely to increase lifetime risk of harm.

>4 standard drinks (single occasion at least monthly) is defined as consuming alcohol at levels with increased risk of injury on a single occasion.

Spotlight on dual diagnosis

Dual diagnosis is when someone has a mental health condition and an alcohol or other drug (AOD) use problem at the same time (ADF 2021).

The 2022-23 National Drug Strategy Household Survey (NDSHS) (AIHW 2024d) found that compared with adults experiencing low levels of psychological distress, those experiencing high or very high levels of psychological distress were:

- More likely to drink alcohol at risky levels (39% compared with 30%).
- 2.3 times as likely to smoke daily (15% compared with 6.7%).
- 4.1 times as likely to use vape or use e-cigarettes (16% compared with 3.9%).
- 2.5 times as likely to use any illicit drug (32% compared with 13%).

People with a dual diagnosis have higher rates of (DH 2015):

- Severe illness course and relapse,
- Violence, suicidal behaviour and suicide,
- Infections and physical health problems,
- Social isolation and family/carer distress,
- Service use,
- Anti-social behaviour and incarceration, and;
- Homelessness.

There are often significant underlying factors for dual diagnosis including discrimination, unemployment, family breakdown, homelessness, poverty and social isolation (GPHN 2024c & GPHN 2024e)

Based on Gippsland general practice data, 65% of people with an AOD diagnosis also had a mental health diagnosis (GPHN 2024f).

Service System

The Australian Community Support Organisation (ACSO n.d) provides an overview of the Gippsland specialist alcohol and drug treatment services available which includes specialist services for young people and Aboriginal and/or Torres Strait Islander peoples. Some providers now offer digital options for AOD support.

Gippsland PHN commissioned Alcohol and Other Drug (AOD) services that 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 Short-Term Intervention Program (STIP) which is a multimodal program for vulnerable and at-risk persons.

Pharmacotherapy services in Victoria are undergoing reform. Availability of pharmacotherapy prescribing in Gippsland is through GP prescribers and nurse practitioners (workforce numbers not available).

Pharmacotherapy medications moved on to the PBS 1 July 2023 and prescriptions have recently increased from a maximum of 2 repeats to up to 5 repeats (where appropriate). Pharmacists and nurse led clinics are now administering medications in three locations in Gippsland and this is expected to increase. The region has a total of 45 dispensing pharmacies (of a total 70 community pharmacies), covering all Gippsland LGAs (Regional Pharmacotherapy Network Coordinator, Latrobe Community Health Service, Personal communication, October 2024).

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

Service Use

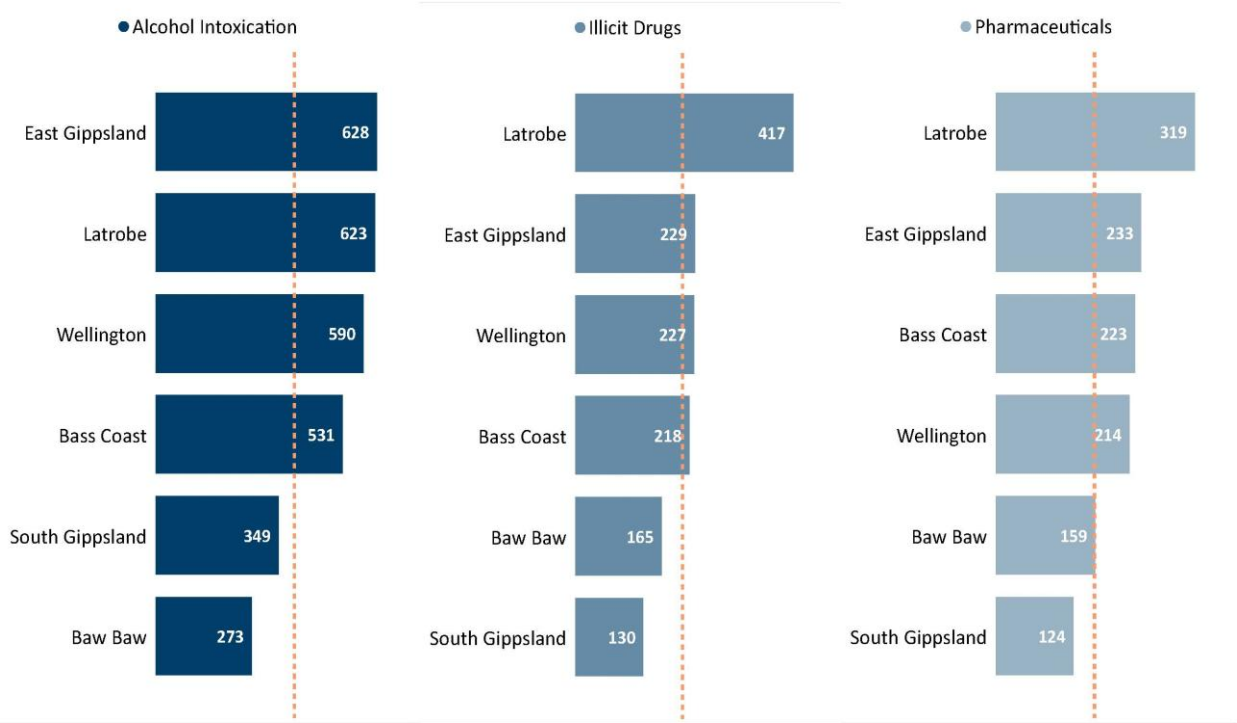
Ambulance attendances

Ambulance attendance rates related to alcohol and other drugs remained high in many parts of Gippsland in 2022-23 (**Figure 54**):

- **Alcohol intoxication:** Ambulance attendances involving alcohol intoxication were most prevalent, with East Gippsland, Latrobe and Wellington recording rates amongst the highest 25% of Victorian LGAs
- **Illicit drugs:** Ambulance attendance involving illicit drugs in Gippsland were twice the Victorian rates in Latrobe. East Gippsland and Wellington also recorded rates amongst the highest 25% of Victorian LGAs

- **Pharmaceuticals:** Latrobe recorded the highest rates of ambulance attendances involving pharmaceuticals in Victoria. East Gippsland, Bass Coast and Wellington also recorded rates amongst the highest 25% of Victorian LGAs.

Figure 54. Ambulance attendances related to alcohol and other drugs in Gippsland, 2022-23, rates per 100,000 population (Turning Point 2024).



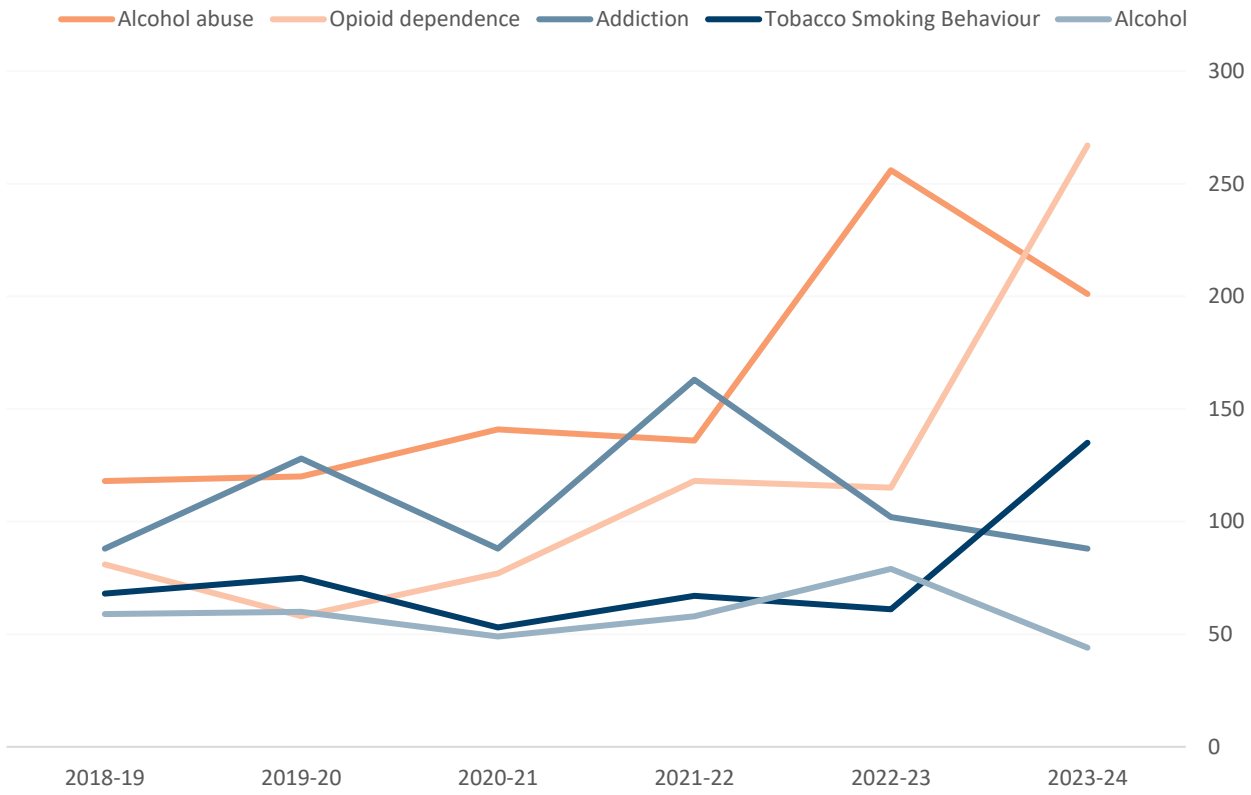
General practice

In Gippsland, 1.9% of all active patients in general practice had an active diagnosis related to alcohol and other drugs in 2023-24 (GPHN 2024f).

In 2023-24, the most common new AOD related diagnoses recorded amongst general practice patients was opioid dependence, followed by alcohol misuse (**Figure 55**):

- **Alcohol Consumption:** consumption is decreasing by 4.8% per year
- **Alcohol misuse increase:** rising by 9.3% per year
- **Opioid Dependence growth:** increasing by 22% per year with 43.1% surge between 2022-23 and 2023-24
- **Tobacco smoking behaviour:** rising by 12.1% per year

Figure 55. Top five active AOD related diagnoses among Gippsland patients, 2018-19 to 2023-24 (GPHN 2024f)



Hospital activity

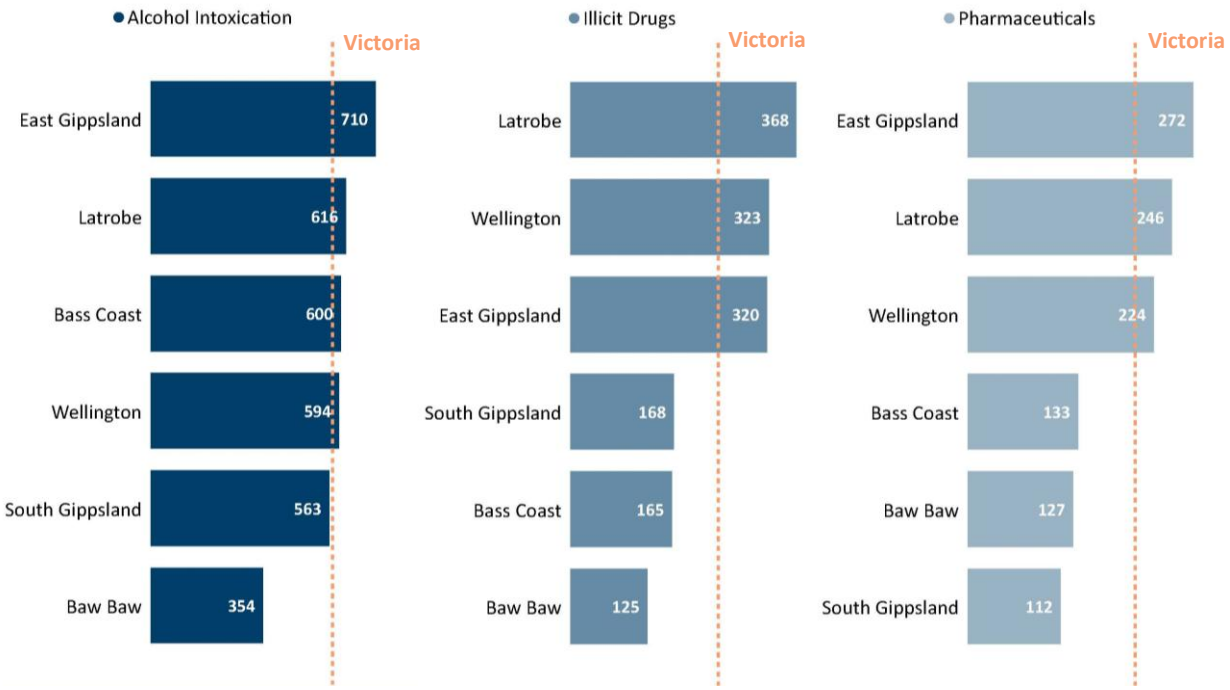
Hospital admission rates related to alcohol and other drugs were high in some parts of Gippsland in 2021-22, but relatively low in others (**Figure 56**):

- **Alcohol intoxication:** Admissions involving alcohol intoxication were most prevalent; East Gippsland recorded a rate amongst the highest 25% of Victorian LGAs.

- **Illicit drugs:** Admissions involving illicit drugs were high in Latrobe, East Gippsland and Wellington (ranking amongst the highest 25% of Victorian LGAs).

- **Pharmaceuticals:** Admissions involving pharmaceuticals were high in Latrobe and East Gippsland (amongst the highest 25% of Victorian LGAs).

Figure 56. Hospital admissions related to AOD, 2021-22 rates per 100,000 population (Turning Point 2024).



Alcohol and drug treatment services

Data from the National Minimum Dataset for Gippsland for 2022-23, compared to 2019-20 and (national data), show (AIHW 2024t):

- **Agency reporting:** 27 agencies in Gippsland reporting data to the national data set, up from 24 in 2019-20.
- **Service use:** Gippsland had the third highest number of clients receiving services per population among Australia's PHN regions, consistent with 2019-20.
- **Client services:** 82% of clients received a service for their own drug use, compared to 93% nationally.
- **Principal drugs:** The most common drug types compared to national averages:
  - Alcohol: 42%, up from 25% in 2019-20 (national average 40%)
  - Amphetamines: 25%, steady (national average 23%)
  - Cannabis: 20%, up from 14% (national average 20%)
  - Heroin: 3%, steady (national average 5%)

- **Treatment type in Gippsland:**
    - Counselling: 33% (national average 41%)
    - Assessment only: 32% (national average25%)
    - Support and case management: 15% (national average12%)
    - Withdrawal management: 9% (national average 6%)
    - Rehabilitation: 1% (down from 2%), (national average 5%)
    - Information and education: <1% (national average 3%)
    - Pharmacotherapy not available for Gippsland (national average 2%)

- **Referral source** for Gippsland clients were:
    - Self-referral: 24% (national average 36%)
    - Health service referral: 25% (national average 29%)
    - Corrections: 21% up from 11% (national average 13%)
    - Diversions: 2% up from 1%, (national average 11%)
    - Other: 28% down from 47% (national average 11%)

- **Treatment delivery setting:**
    - Non-residential setting 47%; down from 63% (national average 72%)
    - Residential treatment facility 8%; up from 5% (national average 10%)
    - Home 10%; up from 5% (national average 4%)
    - Outreach setting 6%; down from 10% (national average 7%).

Gippsland PHN commissioned services

Referrals to Gippsland PHN Commissioned AOD services were from:

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

In 2023-24, a total of 326 clients used the family and carer support and short-term intervention program AOD services, with a total of 3,665 sessions or an average of 12 sessions per client (GPHN 2024k).

- Nearly half of all clients were male (48.6%)
- 75% of clients in the family and care support program were aged 50 years or older, underscoring the need for support among older adults
- Over half (51%) of clients in the short-term intervention program were Health Care Card holders, pointing to financial and cost of living factors among those seeking help.

Professional Stakeholder Perspective

Insights from professional stakeholders

Consultations with professional stakeholders (GPHN 2024e and GPHN 2024g) have provided local insights.

- How services can improve to better meet client needs:
    - Respectful, empathetic and non-judging care is imperative
    - There is a need to provide information, useful tools and education to both clients and carers
    - There is a need for more lived experience workers who are often able to make a meaningful connection
    - Providing support groups where clients can meet others experiencing the same issues
    - Prevention and early intervention need to be addressed, including the stressors that cause misuse, such as family violence.
    - Dental issues often impact people with AOD misuse and appropriate dental treatment can improve quality of life
    - There is a need for prescribers, including through a nurse practitioner model
    - Recruiting and appointing Hepatitis C specialists
    - Address stigma in GP clinics regarding AOD use.
- There is an ongoing lack of local rehabilitation and detoxification services (both community and residential), and often there is a need to travel to access care, especially from East Gippsland.

Insights from Gippsland PHN commissioned services

Themes from Gippsland PHN commissioned services consultations during 2024 (GPHN 2024g):

- All currently commissioned services are meeting important needs but are not able to meet demand.
- What is working well:
    - Assertive outreach support for young people and co-location with headspace.
    - Co-location of mental health and AOD services can help manage wait lists due to a high demand for services by referring clients to another service if an appointment is not immediately available.
    - The Short-term Intervention Program is meeting a need for high-risk clients.
    - 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 ensures that the complex needs of vulnerable clients are met.
    - Support for families and carers of people requiring substance misuse issue 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, due to a number of referrals for young people who were experiencing homelessness, or at risk of homelessness.
    - Dual diagnosis support is a widespread gap and requires an integrated approach where services take responsibility for both mental health and AOD.
    - Additional support for the older population is needed, including within residential aged care.
    - Addressing services gaps for Aboriginal and Torres Strait Islander people.

Insights from AOD service providers

- Brokerage funding can be useful to support clients with immediate needs for essentials.
- The geographical locations of detoxification and rehabilitation beds can make it very difficult for clients in parts of Gippsland to access care. A 'dayhab style' program where clients can attend but stay in their home is needed in more places.
- A virtual short rehabilitation program is being trialled.
- A walk in service is operating and going well.
- There are concerning numbers of clients waiting.
- The sector is attempting to implement the recommendations related to mental health reform, but there is a lack of engagement in these attempts to improve integration and there is no funding in the AOD sector for parallel reforms.
- Workforce gaps include addiction medicine, psychologists for AOD and an increased peer workforce.
- Nurse practitioners continue to offer an important service.
  "More publicly funded nurse practitioner positions … would be enormously helpful for the NPs to be appropriately remunerated for the essential work they do."
- Availability of pharmacotherapy in Gippsland:
    - Accessing a pharmacotherapy prescriber in Gippsland is becoming increasingly difficult with prescribers leaving the area, retiring, close to retiring or being at capacity and no longer taking on new clients.
    - Some patients choose to travel to Melbourne to access a prescriber, but a number of these clinics have closed and the remaining ones are generally at capacity.
    - Nurse practitioners are important in complementing general practitioners who can be difficult to access.
    - There is still a considerable stigma for clients with AOD issues, including opioid use disorder, among health professionals.
    - Some pharmacies withdrew from pharmacotherapy services when pharmacotherapy went onto the PBS due to new processes and small pharmacotherapy programs.

Community, Consumer and Carer Perspective

Insights from the Tell Gippsland PHN projects and ongoing consultations (2024c, 2024d & 2024e) related to AOD:

Experiences of AOD

- Many people spoke about their experiences with AOD, and AOD recovery.

  "I've just come out of rehab, so I've dealt with prescription medication abuse since I was 14. I'm currently 22 so yeah… drug addiction has been a massive problem in my life." (Community member)

  "For instance, ex-alcoholic/ semi-ex-alcoholic (sic), I haven't had a drink in like six weeks, seven weeks now." (Community member)

- Community members identified that in some cases men use AOD as a coping mechanism when they are having health issues. They identified a need for more awareness, and a need to make it okay for men to ask for help in relation to AOD supports.
- Some young people are using cannabis and alcohol to cope with anxiety and other mental health struggles.

Services

- Services that support rehabilitation were seen as important by community members. There were often concerns about access, availability, and wait times for these services.

  "…more money towards like, people with alcohol and drug problems, I think that would definitely help, because it is a bit of an issue in Australia anyway, it's just all over the place I think." (Community member)

  "But because we're here and Traralgon's so far away – to try and to go to Traralgon for any follow-up thing, it's just impossible. Especially if you don't drive, you know what I mean?" (Community member)

- Stigma among providers blocks people from seeking help for drug, alcohol, and gambling issues. People have talked about a lack of trust in the healthcare system and "don't believe they can help".

AOD and dental health

- Dental issues often impact people with AOD misuse and appropriate dental treatment can improve quality of life

  "So I'm bouncing back and it's just the teeth at the moment. Like I want to go back to work and like it doesn't look the best. And that was all caused from that drug habit that I had for that year." (Community member)

"So yeah, just working on the teeth…. We had some family photos done just me and the kids and I had to keep my mouth shut." (Community member)

Carer perspectives

- Many participants spoke about loved ones who experienced substance use disorders, and how this had impacted their lives.

  "My daughter got into the ice. And I actually raised her son." (Community member)

- There is a lot of strain on family and carers who often report difficulty obtaining information about services and supports for people misusing alcohol and other drugs. Due to long wait times and lack of appropriate supports, family and carers are often left as the affected person's only support.

  "...community members are often reticent to seek help, either for lack of knowledge or fear of ridicule and stigma." (Community member)

  "AOD [alcohol and drug misuse] nearly always has underlying mental health issues and this needs to be better coordinated." (Community member)

  "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." (Community member)

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

Chapter 4: Mental Health and Wellbeing, Including Suicide Prevention

Mental health affects how we think, feel and act and impacts our everyday activities and quality of life. The World Health Organisation (WHO) state mental health "….is an integral component of health and wellbeing that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in." The mental health continuum acknowledges that an individual's mental health may change over time.

Summary

Gippsland health insights

- An estimated 20.3% of people in Gippsland had a mental health condition in the past 12 months (2020-2022); the highest prevalence was 39.2% for 16–24-year-olds.
- In Gippsland, 11.0% of the population had a diagnosed mental health condition, compared to 8.8% for Victoria and Australia.
- East Gippsland and Wellington had some of the lowest rates for Medicare subsidised services for clinical psychology and psychiatry in Australia.
- Gippsland PHN had the seventh highest mental health prescribing rate of PHN regions in 2022-23 and there was an increase from 204 prescriptions per population in 2017-18 to 227 in 2022-23. An increase was seen in both males and females.
- East Gippsland had the highest suicide rate in Victoria in 2018-2022 and there has been an increase in suicide rates for both males and females in Gippsland.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Improved experiences for consumers seeking continued support for their mental health across the mental health system.
- Improved access to mental health workforce, including psychology and psychiatry.
- Improved access to mental health services and supports for children and young people.
- More connected communities supporting mental wellbeing, especially for children and young people.
- Improved physical health for people with an ongoing mental health condition.
- Improved access to support for eating disorders and perinatal mental health.
- Reduced rate of people reporting high or very high psychological distress for all age groups.
- Reduced suicide rates.
- Reduced intentional self-harm hospital activity (admitted and emergency department).

Community voices

"I want all health professionals trained to provide suicide intervention."

"I want better access to mental health services for people in need – not only in a crisis situation."

"I want mental health screening included in my health care."

"I want to be the navigator of my recovery journey."

Health Status

National data

Prevalence

The National Study of Mental Health and Wellbeing 2020-2022 (ABS 2024e) provides the most recent estimates of prevalence of mental health conditions for people aged 16-85 years. Nationally:

- 42.9% of people aged 16–85 years had experienced a mental condition at some time in their life (lifetime mental condition)[11].
- 20.3% of people had a 12-month mental health condition[12].
- Changes in prevalence since 2007 show that rates have remained the same for most age groups, but 12-month mental health conditions have increased for 16–24-year-old females from 30% to 46% in 2023.

Tracking of mental health scores over time via the Household, Income and Labour Dynamics in Australia Survey (HILDA) survey shows deteriorating mental health in the Australian population between 2014 and 2021, especially among people aged 15-34 years, with females recording the worst scores (AIHW 2024e).

The most recent survey of children was the Australian Child and Adolescent Survey of Mental Health and Wellbeing, (also referred to as the Young Minds Matter Survey) undertaken in 2013–14 when about 14% of 4–17-year-olds were estimated to have experienced mental illness in the previous 12 months (TKRIA 2017). The most common mental illnesses among all children and adolescents nationally were (TKRIA 2017):

- Attention Deficit Hyperactivity Disorder (7%)
- Anxiety disorders (7%)
- Major depressive disorder (3%)
- Conduct disorder (2%)

Burden of disease

According to Australia Burden of Disease Study 2023, mental health conditions and substance use disorders was the second highest disease group, responsible for 15% of the total disease burden in Australia in 2023 (AIHW 2023a). For overview, see **Gippsland Main Health Issues**.

- There has been a 33% increase in anxiety disorders and a 11% increase in depressive disorders between 2003 and 2023 (AIHW 2023a).

[11] Lifetime mental condition refer to the number of people who met the diagnostic criteria for having a mental condition at some time in their life. This does not imply that a person has had a mental condition throughout their entire life

[12] 12-month mental condition refer to the number of people who met the diagnostic criteria for having a mental health condition at some time in their life and had sufficient symptoms of that condition in the 12 months prior to when they completed the survey.

- The experiences of mental conditions vary by age and between males and females (AIHW 2023a):
    - **Among children aged 5–14 years:** mental disorders contribute substantially to burden of disease with anxiety disorders contributing most among females (10.4%) and autism spectrum disorders most among males (15.9%).
    - **Among young people aged 15-24 years:** anxiety disorders contribute most among both females (16.8%) and males (10.5%). Eating disorders rated as the third cause of disease burden for females aged 15-24 years and fifth among females aged 25-44 years.

Population groups more likely to be impacted by mental illness (AIHW 2024e):

- **Females**: According to 2021 census data, nearly twice as many young women in Victoria aged 20-29 (16%) are diagnosed with mental illness compared to their male counterparts (8%), with female rates consistently higher across all age groups.
- **People living with a disability:** According to the 2020–21 National Health Survey, an estimated 33% of adults with disability experienced high or very high psychological distress in the previous week – nearly triple the rate of those without disability (12%). People with psychosocial disability faced the highest levels of distress, with 76% reporting significant or very high psychological distress, followed closely by those with intellectual disability at 53%.
- **LGBTIQA+**: In 2020, an estimated 61% of LGBTIQA+ people reported a depression diagnosis, and 47% an anxiety disorder. Further, 57% reported experiencing high or very high levels of psychological distress within the past four weeks, highlighting the significant mental health challenges within this community.
- **People not in education or employment.**
    - See also **Aboriginal and/or Torres Strait Islander Health and Wellbeing**
    - See also **Alcohol and Other Drugs**
    - See also **Access to primary care for marginalised communities**

Comorbidities

People living with mental illness, and in particular severe mental illness, are more likely to experience comorbidity of physical health conditions, more likely to be hospitalised for potentially preventable reasons and tend to die earlier than the general population (AIHW 2024e). See also **Chronic Conditions**.

In summary:

- An estimated 8.4% of adults experiencing both a mental illness and a long-term physical health condition.
- Long-term physical health conditions were reported to be around twice as common for people living with mental illness, including arthritis, asthma, cancer, diabetes, and health disease.

The reasons people living with severe mental illness experience poorer physical health include:

- Increased exposure to known risk factors for physical disease including lower socio-economic status, smoking, poor nutrition, less physical activity and higher sedentary behaviour
- Reduced access to and quality of health care due to financial barriers, and stigma and discrimination among health care providers
- Systemic issues in health care delivery, including the lack of integrated care across mental and physical health services, and unclear accountability for monitoring physical health that leave gaps in comprehensive and cohesive care that addresses both needs
- Adverse effects of psychotropic medication, in particular their contribution to metabolic syndrome, obesity, cardiovascular disease, and type 2 diabetes
- Impacts from polypharmacy (the prescription of multiple medications).
- Lack of capability among both generalist and specialist health care staff to manage complex comorbidities. Mental health staff may lack skills, training, and confidence to address and treat physical conditions, while physical health teams lack training and confidence to manage mental health conditions.

Mortality

People living with mental illness have a lower estimated life expectancy- 16-years less for males and 12-years less for females. This is mainly due to premature deaths from potentially preventable physical health conditions. Among all mental illness types, substance use disorder has been associated with the poorest health outcomes.

Gippsland data

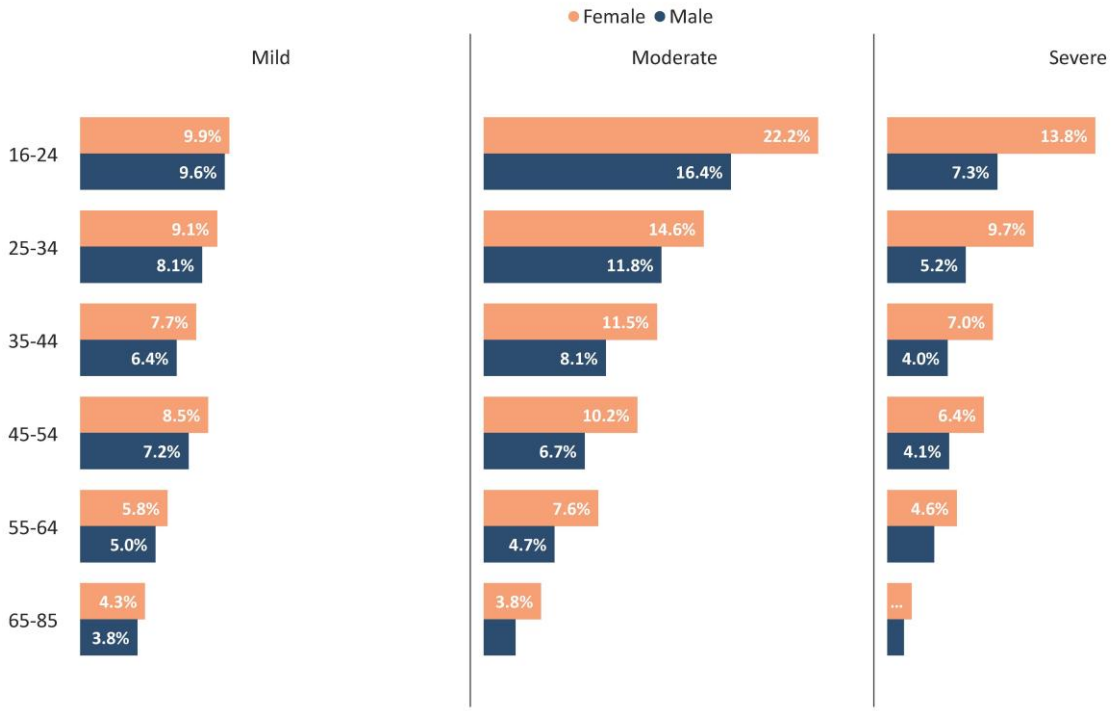
Latest census data indicates that 11.0% of the Gippsland population had a diagnosed mental health condition, compared to 8.8% for Victoria and Australia respectively (ABS 2021a).

According to the National Study of Mental Health and Wellbeing 2020-2022 (ABS 2024e) an estimated 20.3% of people in Gippsland had a 12-month mental health condition[11]. Key findings (**Figure 57**) suggest:

- Prevalence was greater in females across all severity levels and age groups than males.
- Overall estimates indicate 23.6% of females experienced a 12-month mental health condition compared to 16.8% of males.
- Prevalence was greatest among 16–24-year-olds.

- Of survey participants, 8.8% of people were estimated to have a comorbidity of any 12-month mental health condition and a physical condition.
- Rates in Gippsland are higher than Victoria across all gender, severity and age groups, except for young males aged 16-24 years and 25-36 years with severe mental health conditions (**Appendix 9**).

Figure 57. Proportion of people with lifetime and 12-month mental conditions in Gippsland by severity, age group and gender, 2020-22 (ABS 2024e).



Prevalence for 16–85-year-olds by severity in Gippsland was 4.8% for severe mental health conditions, 8.5% for moderate mental health conditions and 6.5% for mild mental health conditions (ABS 2024e).

Prevalence estimates for the type of disorder are below (ABS 2024e):

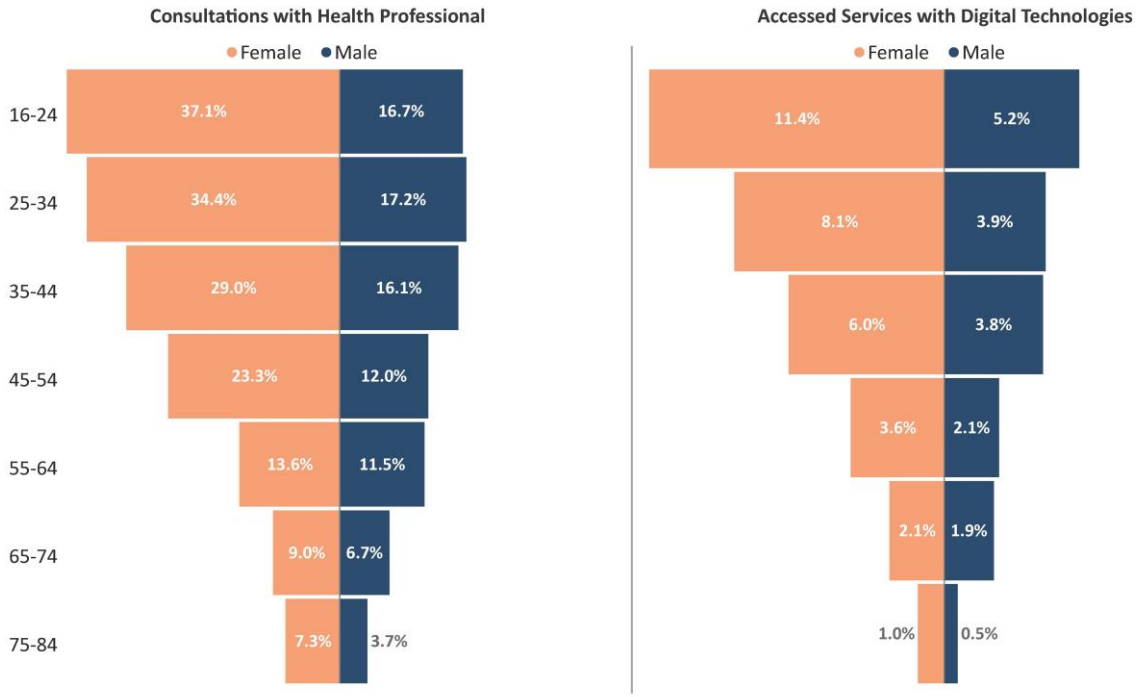
- Affective disorder: 7.0% (includes depression)
- Anxiety disorders: 17.4%
- Substance use disorder: 3.5%

Professional support

In Gippsland, 16.6% of people aged 16-85 years were estimated to have had at least one consultation with a mental health professional in the past 12 months (ABS 2024e) (**Figure 58**). Females were more likely to seek professional help; with 21.1% having done so compared to 11.9% of males. (ABS 2024e). Younger age groups were more likely to seek support, particularly 16–24-year-old females (ABS 2024e).

In addition to mental health related consultations with health professionals, an estimated 3.4% of people in Gippsland also accessed other services for their mental health using phone, internet, or another digital technology[13]. The proportion was highest for 16–24-year-olds at 8.2% of the total participants, a distribution by age group and gender of service users can be seen in **Figure 58**.

Figure 58. Consultations with mental health professionals and access of services with digital technologies[12] in the past 12 months, Gippsland by age and gender (ABS 2024e).



[13] 'Digital technology' refers to services other than consultations with health professionals accessed using phone, internet or another digital technology, including:

- Crisis support or counselling services (e.g. Lifeline)
- Treatment programs, training assessments, or other tools to improve mental health (e.g. MindSpot, MoodGym, MyCompass)
- Mental health support groups, forums, or chatrooms (e.g. SANE, Beyond Blue, or CanTeen forums)
- Information about mental illness, treatment options or services.

The **Victorian Population Health Survey** (DH 2020) provides prevalence estimates (age-standardised) for mental health related conditions among adults. Rates in Gippsland, compared to the Victorian average, are reported below:

- Ever been diagnosed with anxiety or depression: 37% in Gippsland (higher than the Victoria average of 32%)
- Current high or very high psychological distress: 21% in Gippsland (lower than the Victorian average of 24%)
- Had been diagnosed with bipolar disorder: 2.5% in Gippsland (more than twice the Victorian average of 1.1%)
- Had been diagnosed with schizophrenia: 1.9% in Gippsland (three times higher than the Victorian average of 0.6%)
- Feeling never or not often feel valued by society: 13% in Gippsland (compared to the Victorian average of 11%). Notably, in Latrobe, this figure increased to 18%, the highest proportion in the state.

Service System

Background

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. This included joint regional planning between Local Health Networks (LHNs) and Primary Health Networks (PHNs). In Gippsland, a Regional Mental Health and Suicide Prevention 'Plan on a Page' was published in 2020 (GPHN 2024i) and it identifies a vision, mission, values, and commitments. Proposed areas of focus included the following:

- 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.

A bilateral Mental Health and Suicide Prevention Agreement between the Commonwealth and Victoria was executed in 2022 and sets out a shared commitment to working together to improve mental health and wellbeing. A Gippsland overview of the evolving service system was published in July 2023 (GPHN 2024i).

In addition, the recently published Statewide Mental Health and Wellbeing Service and Capital Plan 2024–2037 is a first for Victoria and will play an important role in the transformation of the mental health system. The Plan is a step towards a new approach to planning for mental health and wellbeing treatment, care and support. It will be used as a guide for future planning and investments with community mental health treatment, care and support at the centre, and as a framework to help guide and support mental health related decision making through Victoria.

The Statewide Mental Health and Wellbeing Service and Capital Plan 2024-2037 also provides response to Recommendation 47 of the Royal Commission into Victoria's Mental Health System published in 2021. The Royal Commission report outlines change required to create a future mental health and wellbeing system that provides holistic treatment, care and support for all Victorians. The report includes a total of 65 recommendations in addition to nine interim report recommendations which are designed to set out a 10-year vision for mental health reform in Victoria.

Gippsland PHN funds a variety of primary mental health services that deliver care across the stepped care continuum. Services include headspace and Head to Health centres, as well as care provided by mental health practitioners, peer workers, nurse practitioners, and social workers.

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

- The Latrobe Regional Health (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 only available at the Traralgon campus of Latrobe Regional Health.
- Specialised services for Indigenous people are limited with two providers with an ongoing presence in two LGAs.
- Specialised services for children and people aged 65 years or older are very limited and/or are being phased out.
- Public psychiatry is available through the Area Mental Health Service.
- Secondary consultations are available through the Area Mental Health Service and via telehealth.
- Dual diagnosis services are available through a limited number of providers.
- Programs including a peer support workforce are limited but growing.
- 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, LGBTIQA+ people), and/or geographies (including far East Gippsland).
- There are no LGBTIQA+ specific services provided in Gippsland.

Service Use

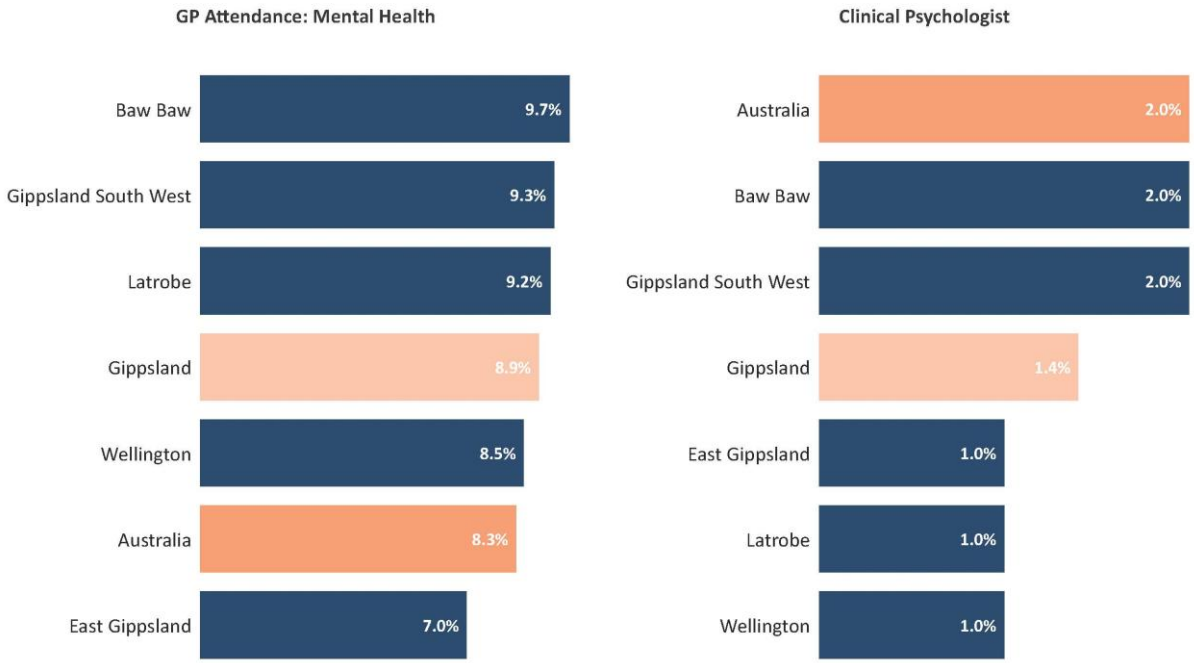
Medicare subsidised services

Medicare subsidised services related to mental health care were delivered to a lower proportion of the population compared to Australia for all professions except GPs in 2022-23 (AIHW 2024f) (**Appendix 10Error! Reference source not found.**). Of note, there are significant access issues:

- Allied health, clinical psychologist, other psychologist and specialist attendance in Wellington were in the bottom 25% of SA3 sub-regions nationally.
- Baw Baw (9.7%), Bass Coast / South Gippsland (9.3%) and Latrobe (9.2%) all have mental health General Practice mental health attendances above the national rate (8.3%).
  In contrast, East Gippsland (7.0%) falls below the national rate (8.3%)
- East Gippsland and Wellington were amongst the bottom 25% in Australia for access to clinical psychology and psychiatry.

General Practice and clinical psychologist attendance is shown in **Figure 59**, noting GP attendance for mental health conditions in Baw, Latrobe and Gippsland South West is in the top 25% of SA3 sub-regions nationally.

Figure 59. Medicare subsidised mental health care, percentage of people who used a GP or clinical psychologist service, by Gippsland SA3 sub-region, 2022-23 (AIHW 2024f).



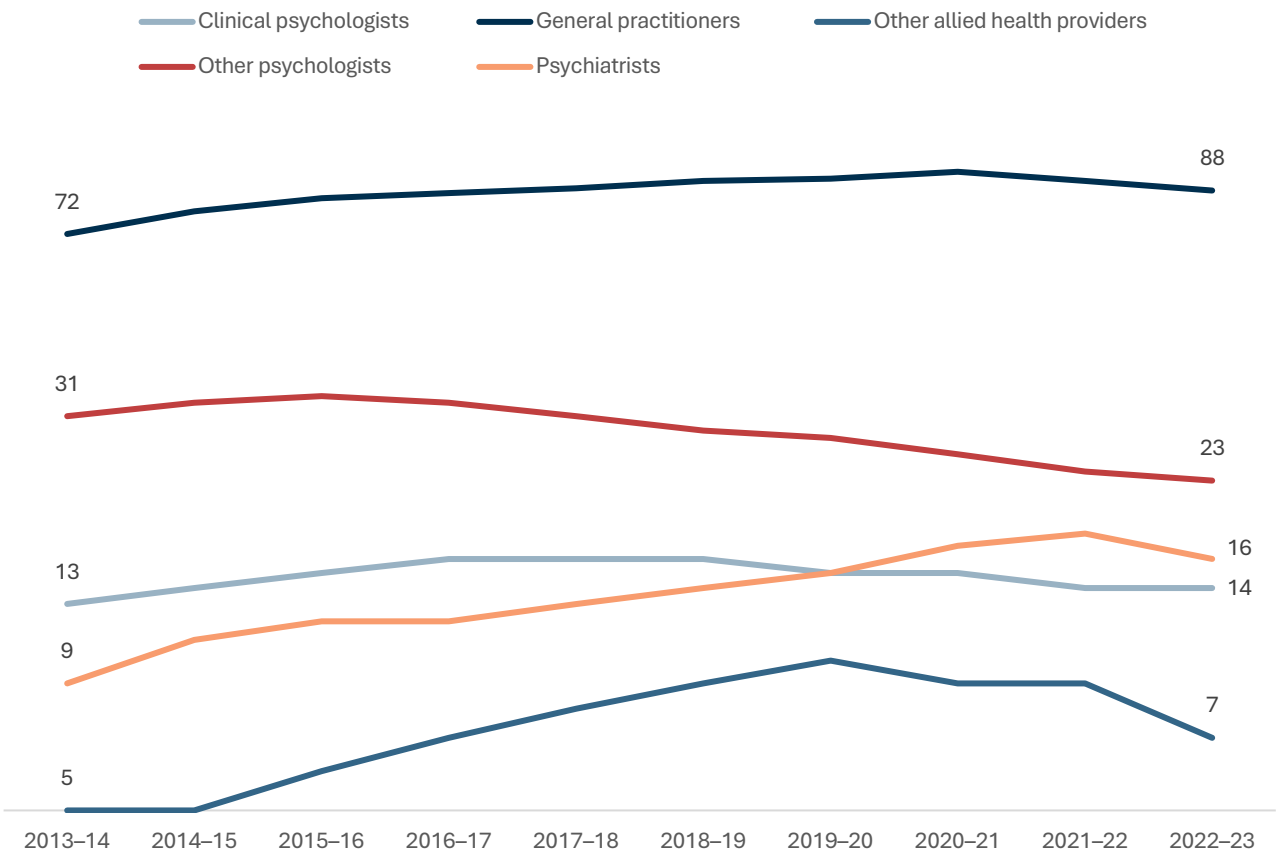
Trends over time for the use of Medicare funded services for mental health in Gippsland by profession are shown in **Figure 60** (AIHW 2024f). It can be noted that:

- **Mental health care by GPs:** In 2022-23 General practitioners provided mental health care to 88 out of every 1,000 residents; a slight decrease from 93 in 2019-20. This remains higher than the national average of 82 per 1,000.

- **Psychiatry services:** There were 16 psychiatry services per 1,000 people in 2022-23; down from 18 in the previous year and below the national rate of 20 per 1,000.

- **Psychology services:** While the rate of services by clinical psychologists has remained stable since 2014-15, the rate of services by other psychologists has dropped to a low of 23 patients per 1,000 population in 2022-23, down from 34 in 2015-16.

Figure 60. Medicare subsidised mental health care, patient rate per 1,000 population by profession in Gippsland, 2013-14 to 2022-23 (AIHW 2024f).



Demographic comparisons

Data by age and gender were not available for smaller geography such as Gippsland, but national data comparing the rate of the population receiving a Medicare mental health services show:

- **High uptake by young people:** The highest rate of people receiving Medicare mental health services are 18–24-year-olds.
- **Gender disparity:** Females accessed these services at a 64% higher rate than males.
- **Urban versus rural divide:** Major cities had the highest rates with 35% lower rates in outer regional areas while very remote areas had a 145% lower rate.
- **Inequity:** The most disadvantaged areas had 60% lower rate than those in the most advantaged areas of Australia.

Mental health related prescriptions

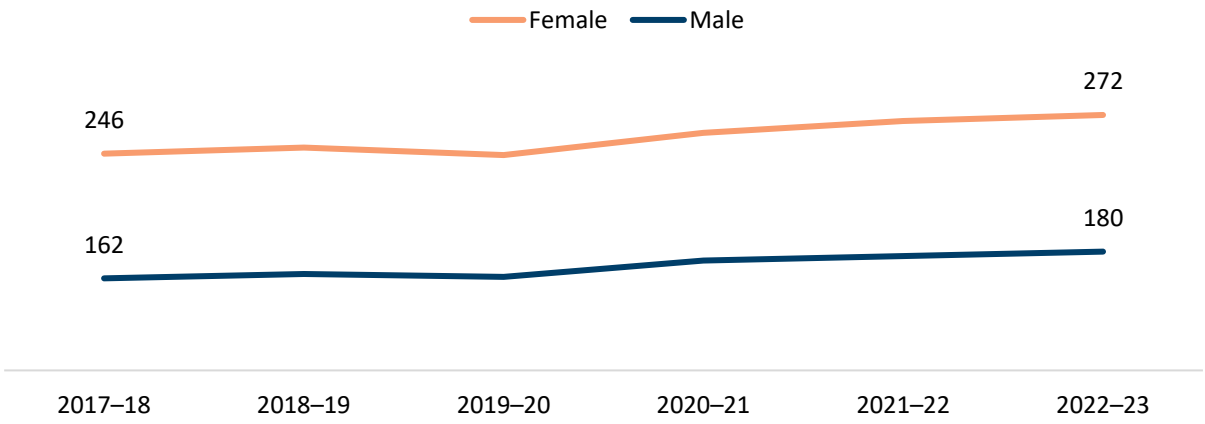
In 2022-23, 69,069 Gippsland residents received a mental health related prescription (AIHW 2024e):

- Gippsland PHN had 227 prescriptions per population in 2022-23: higher than the rate in Australia (184) and the seventh highest prescribing rate of PHN regions
- There was an increase in prescribing rates in Gippsland from 204 prescriptions per population in 2017-18 to 227 in 2022-23; an increase was seen for both males and females (**Figure 61**).

For SA3 sub-regions in 2021-22:

- All Gippsland SA3s had a high prescribing rate with the highest rates in East Gippsland (243) and Latrobe (238)
- 23% of Gippsland residents were prescribed a mental health related medication; much higher than 18% of the Victorian and Australian population
- East Gippsland had the fastest increase in mental health related prescribing in Gippsland

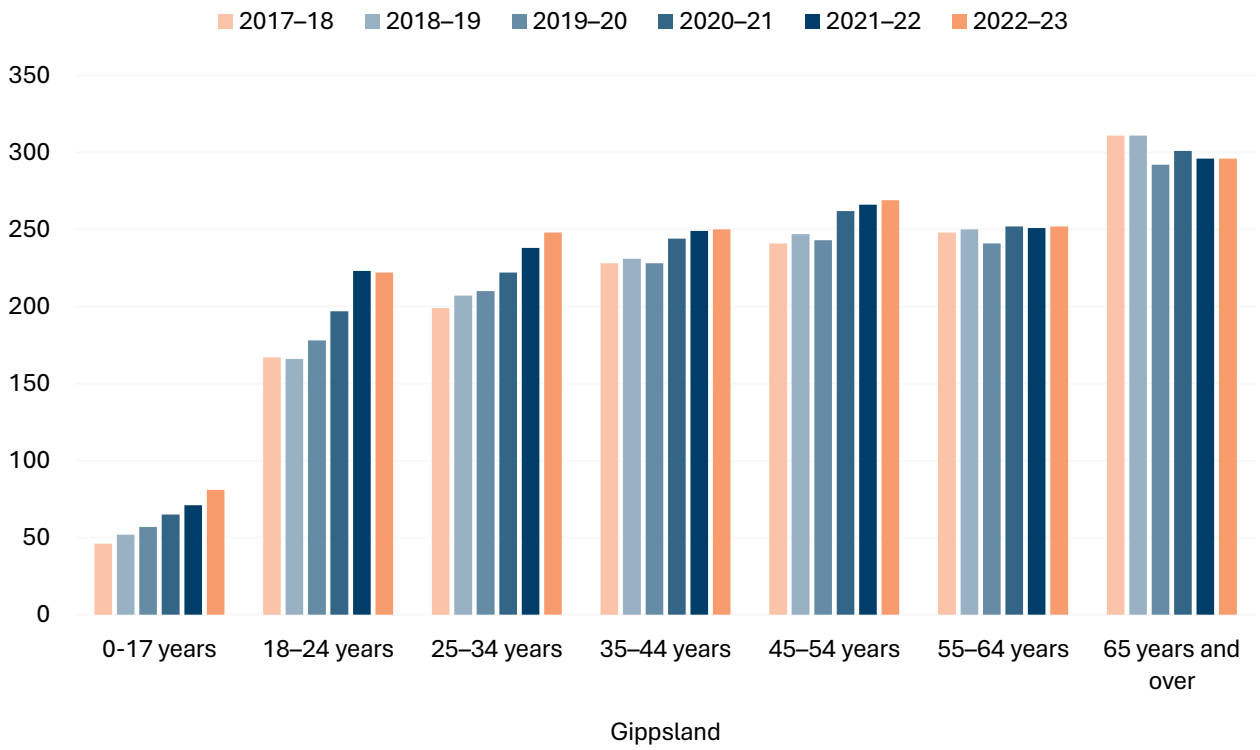
Figure 61. Gippsland population with mental health related prescriptions by gender, 2017-18 to 2022-23 (AIHW 2024e)



Mental health related prescribing by age group over time in Gippsland is shown in **Figure 62**. Of note:

- The highest prescribing rates are seen among people 65 years or older, but these rates have fallen by 5% since 2017-18.
- Prescribing rates among children (0-17 years) are low but have increased substantially (76% growth) since 2017-18.
- There has been a 33% increase in prescribing rates among 18–24-year-olds.
- There was a smaller increase in prescribing rates among 25–34-year-olds (up by 25%), 35- to 44-year-olds (up by 10%) and 45–54-year-olds (up by 12%).

Figure 62. Mental health related prescriptions in Gippsland by age group, 2017-18 to 2022-23 (AIHW 2024e).



General practice

In 2023-24, nearly one in three Gippsland patients (27.1%) presenting to general practice had an active mental health diagnosis (GPHN 2024f). Of these:

- A total of 354 patients had an active diagnosis of any eating disorder (184 had anorexia nervosa and 96 bulimia).
- There were 14,941 referrals for psychology across Gippsland (6,538 of these were for a patient with an active mental health diagnosis). By LGA, 22% were for patients in East Gippsland, 26% for Latrobe, 19% Baw Baw, 19% Wellington, 7% Bass Coast and 8% South Gippsland.
- The most common mental health diagnosis in 2023-24 was Depression, followed by anxiety and mixed anxiety and depression disorder (**Figure 63**).
- The proportion of patients with an active mental health diagnosis prescribed selected groups of medications:
    - Antidepressants: 43.5% of patients
    - Opioids: 38.2%
    - Antipsychotics: 19.0%
    - Anxiolytics: 20.4%
    - Hypnotics and sedatives: 24.7%
    - Psychostimulants: 2.0%
- The most common new mental health related diagnosis in 2023-24 was anxiety, overtaking depression diagnoses which had been the highest prior to 2020-21 (**Figure 64**).
- Additionally, new diagnosis of attention deficit hyperactivity disorder has increased at the fastest rate of the top 5, growing at 32.9% per year, and was the only top 5 condition to have increased between 2022-23 and 2023-24.
- 39.3% of patients with an active mental health diagnosis had a GP Mental Health Care Plan.

Figure 63. Top 10 active mental health related diagnoses among general practice patients in Gippsland, 2023-24 (GPHN 2024f)

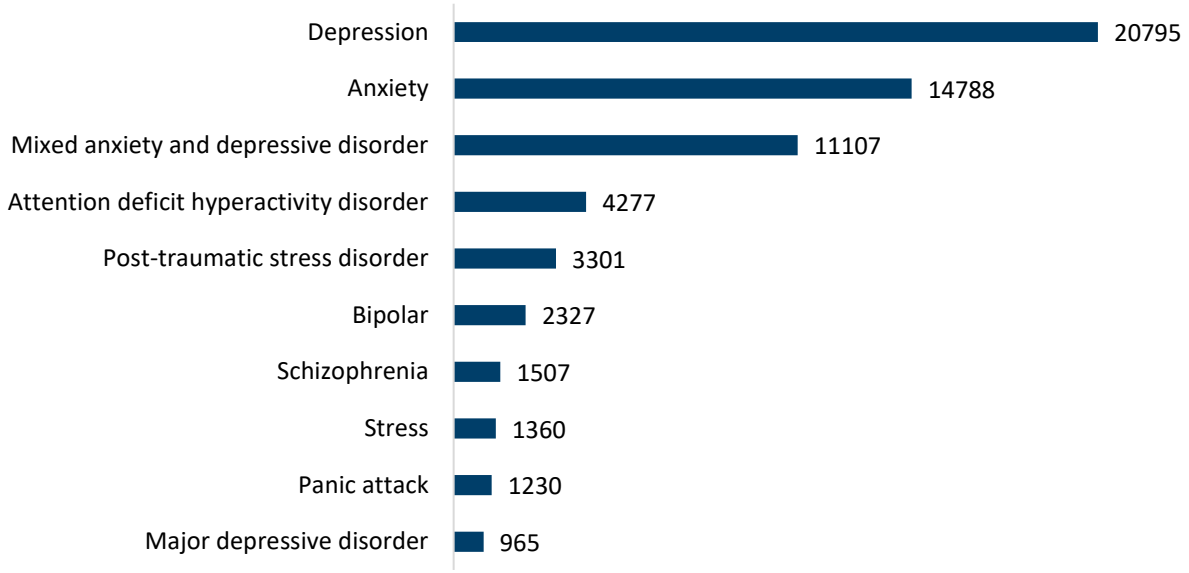
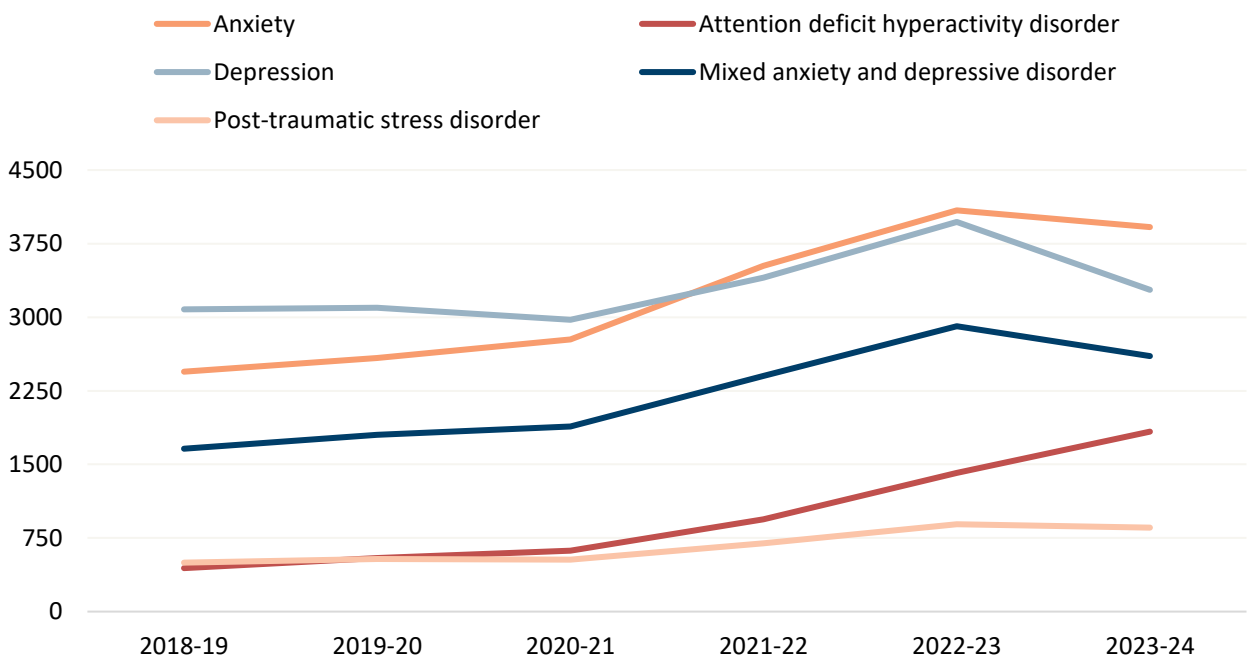


Figure 64. Top five new mental health related diagnoses among general practice patients in Gippsland, 2018-19 to 2023-24 (GPHN 2024f)



Gippsland PHN funded primary mental health services

- In 2023-24, there were 4,822 clients accessing Gippsland PHN funded Primary Mental Health care services with 5,002 episodes of care and 32,411 service contacts. (GPHN 2024k).
- Of all service contacts in 2023-24 (and comparison to 2019-20):
    - **Health care card holders:** 36.2% (steady since 2019-20)
    - **NDIS Participants:** 2.4% (previously 2.7%)
    - **GP mental health plan:** 31.3% (down from 54.4%)
    - **Employment status:**
        - Full time: 14% (previously 9%)
        - Part time: 15% (previously 9%)
        - Not in the workforce: 61% (previously 54%)
    - **Referred by:**
        - Referred by a GP: 42% (previously 67%)
        - Self-referred: 25% (previously 14%)
        - Referrer profession was “other”: 18%
    - **Main Diagnosis:** The principal diagnoses of contacts was subsyndromal problems (**Table 11**). The most frequently diagnosed additional diagnosis was subsyndromal problems (**Table 12**).
    - **Income source:** Paid employment for 27.5% of contacts (up from 17% in 2019-20) (**Table 13**).
    - **Types of contacts (Figure 65):**
        - Psychosocial support: 32.5% (up substantially from 16.7%);
        - Structured psychological intervention: 31.7% (down from 34.5%)
        - Clinical care coordination: 14.6% (down from 18.8%)

Table 11. Percentage of service contacts by principal diagnosis in Gippsland, 2023-24 (GPHN 2024k).

Principal diagnosis	Service contacts (%)
No formal mental disorder but subsyndromal problems	54.9
Anxiety disorders	20.4
Affective (mood) disorders	15.3
Other mental disorders (4.7%)	3.4
Psychotic disorders	2.4
Disorders with onset usually occurring in childhood and adolescence not listed elsewhere	1.9
Substance use disorders	1.0
Missing or unknown	0.6

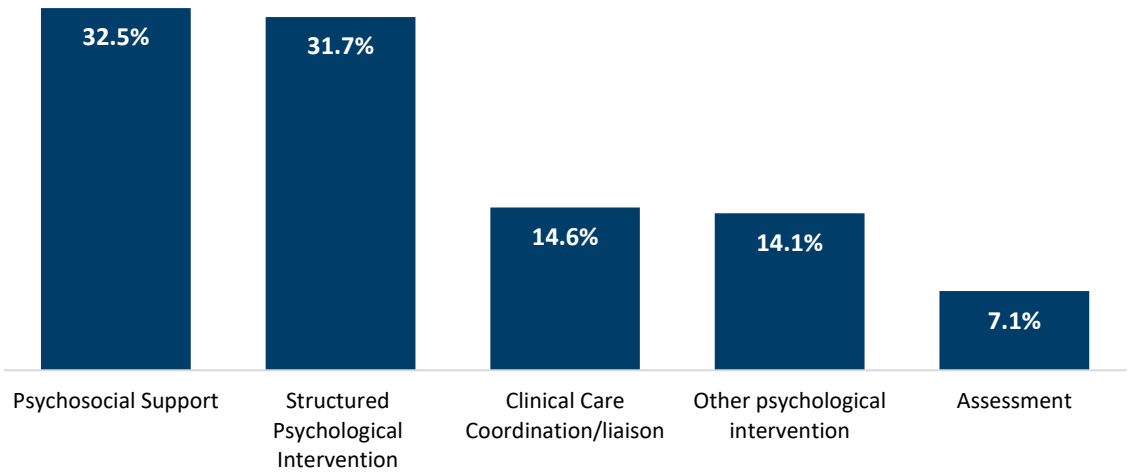
Table 12. Percentage of service contacts by additional diagnosis in Gippsland, 2023-24 (GPHN 2024k).

Additional Diagnosis: Grouped	Service contacts (%)
No formal mental disorder but subsyndromal problems	34.0
No additional diagnosis	33.6
Anxiety disorders	16.2
Affective (mood) disorders	8.2
Other mental disorders	3.0
Disorders with onset usually occurring in childhood and adolescence not listed elsewhere	1.5
Psychotic disorders	1.3
Substance use disorders	1.2
Missing or unknown	0.8

Table 13. Service contacts by source of cash income for Gippsland, 2023-24 (GPHN 2024k).

Source of Cash Income	Service Contacts	
	Number	Percentage
Other pension or benefit	9,882	30.5%
Paid employment	6,857	21.2%
Disability Support Pension	4,349	13.4%
N/A Client aged less than 16 years	4,013	12.4%
Not stated/inadequately described	2,809	8.7%
Not known	2,412	7.4%
Nil income	1,295	4.0%
Other (e.g. superannuation, investments etc)	527	1.6%
Compensation payments	267	0.8%

Figure 65. Percentage of service contacts by service contact type in Gippsland, 2023-24 (GPHN 2024k).



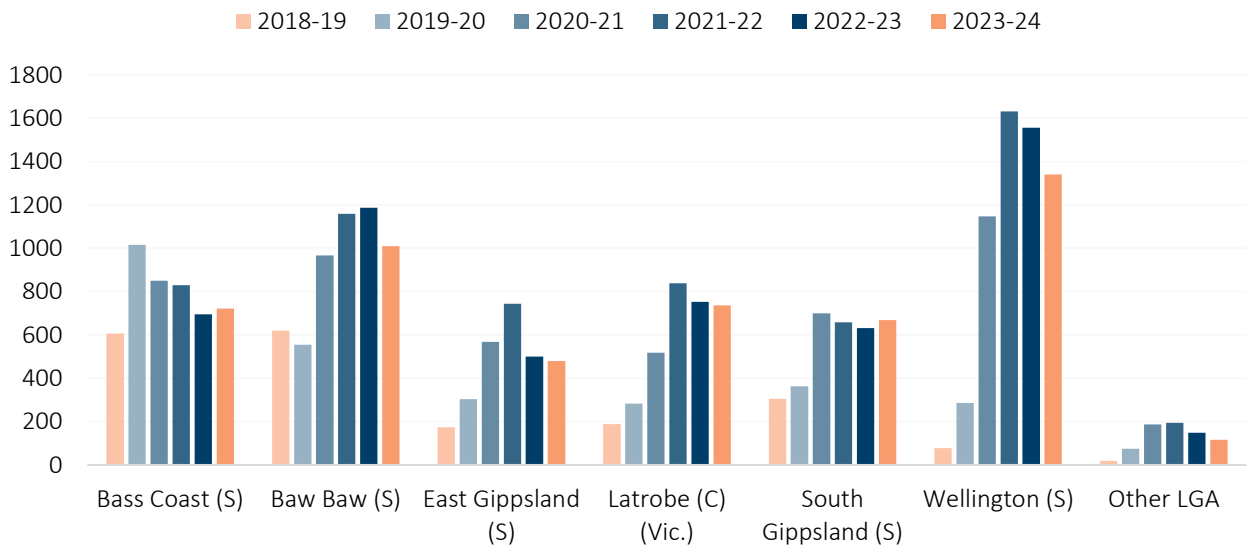
Demographic details over time are shown in **Table 14**. Very little variation over time is noted, with the exception of a slight decrease in the proportion of female clients.

Table 14. Client demographics, Gippsland PHN funded primary mental health services, 2021-22 to 2023-24 (GPHN 2024k).

Client characteristic	2021-22	2022-23	2023-24
Age 25-64 years	56.3%	55.9%	56.6%
Gender identification as female	66.3%	64.2%	62.1%
Main language spoken at home was English	99.3%	99.3%	99.5%
Aboriginal and/or Torres Strait Islander identification	3.6%	3.8%	3.4%
Country of birth was Australia	94.2%	92.7%	92.8%

The distribution of clients by residential LGA was estimated based on postcode (**Figure 66**). It can be noted that there has been an increase in client episodes in Gippsland PHN mental health commissioned services over time for most LGAs. Since 2019-20, Gippsland PHN commissioned services included in the PMHC-MDS changed to include HeadtoHealth and bushfire funded services. This change has likely driven the rise in self-referrals, a reduction in services delivered as part of a GP mental health treatment plan, an increase in services provided to people with no formal diagnosis and more services delivered to people in paid employment. Bushfire funded services contributed to the increase in psychosocial support category. The peak in 2021-22 was impacted by HeadtoHealth service provision and bushfire funded services and may have been impacted by a return to 'business as usual' following the COVID-19 pandemic.

Figure 66. Number of client episodes for Gippsland PHN funded primary mental health services, by LGA, 2018-19 to 2023-24 (GPHN 2024g).



headspace services

See **Chapter 7: Growing Up Healthy** for details.

Hospital admissions

National Hospital Morbidity Database

In some cases, an individual's mental health care needs may require engagement of inpatient care at a public or private hospital. National data shows that in 2022-23 (AIHW 2024e):

- 79% of longer stays (involving at least one overnight stay) occurred in public hospitals,
- 21% of same day hospital admissions were in public hospitals, and;
- Hospital admissions with psychiatric care have decreased, especially since 2020-21.

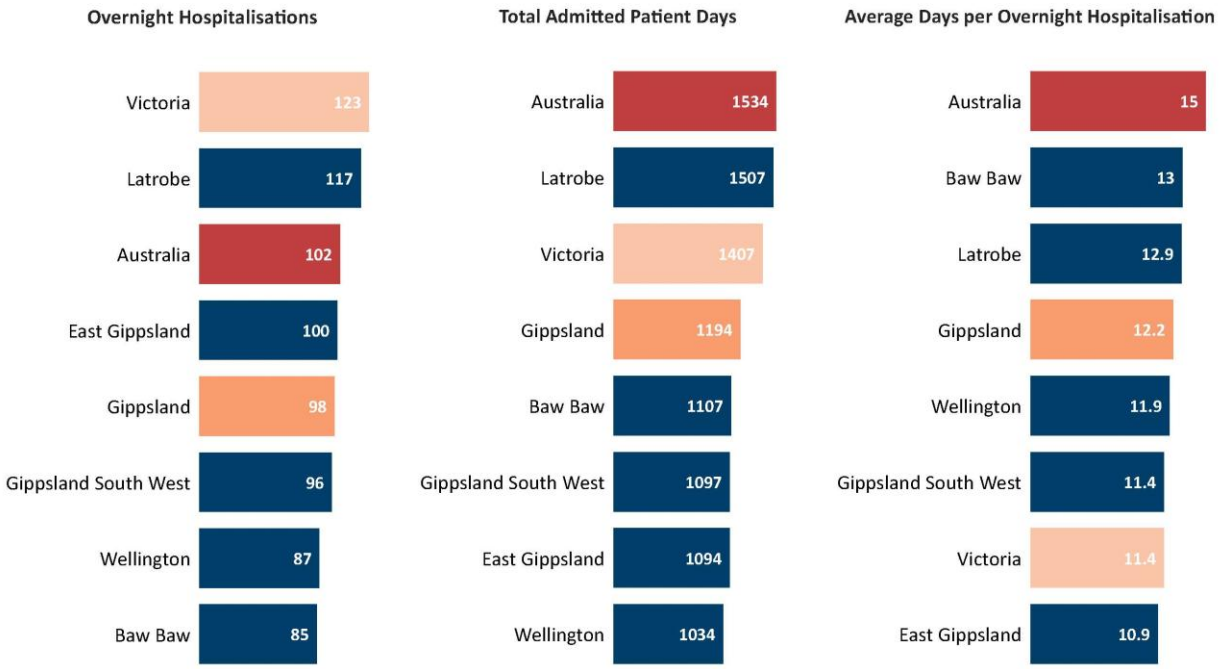
Mental health hospital admission rates (per 10,000 population) for Gippsland residents in 2021-22 (AIHW 2024e) are shown in **Figure 67**:

- **Overnight stays:** Mental health related hospital admissions that included at least one overnight stay were generally lower in Gippsland compared to Victoria, except for the high rate in Latrobe.

- **Admitted:** Gippsland had a lower rate of admitted patient days compared to Victoria and Australia; especially in Wellington, but the Latrobe rate was higher.

- **Average days per overnight hospitalisation:** Gippsland and Victoria are below the national average; East Gippsland has the lowest average days in Gippsland, below the Victorian average.

Figure 67. Mental health hospital admissions (per 10,000 population) that included at least one overnight stay for Gippsland residents, 2021-22 (AIHW 2024e).

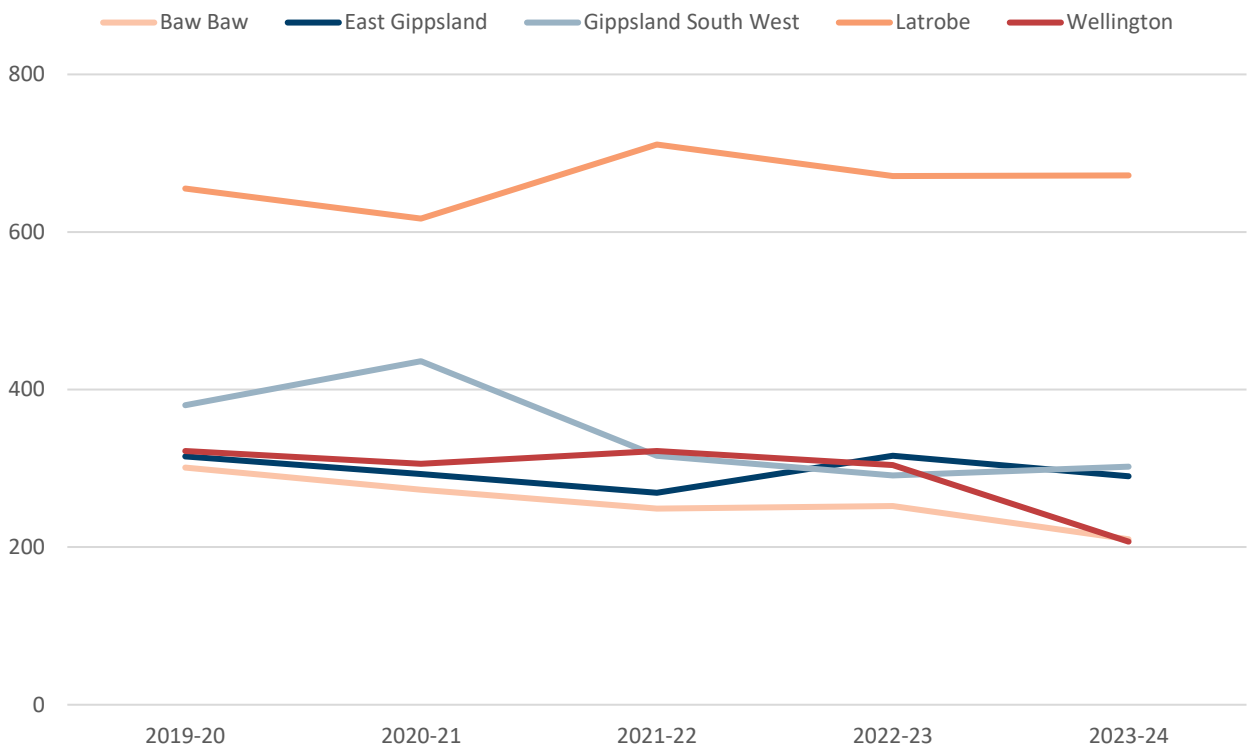


Victorian Department of Health (DH) Victorian Admitted Episodes Dataset (VAED)

There was a total of 1,681 mental health admissions to hospital for Gippsland residents in 2023-24, down by 15% from 1,973 in 2019-20, see **Figure 68** for details. Latrobe was the only area with annual growth, increasing 0.6% per year; by contrast, Wellington and Baw Baw saw the greatest annual declines (-10.5% and -8.6% per year, respectively). Distribution by SA3 sub-regions over the five years are as follows:

- Latrobe residents: 36% of admissions
- Gippsland South West residents: 19%
- East Gippsland residents: 16%
- Wellington residents: 16%
- Baw Baw residents: 14%

Figure 68. Number of mental health hospital admissions among Gippsland residents, 2019-20 to 2023-24 (DH 2024a).

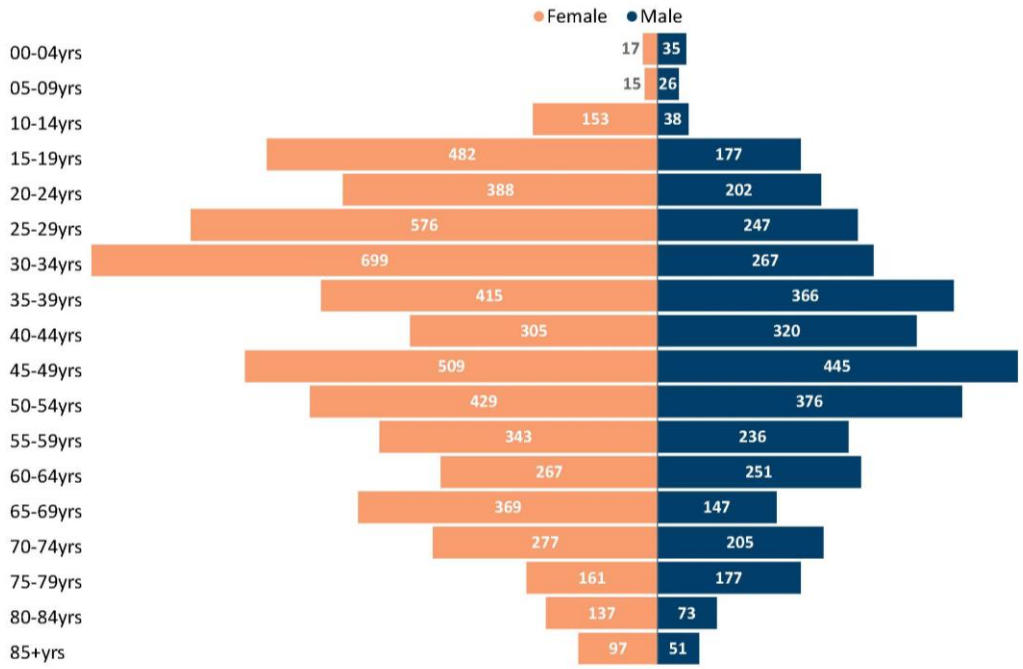


Demographics of admissions (DH 2024a) (**Figure 69**) show that:

- **Gender breakdown:** 61% of mental health admissions were for females
    - 38% of female admissions were 15 to 34 years olds
    - 41% of male admissions were 35–54-year-olds

- **Age group breakdown:** 3.1% of admissions were for 0–14-year-olds (284); 13.5% were for 15–24-year-olds (1,249) and 18.3% were for people aged 65 or above (1,694)

Figure 69. Age and sex for mental health hospital admissions for Gippsland residents 2019-20 to 2023-24 (DH 2024a).



The top diagnoses (noting more than one can apply to each admission) among mental health hospital admissions are listed in **Table 15**.

Table 15. Top mental health diagnosis among admissions for Gippsland residents, number and percentage of all mental health admissions, 2019-20 to 2023-24, n=9,280 (DH 2024a).

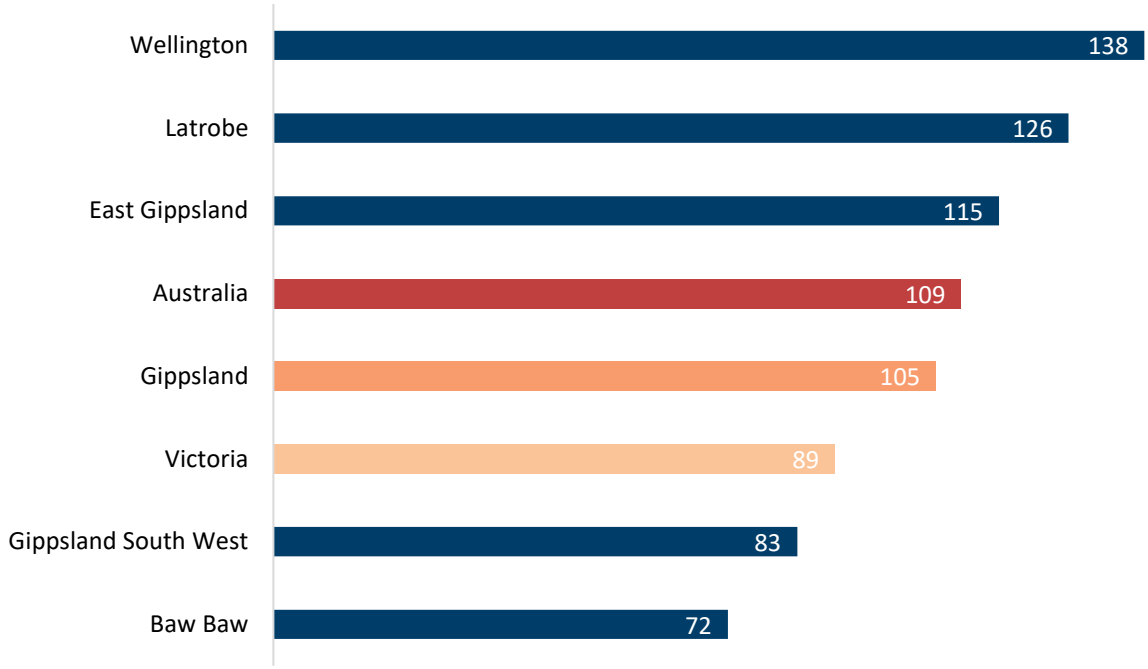
Diagnosis	Number	Percentage
Depression (any)	4,219	45%
Schizophrenia (any)	1,565	17%
Anxiety (any)	1,510	16%
Personality disorder (any)	1,384	15%
Bipolar disorder (any)	1,030	11%

Emergency department presentations

In 2021-22, Gippsland had a higher rate of mental health related emergency department presentations compared to Victoria, but similar to the Australian average (**Figure 70**). LGA analysis reveals the following:

- **Wellington:** Highest rate and rates have been stable since 2019-20
- **Latrobe:** High rates reduced slightly from 137 in 2019-20
- **East Gippsland:** High rates but have reduced from 181 in 2019-20

Figure 70. Mental health related emergency department presentations for Gippsland residents, 2021-22 (AIHW 2024e).



Suicide Prevention

Australian context

The latest finalised suicide-related data for Australia is for 2022 (ABS 2024f):

- There were 3,249 deaths due to suicide (2,455 males and 794 females). This compares to 3,166 suicides in 2021 (2,375 males and 791 females). Suicide remained the 15th leading cause of death.
- The age-standardised suicide rate was 12.3 deaths per 100,000 people, which similar to 12.1 per 100,000 people in 2021.
- **Gender:** The age-standardised suicide rate increased by 2.7% for males from 2021, while the rate for females decreased by 3.3%.
- **Median age at death**: For people who died by suicide was 45.6 (46.0 for males and 44.1 for females).
- **Risk factors present:** Almost 85.8% of people who died by suicide had risk factors identified. The most commonly recorded suicide risk factors included mood affective disorders, suicide ideation, problems with spousal relationships, and personal history of self-harm.

Burden of disease

According to Australian Burden of Disease Study 2023, 'Suicide and Self-inflicted injuries' was the leading cause of disease burden (fatal and non-fatal) among males aged 15-24 years and 25-44 years; it was the third cause for males aged 45-64 years (AIHW 2023a).

In 2022, 'suicide and self-inflicted injuries' was the second leading cause of fatal burden among all people (coronary heart disease is leading cause of fatal burden), with an estimated 159,200 total Years of Life Lost (YLL). Approximately 121,200 YLL were lost to suicide and self-inflicted injuries among men and 38,000 YLL among women. In 2022, suicide and self-inflicted injuries were also the second leading cause of fatal burden among men and the ninth leading cause of fatal burden among women (down from eighth in 2018).'

Contributing factors

In 2019, 'child abuse and neglect' during childhood was the greatest contributor to the years of healthy life lost due to suicide and self-inflicted injuries in both men and women in all age groups. The exception are women aged 85 years and over where 'intimate partner violence' was the highest contributor. The majority of the 'child abuse and neglect' burden was experienced among people aged 15–44 years. In females, the number of Disability-Adjusted Life Year (DALYs) was similar across these age groups (about 2,000–2,900 DALYs). The highest among men was between ages 25–34 years (7,000 DALYs).

Similarly, most of the years of healthy life lost due to suicide and self-inflicted injuries attributable to 'alcohol use' or 'illicit drug use' was experienced in ages 15–54 years. Both risk factors were highest among both men and women aged 15–34 years.

The years of healthy life lost due to suicide and self-inflicted injuries in women that were attributable to 'intimate partner violence' was highest among women aged 35–44 years.

In 2021, the overall suicide rate for people living in the most disadvantaged areas (18.4 deaths per 100,000 population; Quintile 1) was more than twice that of those living in the least disadvantaged areas (8.1 deaths per 100,000 population).

Psychosocial risk factors for suicide

Circumstances relating to a suicide are complex and multifaceted. Often, it is the combination of multiple factors rather than a single reason that contribute to a person dying by suicide. Risk factors should not be considered in isolation (ABS 2024e).

- **'Personal history of self-harm'** was the most common risk factor in males and females in all age groups (except 65 and over) with 16% and 33%, respectively.
- **'Limitation of activities due to disability'** was the most common risk factor in males and females aged 65 and over (25% and 22% respectively) and 2nd most common risk factor in females aged 55-64 (third for men).
- **'Disruption of family by separation and divorce'** and 'Problems in relationship with spouse or partner' were common risk factors in males and females aged under 55.
- **'Problems related to other legal circumstances'** was a common risk factor in males aged 25–54 (associated with more than 10% of deaths by suicide).
- **'Other problems related to housing and economic circumstances'** emerged as another common risk factor in males aged 35-64 (associated with 9% of deaths by suicide in these age groups).
- **'Disappearance and death of a family member'** was also identified as a frequently occurring psychosocial risk factor in males and females.

Gender considerations

In 2022 for **males** who died by suicide:

- Mood disorders (including depression) were the most common risk factor to be identified overall, as well as for those aged 5-24, 45-64 and 65-84 years.
- The top risk factor for males aged 25-44 years was problems in spousal relationships circumstances, present in over one-third of suicides. Problems in spousal relationships overtook mood disorders as the top risk factor in this age group for the first time and can include separation and divorce as well as arguments and domestic violence situations.
- There was overall a higher proportion of acute substance misuse disorders than chronic substance misuse disorders identified.
- Males aged 25-44 years were the most likely age group to have substance misuse identified as a risk factor, including:
    - Acute psychoactive substance use and intoxication (20.6%)
    - Chronic psychoactive substance misuse disorders (20.0%)
    - Acute alcohol use and intoxication (19.5%)
    - Chronic alcohol misuse disorders (14.8%).

In 2022 for **females** who died by suicide:

- Mood disorders (including depression) were the most common risk factor, identified as a risk factor in over 40% of all female suicides, and over 50% of suicides of females aged 45-64 years.
- Personal history of self-harm was the most common risk factor for those aged under 25 years.
- Suicide ideation was identified as a risk factor in over one quarter of suicides in every age group.
- Overall, substance misuse was less commonly mentioned as a suicide risk factor for females than for males.
- Acute psychoactive substance use was the most common form of substance misuse for those aged 5-24 years.
- For all other age groups, the most common form of substance misuse was either acute or chronic alcohol use.

Gippsland data

The **National Study of Mental Health and Wellbeing 2020-2022** (ABS 2024e) provides the most recent estimates of prevalence of suicidal thoughts and self-harm at PHN geography for people aged 16-85 years. It is noted that these are modelled estimates intended to provide an indication of the likely number and age/sex distribution of people.

Nationally, 16.7% of people aged 16–85 years had experienced suicidal thoughts at some time in their life. In the previous 12 month, 3.3% of people had experienced suicidal thoughts or behaviours, 1.2% had planned to take their own life, while 0.3% had attempted to take their own life.

In Gippsland, the figures are higher, with an estimated 17.9% having suicidal thoughts in their lifetime and 2.9% in the past 12 months.

- **Lifetime thoughts**: The highest estimates are among 16–24-year-olds, with 22.6% (females 25.7% and males 19.7%)
- **Recent thoughts:** The highest estimates in the past 12 months are among 16–24-year-olds, with 6.5% (females 8.2% and males 4.9%)

Self-harm refers to a person intentionally causing pain or damage to their own body (ABS 2024e). This behaviour may be a way of expressing or controlling distressing feelings or thoughts. Self-harm and suicide are distinct and separate acts although some people who self-harm are at an increased risk of suicide.

Nationally, 8.7% of Australians aged 16–85 years had self-harmed in their lifetime and 1.7% had self-harmed in the previous 12 months.

In Gippsland, it is estimated that 8.2% had self-harmed in their lifetime, while 1.9% had self-harmed in the past 12 months.

- **Lifetime self-harm:** The highest estimates are among 16–24-year-olds, with 23.1% (females 29.6% and males 16.9%)
- **Recent self-harm:** The highest estimates in the past 12 months are 16–24-year-olds, with 8.3% (females 10.5% and males 6.2%)

Suicide rates in Gippsland are high compared to Australia (**Figure 71**). Rates for males in Gippsland are around 5 times higher than for Gippsland females, remaining constant over time and larger than the national difference. There has been an increase in the rates for both males and females in Gippsland while rates in Australia have remained steady or reduced slightly.

Rates in Gippsland SA3 sub-regions over time are shown in **Figure 72**:

- East Gippsland had the highest rate and was also the highest in Victoria in 2018-22.
- All SA3 areas had higher rates than Australia in 2018-22.
- The largest percentage increase was seen in Wellington, Gippsland South West and Baw Baw (7.8%, 7.5% and 5.9% per year, respectively).

Figure 71. Age-standardised suicide rates, by year of death and gender in Gippsland and Australia, 2014–2018 to 2018–2022 (AIHW 2024p).

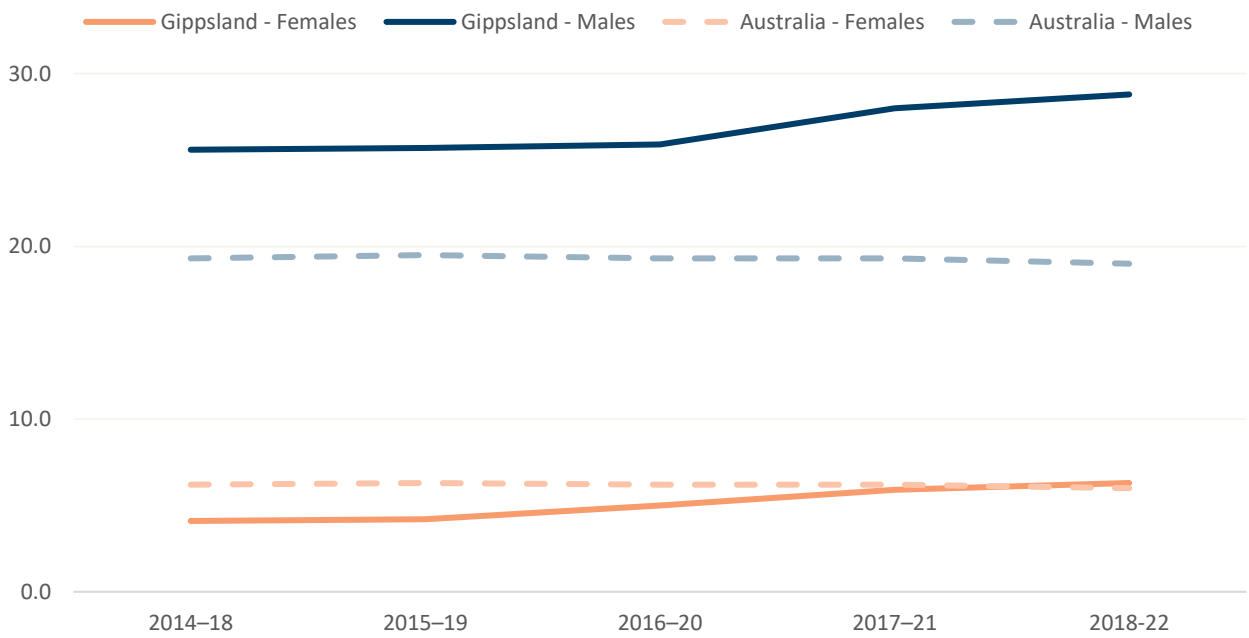
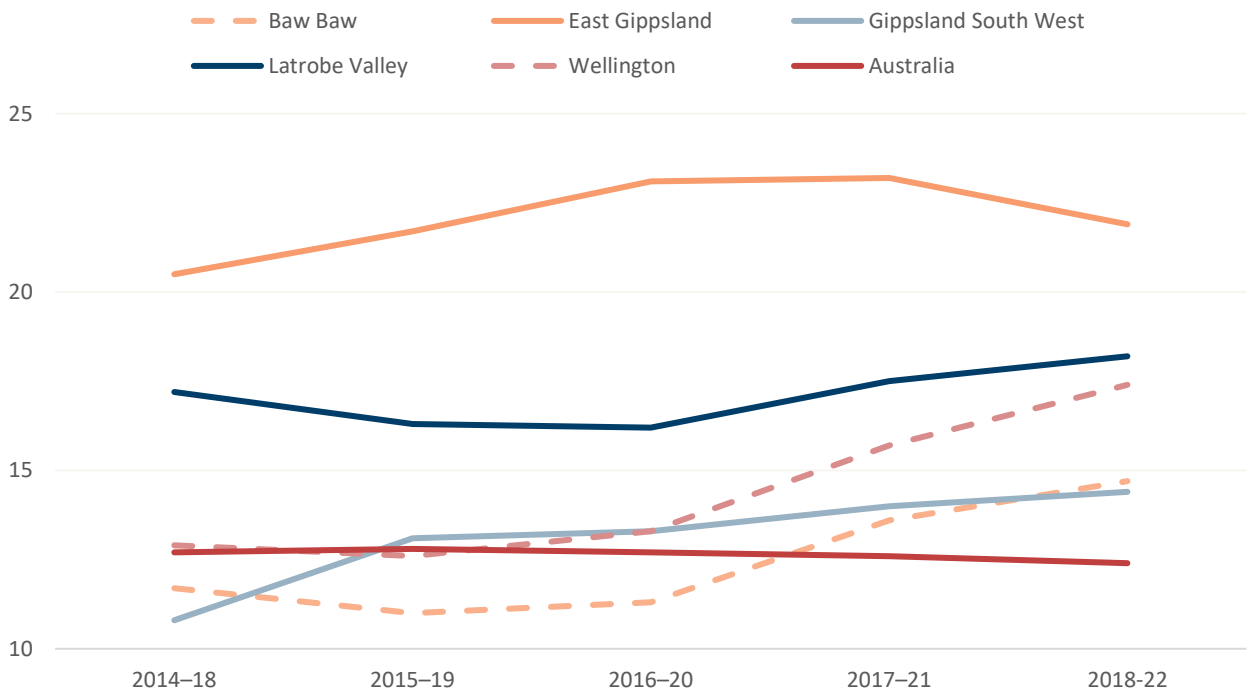


Figure 72. Age-standardised suicide rates, by year of death and SA3 sub-region in Gippsland and Australia, 2014–2018 to 2018–2022 (AIHW 2024p).



Suicide prevention services commissioned by Gippsland PHN:

- The Support After Suicide program provides Suicide bereavement counselling and is delivered by Jesuit Social Services across Gippsland via phone and telehealth.
- From 2016-22 Gippsland PHN delivered the Place-Based Suicide Prevention Trials project within Bass Coast/South Gippsland (Federally funded site) and Latrobe Valley (State funded site). The project used the Black Dog institute's Lifespan Model of Suicide Prevention to build a community safety net that helps prevent suicide.
- Currently (2023-25) Gippsland PHN is coordinating the Targeted Regional Initiatives for Suicide Prevention (TRISP) project across Gippsland with the aim of reducing suicide rates and the impact of suicide in communities. The focus is on community led initiatives and sustainability.

Emergency department presentations

There were 3,573 ED presentations for self-harm (with or without suicidal intent) over five years 2019-20 to 2023-24 (DH 2024b) (**Figure 73**):

- There were 780 ED presentations of Gippsland residents in 2023-24, an annual increase of 2.5% per year. East Gippsland and Wellington had the highest growth rates in Gippsland, growing at 10.4% and 4.9% per year, respectively.
- Of all presentations, 41% were for Latrobe residents, with 15% each in East Gippsland, Gippsland South West, and Baw Baw and 13% in Wellington.
- Age and gender distribution of presentations are shown in **Figure 74**;
    - 66% were for females with 15–19-year-olds accounting for 26% of all female presentations (605 presentations).
    - 10% were for children aged 0-14 years; 38% for 15–24-year-olds; 48% for 26- to 64-year-olds and 4% for people aged 65 years or older.

Figure 73. Number of ED presentations for self-harm (with or without suicidal intent) among Gippsland residents by SA3 sub-region, 2019-20 to 2023-24 (DH 2024b).

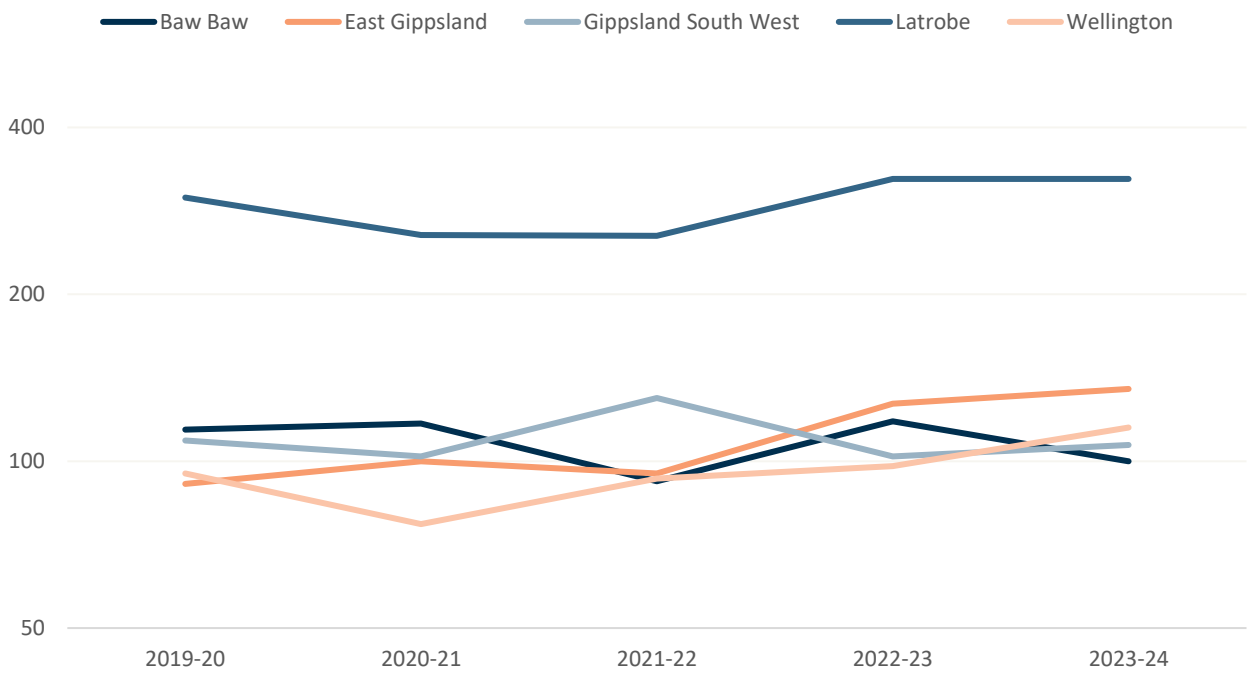
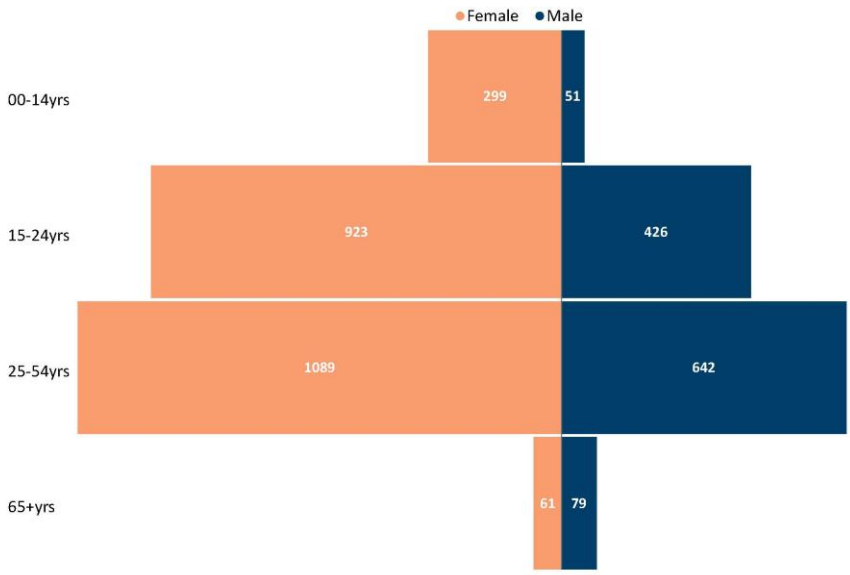


Figure 74. Number of ED presentations for self-harm (with or without suicidal intent) among Gippsland residents by age and gender, 2019-20 to 2023-24 (DH 2024b).



Professional Stakeholder Perspective

Workforce

Feedback from stakeholders suggests that the low numbers of allied health and specialist workforce compared to State average (see **Chapter 5: Health Workforce** for details) impacts the ability to provide services in Gippsland (GPHN 2021, 2024e & 2024g):

- Difficulties in recruiting and retaining skilled and qualified mental health staff is an issue across Gippsland, but especially in the more remote areas. This has been impacted further by mental health reform with new providers entering the market.
- GPs have highlighted difficulties in accessing timely and appropriate referrals to public psychiatrists and paediatricians, leading to long wait times. Private providers may be more accessible but can be associated with high gap fees.
- GPs report feeling supported by a psychiatry advice line
- GPs and other clinicians continue to raise concerns about the difficulty in accessing acute mental health services across Gippsland. This can be especially challenging in more remote areas away from the regional centre.
- Mental health referral options for psychology, perinatal mental health, young people and eating disorders are reported as limited.
- Cost of psychologists and other allied health providers can be a major barrier to accessing care especially for those experiencing cost of living pressures.
- Workforce shortages are particularly noted in child mental health services across the catchment, particularly significant in geographically isolated areas.
- Workforce shortages are noted for mental health specialists.
- Peer workers are a valuable part of the service system.
- A lack of workforce has flow on effects for quality of care, including limits to the time professionals can spend with consumers and lack of access to specialist skills.

Community need

- Mental health and wellbeing, including suicide prevention was consistently rated as a high priority during consultations with key stakeholders in Gippsland, including among workshop attendees and by LGAs through their local feedback.
- Cost of accessing care via private professionals, including psychiatry, psychology, and counselling, is a barrier for many people, leaving crisis hotlines as the only support option.
- Some professionals felt that mental health literacy in their communities is low, impacting ability to seek help when needed.
- An increase in eating disorders among young people has been noted by providers.

- Long wait lists were seen as a significant issue by providers. This included for long term support services.

Service gaps

- Professionals noted the impact of services across the Gippsland region largely being located in regional centres, with limited access in other areas.
- Lack of referral options across IAR levels 2-4 is reported by GPs across Gippsland.
- Existing services designed for mild to moderate support report a lack referral options resulting in the need to manage high acuity clients.
- A potential space for improvement was service coordination and integration across providers, leading to reduced unnecessary assessments and easier transitions between providers.
- Some professionals recalled instances of patients being referred to them for issues or acuity out of their scope. This was often due to the referring clinician not understanding what the service provides. Increased understanding would reduce these inappropriate referrals, and improve service utilisation.
- 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 specific evidence-based treatment options including psychological therapies such as Dialectical Behaviour Therapy (DBT) and other types of group therapy.
- Population groups which continue to have reduced service access include people experiencing:
  - Poverty, including food insecurity
  - Homelessness and housing issues
  - Older people
  - Children and young people, especially if not connected to school or other education and training providers
  - Social isolation
  - Family violence and disabilities
  - Transitions in care from acute to community or from prison
  - Multicultural communities

Service gaps for complex mental health issues

- Professionals report that there are system gaps around complex mental health issues (for example complex PTSD and personality disorders). This was a source of frustration for some, with concerns that there are patients who may be classified as too complex for some services, and simultaneously not complex enough for others.

  "The missing middle is still missing." (Health professional)

- Professionals report seeing an increase in anxiety, including anxiety with greater complexity. This seems to have the flow on effect of a greater threshold in the severity of presentation required to access support through the acute triage service.
- Concerns about increased risk of psychological distress, suicide, and family violence during the holiday season, especially combined with often reduced services and pressures on remaining staff.
- Some services are funded to provide interim support only, and in some cases, referrals can have dead ends.
- Early intervention is needed. This can result in better outcomes for patients and prevent cases from increasing in severity over time. Some professionals participating in a workshop suggested a Mental Health Plan to use at home (similar concept to an Asthma Plan).

  "… a lot of mental health issues are situation related [referring to social determinants of health]." (Health professional)

- Some professionals expressed concerns about high rates of prescribing in their regions. It was felt that this could be in part due to a lack of continuity of care and lack of access to counselling.
- In some cases of dual diagnosis of alcohol and other drug issues and mental health issues, there were issues with patients managing going between the two systems. Increased integration and communication between these systems was suggested as a potential improvement.

Service suggestions

- Professionals noted changes that services could make to better meet the needs of the community:
  - Services need to be safe and welcoming spaces; this is a key message from patient experience survey data.
  - Support for vulnerable clients trying to access financial support or other basic needs such as housing and food needs to be built into the system.
  - Reducing stigma around mental health and alcohol and other drug misuse.
- To see improvements in mental health and wellbeing, social determinants of health need to be addressed (see also **Social Determinants of Health**) with a focus on early childhood identification and intervention, employment opportunities and supports, including for homelessness and housing.

- Consumer voice should be central when designing services. Consumers also need to be involved in developing outcomes measures 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"

- Increased integration and collaboration were suggested to make it easier for patients to access services. There were many suggestions around what this could look like in different locations and settings, including:
  - Co-locating services in locations such as community houses, schools, and medical centres can 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 a 'no wrong door' option.
  - More integrated service models that utilise mental health nurses and provide holistic care could be valuable.
  - Walk in services people can access without needing to pay for mental health support for less severe cases without diagnosis
  - Integration of mental health and alcohol and other drug (AOD) services and supports for dual diagnosis clients.
- A flexible outreach service option is needed to accommodate the needs of vulnerable people across providers – it should not require a referral to another service.
- Increased suicide prevention services and supports, especially in East Gippsland.

A regional workforce survey completed as part of the 2022-2025 Gippsland PHN Health Needs Assessment included some key findings relevant to mental health (GPHN 2021):

- Greatest competency in the mental health sector was reported for treating 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.

Community, Consumer and Carer Perspective

Insights from the Tell Gippsland PHN projects and ongoing consultations (2024c, 2024d & 2024e) related to mental health include:

Self-management

- Participants highlighted challenges managing medications, describing difficulty accessing doctors. They recognised that medications had important benefits but also difficult side effects.
- Participants spoke about engaging in hobbies, volunteering and the critical role of social supports as key to maintaining their mental health.

Health services

- Community members expressed a desire for a holistic approach that incorporates mental health into overall wellbeing.
- Community members experience a shortage of qualified workforce and its impact on quality of care:
    - Mental health reform relies on a workforce which is already stretched
    - Limited staff availability leads to appointments that are regularly cancelled
    - Lack of continuity of care due to clinician changes
    - No or very limited lived experience workforce
    - Inability to offer flexible services such as choice of online or face to face options
    - Skilled clinicians can provide helpful strategies, care planning, hope for the future and individual focus
- Navigation of the mental healthcare system can be difficult:
    - Mental health and alcohol and other drug services are very hard to access, especially ongoing support appropriate for complex cases.
    - Need flexible service offerings to improve access, including in isolated communities, a choice of face to face, phone and online as well as making changes to appointments, response to urgent support, diversity of clinicians (including gender)
    - Misinformation about services can result in inappropriate referrals or a poor service leading to the consumer being unable to have their needs met and may end up with another referral and need to retell their story again
- Consumers expressed concerns about overprescribing
- Improving services and supports for consumers based on feedback surveys (GPHN 2024g):
    - Consumers want services that are safe and welcoming spaces

- Consumers want empathy, care, feeling heard and not judged; a 'non-clinical space'
- Help consumers see hope for the future

- There are insufficient after-hours / crisis services and hospital emergency departments can be the only available option for a person requiring support. Emergency departments are not typically sufficiently resourced to support acute mental health and AOD presentations, so people avoid seeking support.
- Acute responses, especially if involving police, are often traumatising for people experiencing acute psychological distress. Especially if they have had previous traumatic experiences, including family violence.

Suicide

- There is a need to include a focus on suicide prevention, particularly for Aboriginal and/or Torres Strait Islander peoples.
- Suicide specific themes included:
  - 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
  - Need for consistent and available education, training and support for GPs working with people experiencing suicidal symptoms
  - Need for comprehensive suicide prevention training for frontline staff and community (gatekeepers)
  - Need to build the capacity of primary care to support people bereaved by suicide
  - Lack of inpatient capacity and follow up after suicide attempts (this has been addressed somewhat via delivery of the HOPE program across Gippsland)

Social determinants of health

Mental health was a significant concern for community members, *"Mental health is such a big issue and affects everything; it has a domino effect on everything and crosscuts with everything." (community member)*

- Childhood experiences and trauma has a big impact and intervening early is important.

  "Trauma has been a massive thing in my life, and I never really had that support network." (community member)

- Specific population groups who struggle more to access appropriate support include:

- Farmers
- LGBTIQA+ communities
- People who are socially isolated
- People with financial worries, especially in remote communities where the cost of accessing services is impacted by transport costs and fewer local options
- Family, carers, and friends end up taking on more responsibility when service and support options are limited

  "The journey feels exhausting and never ending. I struggle to have hope with so few supports and increasing costs." (Community member)

- Need to address stigma and discrimination, including among the health professionals.
- Community members felt that men were less likely to address their mental health, and had difficulty asking for help when they needed it.

Chapter 5: Health Workforce

The health workforce includes a wide range of support staff and professionals who work to provide healthcare services to the Australian population. Many, but not all, health professionals are registered with the Australian Health Practitioner Regulation Agency (AHPRA), however essential support staff working in the health services are not required to be registered. All contribute to the health of Australians, but data availability varies.

The current list of AHPRA registered health professions includes Aboriginal and Torres Strait Islander health practitioners, chiropractors, Chinese medicine practitioners, medical radiation practitioners, occupational therapists, optometrists, osteopaths, paramedics, pharmacists, physiotherapists, podiatrists, psychologists, oral health therapists, dental hygienists, dental therapists, dental prosthetists, dentists, nurses, midwives, and medical practitioners.

Summary

Gippsland health insights

- There are 102 general practices, six Aboriginal Community Controlled Organisations, 12 public hospitals, three private hospitals, 54 Residential Aged Care Homes, six bush nursing centres, two Urgent Care Clinics and 296 private and community allied health clinics in Gippsland.
- There were 378 general practitioner (GP) Full-time Equivalent (FTE) in 2024.
- There were 123 GP FTE per 100,000 people, higher than the Victorian average of 117 FTE; however, there is an uneven distribution ranging from 302 FTE per 100,000 people in Neerim South, to 67 FTE per 100,000 people in Omeo.
- All of Gippsland has a need for additional health workers; the highest GP workforce needs were identified in Omeo, Orbost and Churchill.
- There were 813 FTE nurses working in primary and community setting in Gippsland in 2023.
- Allied health practitioners with low FTE per 100,000 population in Gippsland compared to Victoria (2023): psychology (-58%), physiotherapy (-43%), podiatry (-35%) and occupational therapy (-33%).
- A lack of health workforce limits access to healthcare services, especially in more remote locations.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Fostering stakeholder partnerships as a foundation for a stronger health workforce and improved access.
- Minimising wait times to access primary care.
- Improving access to timely and appropriate referrals.
- Improving provider experience.
- Improving ability to attract and retain local health professionals.
- Delivery of capacity building activities to the primary health workforce that support new models of care that leverage scope of practice, integrated care models and new ways of working in line with policy settings.
- Locally appropriate implementation of health reform opportunities to address workforce gaps and issues, including support for multidisciplinary teams and allied health.
- Increasing capacity and capability of Lived and Living Experience Workforce (LLEW) and volunteers.
- Increasing availability of field work placements and supported graduate programs.
- Increasing workforce per population for GPs, primary and community nursing and allied health professionals.

Community voices

"I want increased health workforce to meet demand."

"I want effective incentives that bring needed professionals to my district."

"I want community to understand we are working hard to achieve what we can with the limitations and capacity we do have. It will not be perfect, but we are trying."

"I want a supportive multidisciplinary team."

Gippsland Health Services

Gippsland health services as of 2025 are shown in **Table 16**. For health service location visualisations across Gippsland, see also:

- **Health Service Providers** for general practices and ACCOs, and;
- **Appendix 1. Additional Health Service Mapping** for Urgent Care Clinics, allied health providers and hospitals (public & private).

Table 16. Overview of Gippsland health services by LGA, 2025 (DHDA 2025a &*GPHN 2025e).

LGA	GP catchments	General practices *	Residential aged care homes*	Aboriginal Community Controlled Organisations *	Public hospitals	Public hospitals with emergency department	Private Hospitals *	Bush nursing services*
Bass Coast	2	10	7	0	1	1	0	0
Baw Baw	3	22	9	0	1	1	1	0
East Gippsland	5	19	10	4	3	1	0	5
Latrobe	4	29	12	1	1	1	1	0
South Gippsland	4	9	7	0	3	0	0	0
Wellington	4	13	9	1	3	1	1	1
Gippsland	**22**	**102**	**54**	**6**	**12**	**5**	**3**	**6**

Source: Department of Health, Disability and Ageing (2025a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on 10/08/2025. Not for further distribution or publication.*

National Context

Health workforce overview

The health workforce represented 5% of the total employed workforce in Australia in 2022 (AIHW 2024y) and was made up of:

- 54% nurses and midwives
- 26% allied health professionals
- 16% medical practitioners
- 3% dental practitioners.

There was an overall increase of 22% in full-time equivalent (FTE) health workforce members per population between 2013 and 2022, with the highest growth for allied health (53%), followed by medical practitioners (21%). However, the growth in General Practitioner (GP) FTE per population was only 3%.

Australia's total health workforce is not evenly distributed across Australia. The clinical FTE rate per 100,000 people was highest in major cities (2,248 FTE per 100,000 people) and lowest in very remote areas (1,846 FTE per 100,000 people).

Australia relies heavily on internationally recruited health professionals, in particular medical practitioners. The proportion of overseas trained GPs has increased from 34% in 2013 to 42% in 2022, making it the third highest proportion among medical specialists.

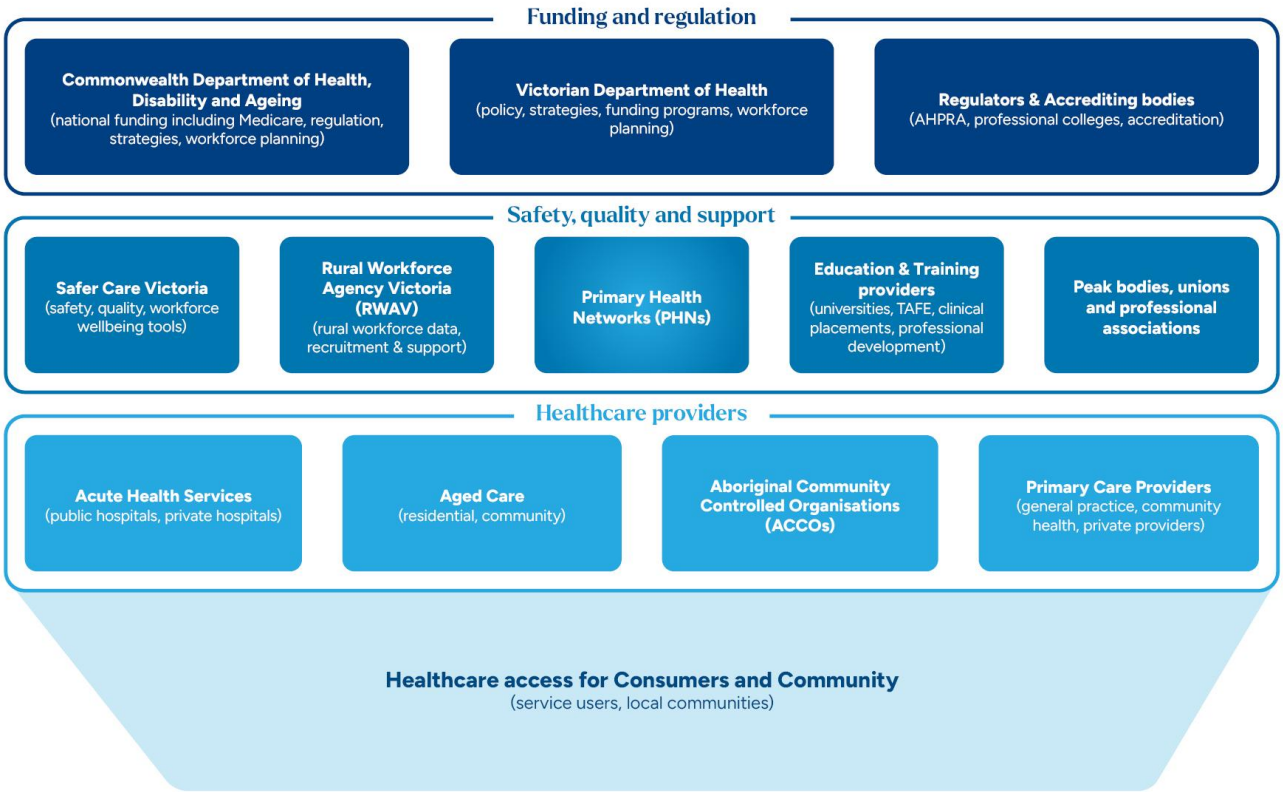
To address future workforce demand, several health workforce reforms are being implemented. A policy review has noted there is a broad range of policy documents reflecting the complexities of the health system. They include specific policies for professions on issues such as rural health workforce, but there is an absence of a unified federal health workforce strategy (Topp et al 2025). This has resulted in a complex mix of programs, incentives and grants with inconsistent nomenclature.

Stakeholders

Gippsland PHN recognise that a strong and sustainable primary healthcare 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, including but not limited to Gippsland PHN, the Rural Workforce Agency Victoria (RWAV), health service providers, Universities and other educational/training providers, and State and Federal government organisations. See **Figure 75** below. There is a strong need for all stakeholders to work together, which may include the following (AHHA 2021):

- Cross-jurisdictional and cross-sector planning approaches
- Changes to scope of practice, and models of care for both regulated and unregulated practitioners
- Improved coordination of education, regulation, and all service levels
- Ensuring equitable access and outcomes is the primary focus, including geographic locations and populations with specific needs
- Utilisation of technological solutions that meet people's needs.

Figure 75. High level diagram of health workforce stakeholders grouped by primary role, in Gippsland, Victoria, showing a complex system.



Key strategies and plans

The Victorian Health Workforce Strategy 2024-34 highlights the strong future demand for healthcare workers. It is projected that nearly 60,000 new workers will be needed in Victoria between 2023 and 2026. Main drivers for the demand are an ageing population and an increasing prevalence of chronic disease. The growth is expected to continue. Focus areas of the strategy include:

- **Strengthen rural and regional workforces**: Improve capacity and distribution in rural and regional locations for equity in access to healthcare.
- **Improve employee experience**: Build a world-leading experience to retain the skilled workers we have and attract new people into healthcare.
- **Leverage digital, data and technology:** Augment workforce capability, patient experience and continued innovation through digital with a focus on patient-centred care and using multidisciplinary teams.

Australia's Primary Health Care 10 Year Plan 2022–2032 outlines strategies to strengthen primary health care as part of the broader health system. There are multiple targeted strategies and plans that will be considered during implementation:

- The Stronger Rural Health Strategy includes a range of incentives that give doctors more opportunities to train and practice in rural Australia. It also strengthens the role of nurses and allied health professionals to deliver more multidisciplinary, team-based models of primary health care.
- National Medical Workforce Strategy 2021–2031
- Nurse Practitioner Workforce Plan aims to better utilise Nurse Practitioners (NP) to deliver person-centred care. The first goal relates to removing barriers affecting the NP workforce.
- Work is in progress to develop a National Allied Health Workforce Strategy to address shortages of allied health workforce.
- The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–31 outlines strategies to attract, recruit and retain a stronger workforce.
- The Unleashing the Potential of our Health Workforce Scope of Practice Review

Models and strategies to address workforce shortages in rural and regional areas

- **A centre of excellence in rural healthcare:** An example of an integrated, multidisciplinary model to address enduring medical workforce challenges (Champion et al 2025). The model is supported by rural generalist training and the broad scope of practice of a well-trained rural generalist workforce, but includes allied health, mental health, nursing and midwifery. After two years, there had been a 25% expansion in medical workforce across both hospital and general practice. This workforce expansion re-engaged the existing workforce, enabled new models of care, brought fresh talent to the region and instilled a renewed sense of optimism for the future.
- **Nurse Practitioner (NP) models:** NPs working in primary care to address workforce shortages show promise (Rossiter et al 2023). There is also evidence that NPs working in a regional emergency department can safely manage a variety of patients with a wide age range and a variety of triage categories and diagnoses (Jackson et al 2024).
- **Promote regional, rural and remote placements:** Rural placements can provide a superior learning experience with a more diverse and challenging experience (Anderson et al 2024) and potential for strong community support. The evidence is clear that medical students who undertake a rural placement are more likely to want to work in a rural area (Medical Deans of Australia and New Zealand 2025), especially if the placement was longer (31% of students who did a 1 year or longer placement compared 3% of students with no rural placement).
- **Collaboration for a strong rural placement program:** Factors associated with medical students experiencing 'high quality' clinical learning have been identified (Mackie et al 2025). They included

developing a supportive learning relationship with a senior rural doctor and a diverse roster across hospital, GP and outreach clinics and with significant placement time in the ED.

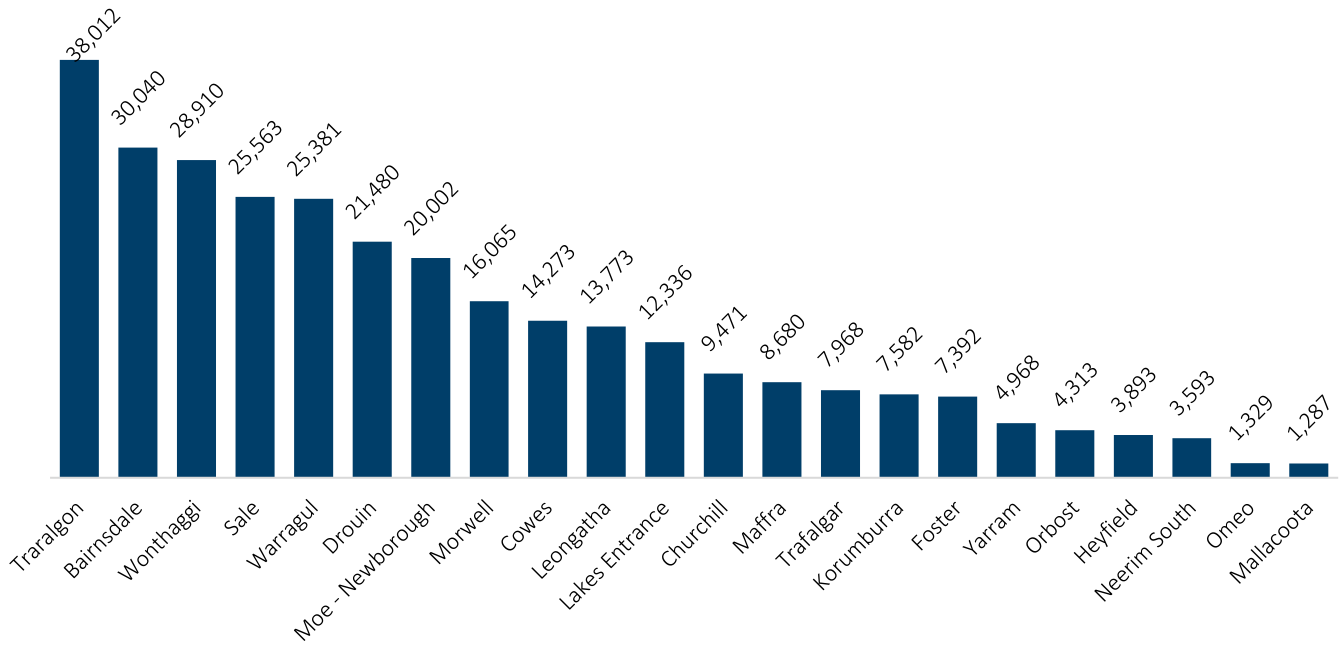
- **Remote supervision model:** There is evidence that a well-supported remote supervision model can be a positive experience for both supervisor and registrar. An evaluation notes that there is a need to ensure that guidelines are flexible and able to be tailored to the context of the registrar, the supervisor and the placement (Benson et al 2025).
- **Supporting the allied health workforce:** Possible solutions to grow and support the allied health workforce include improved support for rural training pathways (Kolt 2025). Positive factors for recruitment and retention include having a rural background or undertaking a rural placement, being older, being integrated into the community, good working conditions and financial incentives (Cleland et al 2025). Funding models to support the rural allied health workforce, and early career allied health workforce models have been identified by RWAV (2025).
- **Community Pharmacist Program**: The Victorian government is expanding the role of community pharmacists (DH 2025c). The program allows participating pharmacies to treat some health conditions without the patient needing to have a prescription. Conditions for which treatments will be prescribed by pharmacists will increase to 22 acute and chronic health conditions.

Gippsland data

The Department of Health, Disability and Ageing (DHDA) HeaDS UPP tool (DHDA 2025a) was used to inform much of the data reported in this section. It is an integrated source of health workforce and service data that informs current and future workforce planning. It includes data by GP catchment areas; a specific geographical definition developed for the tool to assist workforce data analysis by small geographic region relevant to the local population.

Gippsland PHN had an estimated resident population of 307,807 in 2023 and the population distribution by GP catchment area is shown in **Figure 76**.

Figure 76. Estimated resident population by Gippsland GP catchment area, 2024 (DHDA 2025a).



Source: Department of Health, Disability and Ageing (2025a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 10/08/2025*. Not for further distribution or publication.*

Geographical remoteness of Gippsland GP catchment areas is described using the Modified Monash Model (MMM) (DoHAC 2024b). See **Appendix 11** for map of MMM regions, GP catchment areas and general practice locations. Highest levels of remoteness are found in far East Gippsland (MMM category 6), while the most populated areas around Gippsland's main towns are categorised as MMM3. A summary of the health workforce assessment in each LGA can be found in **Table 17** below.

General practice experiences

Engagement with Gippsland PHN's general practices in 2025 (GPHN 2025g) showed that clinics were most confident in their ability to recruit nurses, with 50% of respondents reporting they were 'confident' (**Figure 77);** this was followed by allied health (42% were 'confident') and general practitioners (36% were 'confident'). Lowest confidence in recruiting was for nurse practitioners (34% were 'confident').

General practice confidence in recruiting 'Other professionals', including administrative roles, showed that 43% were 'confident' and 43% were 'not confident' (n=14).

Figure 77. Percent of Gippsland PHN general practice respondents who reported confidence in recruiting by profession, (GPHN 2025g).

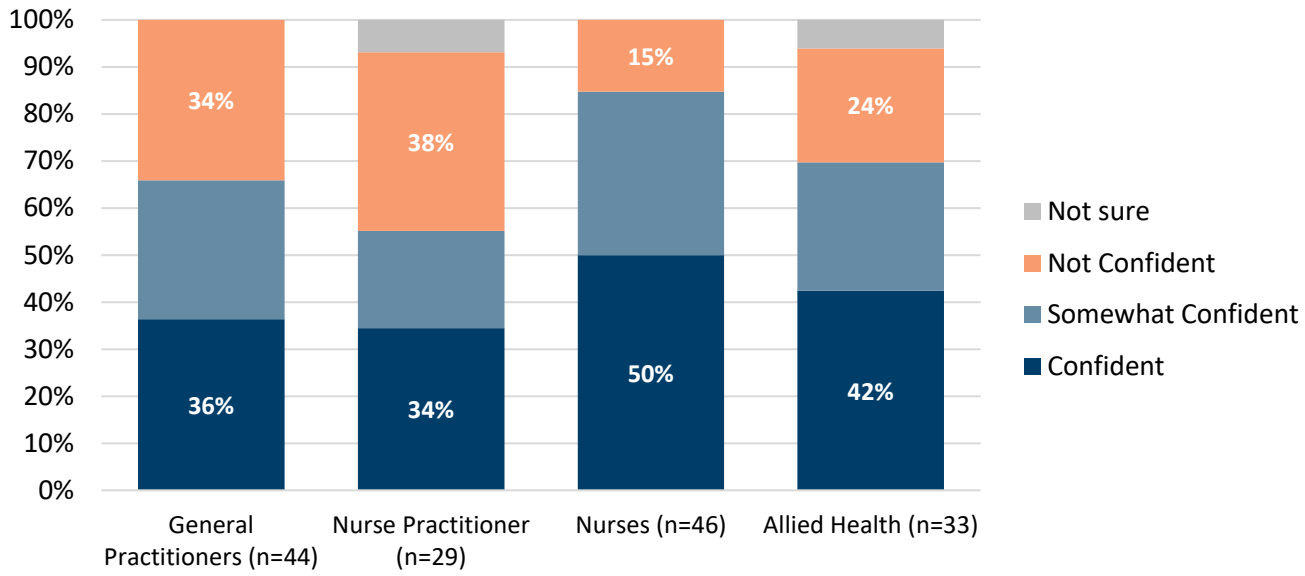


Table 17. Primary health workforce assessment summary and demographic overview for Gippsland LGAs (ABS 2021a, GPHN 2025b, GPHN 2025e and MPHN 2025).

LGA	Demographic Overview	General Practitioners	Nursing	Allied Health
Bass Coast	• Significant population growth. • An older population with a high burden of chronic disease and high rates of preventable deaths from accidental falls and alcohol related deaths. • Areas of high socio-economic disadvantage, with parts of Wonthaggi and Waterline areas (Westernport townships) among the most disadvantaged. • There are many tourist destinations within this LGA and therefore challenged by a seasonal influx of visitors.	• A young GP workforce. • Some of the GP workforce commute from Melbourne with a high reliance on GP locums. • Bass Coast Health operates an Urgent Care Centre in Cowes with on-call GPs and support from the Victorian Virtual Emergency Department. • High users of Gippsland PHN GP telehealth after hours service 2024-2025	• Nurse Practitioner clinics support small communities in Newhaven and Grantville. • More nurses working in primary and community settings per population compared to across Victoria.	• More podiatrists per population than across Victoria. • Few psychologists, physiotherapists and occupational therapists per population compared to Victoria.
Baw Baw	• Desirable location with close proximity to Melbourne, frequent public transport, and Melbourne health services. • A high population of children and young people. • Significant population growth. • Health outcomes are generally good compared to other parts of Gippsland.	• Comparatively high rates of GP workforce and GP training capacity. • Many GPs live in Melbourne suburbs and commute to practice in Baw Baw. • A younger GP workforce. • Workforce limitations exist but are less significant compared to other parts of Gippsland. • A GP-led Urgent Care Centre in Warragul provides an important option to the Emergency Department. • Doctors in Secondary Schools GP clinic at three secondary colleges.	• Fewer nurses working in primary and community settings per population than across Victoria and the lowest in Gippsland.	• Few psychologists, physiotherapists and occupational therapists per population compared to Victoria, but above Gippsland average.

East Gippsland	• A high proportion of Aboriginal and/or Torres Strait Islander people reside in the Bairnsdale and Lakes Entrance catchments. • Poor health outcomes across several health conditions, in particular, mental health and alcohol and other drugs and cardiovascular disease. • An older population with a high burden of chronic disease and high rates of preventable deaths from cancer, heart disease and respiratory issues. • Areas of high socio-economic disadvantage, with Orbost and Lakes Entrance among the most disadvantaged in the region. • There are many remote areas with high risk of bushfires and drought adding threat to an already vulnerable population. • There are many tourist destinations, leading to challenges related to a seasonal influx of visitors.	• There are four ACCOs with a GP FTE ranging from 0-1.0 FTE at each, with one practice supported mostly by locum GPs. • Regional areas are supported by five bush nursing centres located in Buchan, Cann Valley, Ensay, Gelantipy and Swifts Creek with GP support. • Omeo District Health and Orbost Regional Health Service have Urgent Care Centres with on-call GPs and support from the Victorian Virtual Emergency Department. • The GP workforce is ageing and has a lower proportion of female GPs than across Victoria. • Long wait times to see a GP (more than four weeks is often reported) and some practices are not taking new patients. There is a resulting patient overflow to the Emergency Department. • Significant workforce recruitment issues exist being Gippsland's furthest LGA from Melbourne. • Highest use of Gippsland PHN GP After Hours telehealth service 2024-2025. • Doctors in Secondary Schools clinic at two secondary colleges.	• More nurses working in primary and community settings per population compared to across Victoria and higher than the Gippsland average.	• Few podiatrists, psychologists, physiotherapists and occupational therapists per population compared to Victoria.

South Gippsland	• An ageing population and areas of high disadvantage. • Poor health outcomes related to cancer, mental health and respiratory disease. • Tourist destinations within this LGA leading to challenges related to a seasonal influx of visitors.	• A young GP workforce. • No Emergency Department, however Gippsland Southern Health Service (Leongatha and Korumburra campuses) and South Gippsland Hospital (Foster) have Urgent Care Centres with on-call GPs and support from the Victorian Virtual Emergency Department.	• Fewer nurses working in primary and community settings per population than across Victoria and lower than the Gippsland average.	• Few podiatrists, psychologists, and occupational therapists per population compared to Victoria and the lowest in Gippsland. • Fewer physiotherapists per population than across Victoria, but above the Gippsland average.
Latrobe	• A younger population compared to the Gippsland average. • Latrobe includes many areas of high disadvantage with Morwell, Moe-Newborough and Churchill among the most disadvantaged in the region. • Poor health outcomes across several conditions, including chronic conditions and mental health. • A high population of Aboriginal and/or Torres Strait Islander peoples. • High rates of disability.	• An ageing GP workforce. • Challenges with continuity of care due to transient and non-resident GPs. • High workforce needs due to complex health needs of the population. • Many general practices in the region utilise an alternative training pathway to AGPT (including the fellowship support program or independent training pathways). • One Aboriginal Community Controlled (ACCO) service. • Challenges related to registrars and GPs living outside Latrobe in metro Melbourne and commuting. • Doctors in Secondary Schools GP clinic at two secondary colleges.	• More nurses working in primary and community settings per population compared to Victoria and higher than the Gippsland average.	• Few psychologists and physiotherapists per population compared to Victoria and lower than the Gippsland average. • Few podiatrists and occupational therapists per population compared to Victoria but higher than the Gippsland average. • The largest Lived / Living Experience Workforce (Peer workers) in Gippsland is based in the Latrobe Valley.

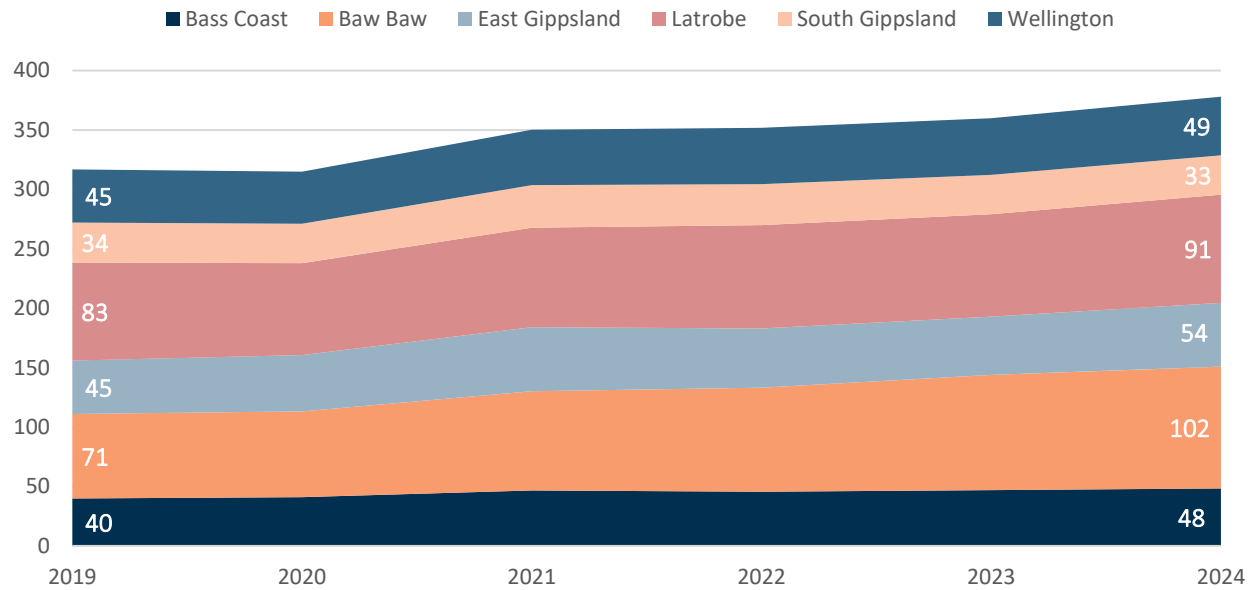
Wellington	• Areas of high disadvantage, with Loch Sport, other coastal areas and Yarram among the most disadvantaged in the region. • Remote and rural areas with high risk of bushfires, drought and coastal inundation. • High population of people aged 65+. • Poor health outcomes including for chronic conditions, accidental falls, cancer and mental health.	• The GP workforce is ageing and there is variable access, including in Yarram and Loch Sport. • Health workforce recruitment issues are significant and impacted by the distance to Melbourne. • There is one bush nursing centre located in Dargo with GP support. • Yarram District Health Service has an Urgent Care Centre with on-call GPs and support from the Victorian Virtual Emergency Department. • A high rate of lower urgency presentations to the Emergency Department. • Doctors in Secondary Schools GP clinic at two secondary colleges.	• More nurses working in primary and community settings per population compared to Victoria and higher than the Gippsland average.	• Few podiatrists, physiotherapists and occupational therapists per population compared to Victoria and lower than the Gippsland average. • Few psychologists per population compared to Victoria but above the Gippsland average.

General Practitioner (GP) Workforce

There was a total of 378 GP FTE servicing Gippsland residents in 2024, up from 317 in 2019 (DHDA 2025a). The distribution by LGA can be seen in **Figure 78** and it can be noted that:

- Baw Baw had a strong increase from 71 to 102 GP FTE between 2019 and 2024.
- South Gippsland had no increase.
- Other LGAs recorded a small increase in FTE.

Figure 78. GP FTE servicing Gippsland residents, 2019-2024 (DHDA 2025a).



Source: Department of Health, Disability and Ageing (2025a) OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on 10/08/2025. *Not for further distribution or publication*.

The Distribution Priority Area (DPA) classification identifies locations in Australia with a shortage of GP services. International Medical Graduates (IMGs) must work in a DPA to be eligible to access Medicare (DoHAC 2024c). It is also used to inform other incentives, such as placements of medical students 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.

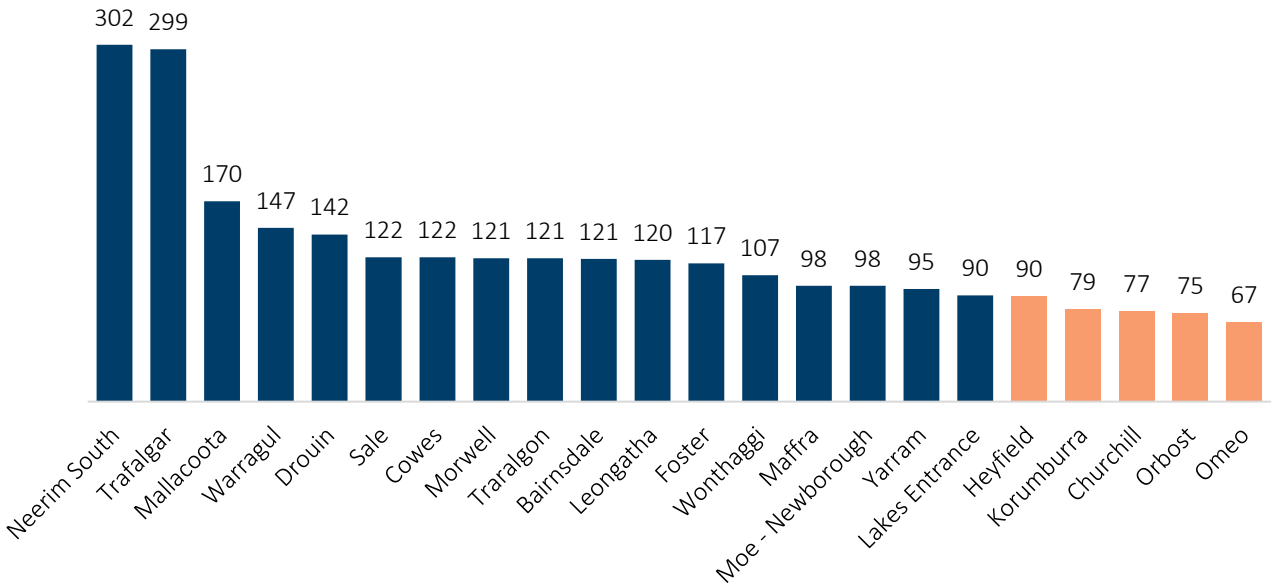
In 2025, all GP catchment areas in Gippsland are classified as a DPA along with all MMM 2 to 7 areas. Prior to 2023, Warragul and Drouin were not classified as DPA and when DPA replaced the previous classification system in 2019, Latrobe was initially not classified as a DPA. These changes likely contributed to the reduced FTE in Latrobe in 2020 and recent strong increase in Baw Baw.

Gippsland had 123 GP FTE per 100,000 people, compared to 117 in Victoria in 2024 (DHDA 2025a). The distribution by GP catchment area can be found in **Figure 79** and it can be noted that:

- **Top five:** GP catchment areas with the highest GP FTE per population were Neerim South (302), Trafalgar (299), Mallacoota (170), Warragul (147) and Drouin (142).
- **Bottom five:** GP catchment areas with the lowest GP FTE per 100,000 population were Omeo (67), Orbost (75), Churchill (77), Korumburra (79) and Heyfield (90).

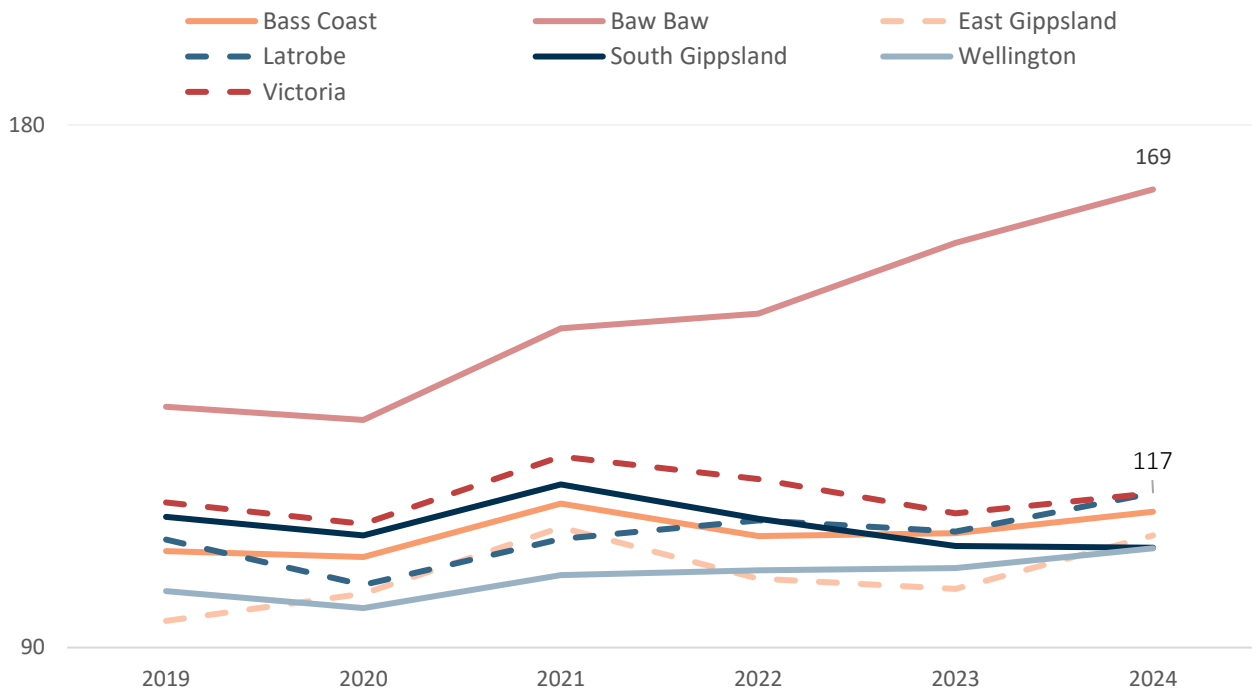
Changes in GP FTE per population in LGA areas since 2019 highlight that Baw Baw has more GPs per population (169) compared to Victoria (117), while other LGAs in Gippsland consistently have fewer GPs per population (**Figure 80**).

Figure 79. GP FTE per 100,000 population by GP catchment in Gippsland, 2024 (DHDA 2025a).



Source: Department of Health, Disability and Ageing (2025a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 10/08/2025*. Not for further distribution or publication.*

Figure 80. GP FTE per 100,000 population by LGA and compared to Victoria, 2019-24 (DHDA 2025a).



Source: Department of Health, Disability and Ageing (2025a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 10/08/2025*. Not for further distribution or publication.*

GP demographics (DHDA 2025a):

- **Solo practices**: 16 solo General Practices (with one GP at an individual practice) in Gippsland; eight in Latrobe, three in East Gippsland, two in Wellington and one in Baw Baw. (GPHN 2025e)
- **GPs aged 65+:** The highest proportion of GPs aged 65 years or older are located in Omeo (100%), Orbost (48%), Churchill (27%) and Cowes (27%). The proportion of GPs aged 65 years and older in Gippsland dropped from 11% in 2019-20 to 10% in 2024-25.
- **GPs aged < 40 years**: The highest proportions are located in Neerim South (75%), Churchill (42%), Mallacoota (41%) and Lakes Entrance (36%). The proportion of GPs aged under 40 in Gippsland has dropped from 26% in 2019-20 to 22% in 2024-25.
- **Female doctors**: Across Gippsland, 44% of GP FTE were female; highest proportions are located in Mallacoota (100%), Orbost (82%), Neerim South (68%) and Heyfield (66%), and the lowest in Omeo (0%), Yarram (2%) and Wonthaggi (27%).

  Vocationally Registered general practitioners are Fellowed and registered with either The Royal Australian College of General Practitioners (RACGP) or The Australian College of Remote and Rural Medicine (ACRRM). The proportion of GPs across Gippsland who were Vocationally Registered in

2024-25 was 60% compared to 86% of GPs across Victoria. The highest rate was found in Wellington (72%), and the lowest rate was in Latrobe (49%).

General Practitioner training

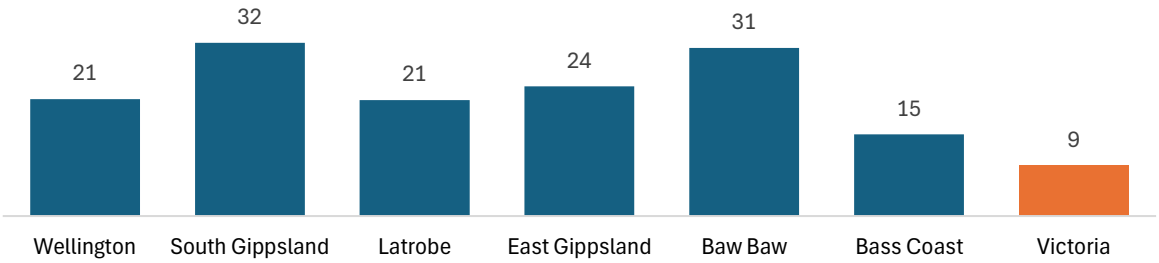
- The **Primary Health Networks** (PHNs) are funded by the Commonwealth to deliver the General Practice Workforce Planning and Prioritisation (WPP) Project to support GP colleges, Australian College of Rural and Remote Medicine (ACRRM) and The Royal Australian College of General Practitioners (RACGP), who manage the Australian General Practice Training (AGPT) program.
- The **Australian General Practice Training** (AGPT) program is a 3-4-year GP registrar training pathway to fellowship and offers 1,500 training places each year in Victoria.
- The **Victorian Rural Generalist Program (VRGP)** is offered to support trainees to navigate rural or regional training pathway through to fellowship.
    - The **Single Employer Model (SEM) Trial** is a Victoria Government initiative to support trainees toward Rural Generalist Fellowship and will benefit Gippsland as Bairnsdale Regional Health Service has been selected as one of three regional trial sites. The trial commenced in February 2025 and will continue to enable accredited primary healthcare providers to participate in the rural generalist training. The SEM objectives are to support the retention of the rural generalist workforce and increase the delivery of services in both rural hospitals and primary care settings by encouraging junior doctors into careers in Rural Health.
- The **Gippsland Regional Training Hub** is a component of the Integrated Rural Training Pipeline for Medicine (IRTP) implemented through the Rural Health Multidisciplinary Training (RHMT). The RHMT program is a long-standing Australian Government initiative which funds the delivery of rural clinical training to medical, nursing, midwifery and allied health students.
- The **Gippsland Rural Intern Training** (GRIT) is an intern program coordinated by Latrobe Regional Health (LRH) and offered at Bairnsdale Regional Health Service (BRHS), Central Gippsland Health (CGH), and West Gippsland Healthcare Group (WGHG). It includes a non-core extended community-based General Practice rotation.
- The **John Flynn Prevocational Doctor Program** is a federal funded program that offers interns the opportunity to undertake a non-core general practice rotation, designed to expose medical interns to General Practice and allows health services to contribute to General Practice Workforce in rural and remote regions.

Registrar data

Based on Gippsland PHN mapping in 2025 (GPHN 2025e), 66 general practices in Gippsland participate in registrar training, representing 65% of all practices (total of 102 practices). There were a total of 154 registrars across Gippsland, supported by 134 GP supervisors.

Data about registrars participating the Australian General Practice Training (AGPT) Program from 2024 shows that all Gippsland LGAs had a higher FTE per population compared to Victoria (**Figure 81**), with the highest rates in South Gippsland and Baw Baw.

Figure 81. Australian General Practice Training trainees by LGA, FTE per 100,000 population, 2024 (DHDA 2025a)

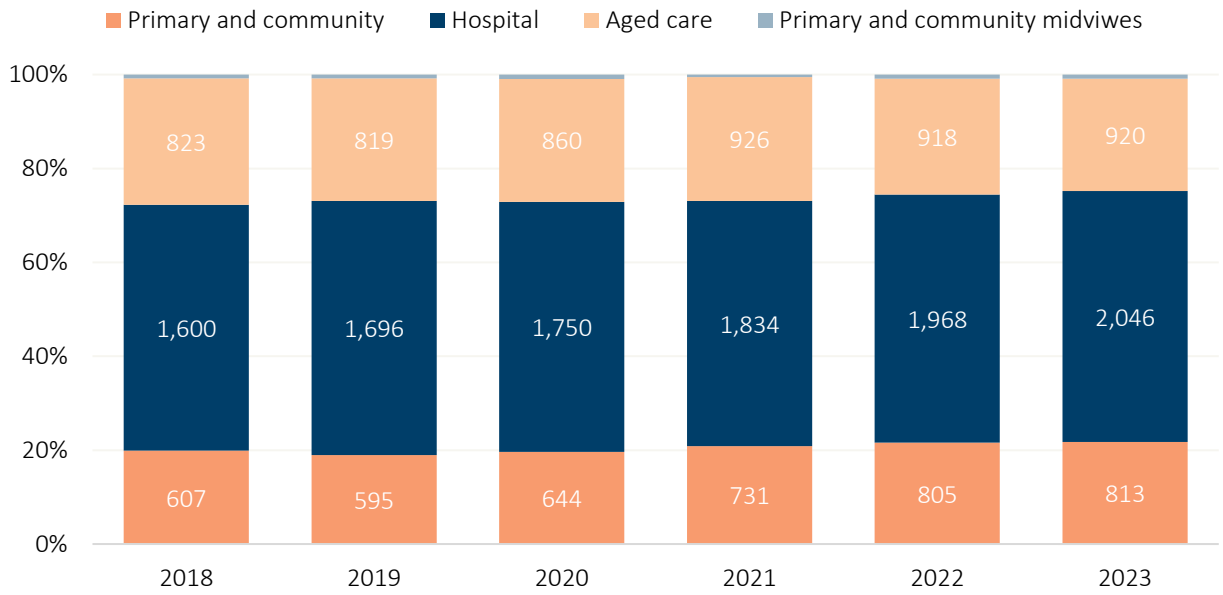


Source: Department of Health, Disability and Ageing (2025a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 10/08/2025*. Not for further distribution or publication.*

Nursing Workforce

There was a total of 3,809 FTE nurses working in Gippsland in 2023, with 21%, or 813 FTE working in a primary healthcare or community setting (DHDA 2024a). There has been an increase in total nursing FTE over time (**Figure 82**), especially for hospital based and primary and community nurses. The aged care nursing workforce declined between 2021 and 2023.

Figure 82. Nurses working in Gippsland by work setting, FTE and percentage of total, 2018-23 (DHDA 2024a).



Source: Department of Health, Disability and Ageing (2025a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 10/08/2025.
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A comparison of the nursing FTE working in a primary and community setting per population shows the highest rates in Latrobe and East Gippsland, while Baw Baw and South Gippsland had less nursing FTE per population when compared to rates for Victoria (231) (**Figure 83**) (DHDA 2025a). General Practice catchments with the lowest primary and community nursing FTE per 100,000 population were Mallacoota (75), Omeo (101), Bairnsdale (107) and Foster (113) (DHDA 2025a).

Figure 83. Total FTE of nurses working in primary and community settings by Gippsland LGA, per 100,000 population, 2023 (DHDA 2025a).

Source: Department of Health, Disability and Ageing (2025a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 10/08/2025.
Not for further distribution or publication.

The numbers of **Nurse Practitioners (NPs) and Rural and Isolated Practice Registered Nurses (RIPRNs)** are growing across Victoria and in Gippsland (DH 2025a). In 2024, Gippsland had:

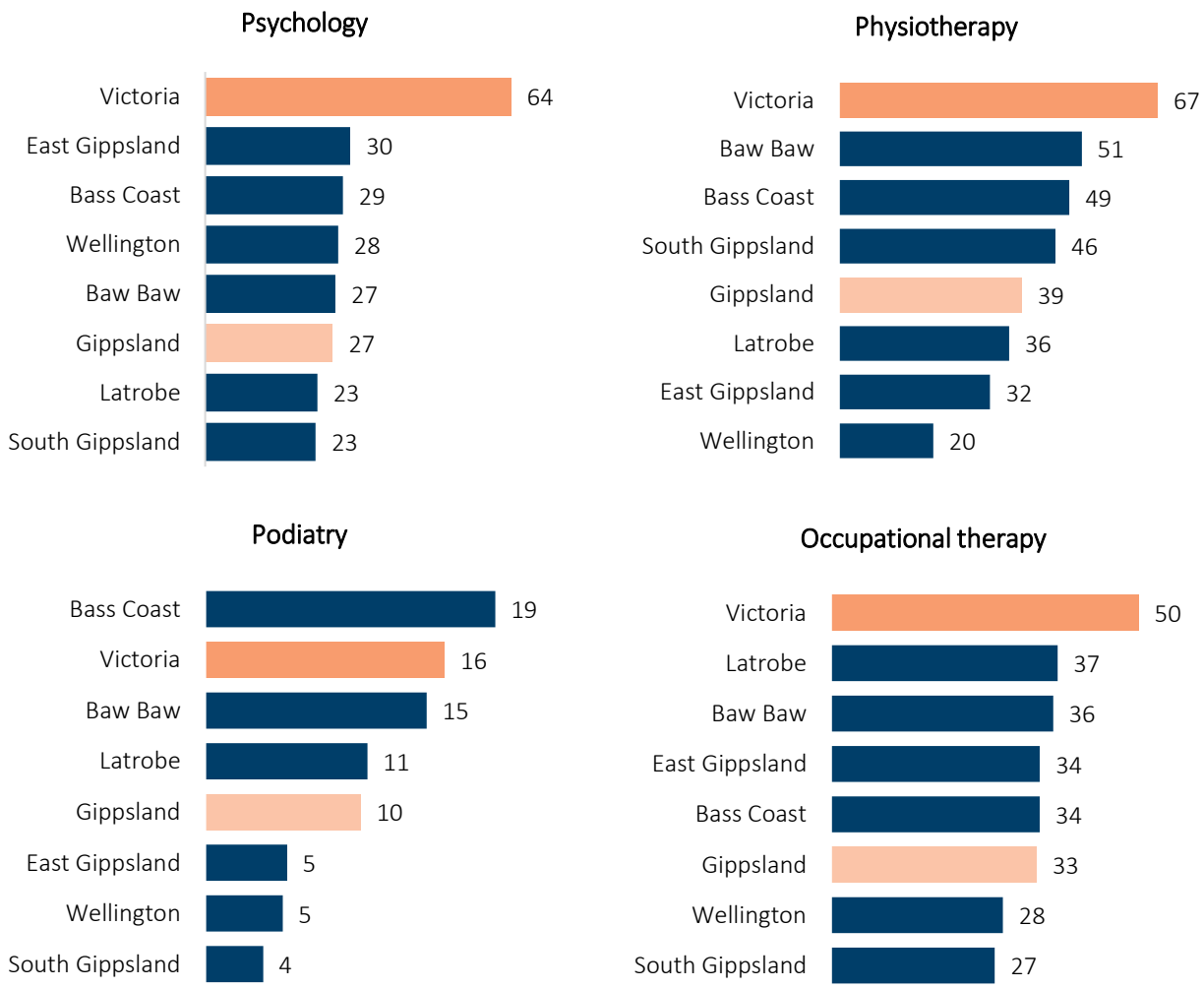
- 51 Nurse Practitioners; accounting for 8% of Victoria's NPs (total 637)
    - There has been a gradual increase from 22 in 2017; with a similar increase seen across Victoria
- 24 Rural and Isolated Practice Registered Nurses; accounting for 10% of Victoria's RIPRNs (total 237)
    - Numbers in Gippsland have been stable since 2018, while some other regional areas have seen an increase

Allied Health Workforce

In 2023, Gippsland had fewer allied health practitioners working in the primary and community care setting compared to Victoria for most professions (FTE per 100,000 population), (see details in **Appendix 12**) (DHDA 2025a). This was especially notable for psychology (58% lower), physiotherapy (43% lower), podiatry (35% lower) and occupational therapy (33% lower) (**Figure 84**).

Allied health practitioners with higher FTE per population compared to Victoria included paramedicine (86% higher), chiropractic (20% higher) and Aboriginal and/or Torres Strait Islander practitioners (193% higher, but a Gippsland total of 4 FTE).

Figure 84. Allied health FTE per 100,000 population (DHDA 2025a).



Source: Department of Health, Disability and Ageing (2025a) *OFFICIAL: SENSITIVE - Data sourced from HeaDS UPP Tool on* 10/08/2025. *Not for further distribution or publication.*

Between 2019 to 2023, podiatrist FTE per 100,000 population decreased by 17%, while there were increases in FTE per 100,000 population for occupational therapy (14%), psychology (11%) and physiotherapy (8%) .

Based on internal mapping (GPHN 2024g), there is estimated to be approximately 296 private and community allied health clinics in Gippsland (inclusive of physiotherapy, pharmacy, dentistry, prosthetics & orthotics, optometry, art therapy, audiology, chiropractic, dietetics, occupational therapy, psychology social work, podiatry, exercise physiology, music therapy and speech pathology).

Lived and Living Experience Workforce

The Lived and Living Experience Workforce (LLEW) is recognised as a unique and separate discipline that offers a valuable contribution, in particular to the mental health, alcohol and other drug and family violence sectors. They may provide support directly to consumers, families, carers and supporters, or indirectly through leadership, consultation, system advocacy, training or research (DH 2025b).

The National Lived Experience (Peer) Workforce Development Guidelines (Byrne et al 2021) were developed as a key reform initiative of the Fifth National Mental Health and Suicide Prevention Plan. They highlight a need to integrate and support the LLEW alongside other health professionals and describe it as a vital component of '*quality, recovery-focused mental health services*'. Support may include strengthening networks and supporting communities of practice.

There is a growing availability of roles in regional and rural areas and the Victorian Department of Health (2022) Lived and Living Experience organisation survey showed that 14% worked in a regional area, and 3% in a rural and remote area compared to 71% working in a metropolitan area. In Gippsland in 2025, there are approximately 70 Lived and Living Experience workers across several organisations, predominantly in mental health services, with some in the alcohol and other drug and family violence sectors. Stigma, lack of ongoing role availability and a lack of local training opportunities have limited the growth opportunities for LLEW in Gippsland.

Other Medical Practitioners

Gippsland had 490 FTE of other medical practitioners in 2023 (including physician, surgery, critical care, paediatrics and child health, obstetrics and gynaecology and other medical specialists and non-specialists), (DHDA 2025a). There were 51% fewer other medical practitioners in Gippsland compared to Victoria; 159 FTE per 100,000 population compared to 324 for Victoria.

Aged Care Workforce

See **Chapter 2. Healthy Ageing (people aged 65+)** and included where relevant throughout this chapter.

Mental Health Workforce

See **Chapter 4. Mental health and wellbeing, including suicide prevention** and included where relevant throughout this chapter.

Professional Stakeholder Perspective

Themes from stakeholder engagement related to primary health workforce based on insights from local healthcare professionals were identified. In 2024 methods included the Gippsland PHN Clinical Council and other regular meetings (GPHN 2024e) and insights identified in internal documents such as reporting (GPHN 2024g). In 2025, methods included the Gippsland PHN Clinical Council and other regular meetings (GPHN 2025b), survey and interviews to inform the Workforce Planning and Prioritisation project (GPHN 2025c), general practice visits (GPHN 2025g) and a survey for commissioned service providers (GPHN 2025h). See also **Stakeholder Consultation** section. Summary themes included:

Training

- General Practices in this region have limited training capacity and require more GP supervisors to support the requirements of registrars.
- GP Supervisors are under increasing pressure, impacted by administration requirements and a lack of support from secondary supervisors. This limits the capacity for the primary supervisor to be able to support and teach the registrar. It was noted that in some cases only one supervisor per practice may be supported by the Colleges and that supportfor additional supervisors would be helpful.
- GPs in rural and regional areas often have multiple responsibilities which impact ability to supervise trainees. Responsibilities may include supporting rural hospitals with maternity services, anaesthetics and other specialty skills in addition to aged care homes and supervision commitments for nurse practitioners, medical students and alternative training pathways.
- Many general practices in the region utilise the fellowship support program or independent training pathways.
- Offer immersive experiences in rural health for all students, for example via a local centre of excellence.
- Support university degrees offered in Gippsland, including allied health.
- A Victorian Government General Practitioners (GP) grant program offering eligible doctors a $40,000 grant to train as GPs has rapidly increased applications in Victoria.

"…no challenges with qualifications, but we have challenges with applicants having suitable experience." (Professional)

Sustainability

- Future planning is required to meet GP workforce demands of a rapidly growing population, especially the ageing population. There are associated high rates of chronic conditions which require ongoing support from an already stretched workforce facing an ever-increasing demand coupled with a lack of referral options and supports, including for dementia diagnoses and support at home.
- There is an ageing GP workforce in many parts of Gippsland. GPs are close to retirement and work part-time, limiting supervision capacity and resulting in rostering difficulties to cover AGPT trainees who work full-time.
- Current and future community needs related to mental health is a significant and a growing health concern with a lack of referral options, especially for those with a complex trauma history.
- Ongoing challenges related to Aboriginal and/or Torres Strait Islander Health and Wellbeing and access to culturally safe and holistic healthcare.
- A funding model that incentivises rural and regional primary care to meet the needs of their community is needed.
- Rural areas have difficulty attracting young GPs due to the more demanding working conditions with greater workload, longer hours, and less pay than general practices in urban areas.
- Funding models which support nurse practitioners and multidisciplinary teams are needed.
- Access specialist services via telehealth where appropriate.

"Increased use of nurse practitioners for prescription repeats, aged patient checkups…" (Professional)

"Seeing psychiatrist online for ADHD medication prescribing ($300 each time)." (Community member)

Recruiting and retention practices

- There are difficulties in recruiting when only able to offer short term contracts.
- Registrar placements outside commuting distance from the closest metropolitan area are hard to fill.
    - Short placements do not encourage relocation and development of community connections
    - Many registrars commute if their placement is within 2 hours of a metropolitan area
    - Creates a lack of community connection and a lack of continuity of care
- Some providers have noted that hiring local people, even if they are not yet qualified, can be a real strength as they understand the community.
    - Education and opportunities for high school students can help

- Recruitment and retention strategies are important to support existing staff to stay as well as attracting new professionals. Possible solutions include:
    - Accommodation support.
    - Childcare support.
    - More stable employment across providers.
    - Opportunity for growing the lived experience workforce.
    - Flexible working conditions and work from home options.
    - Attractive remuneration for new graduates.
- **Suggestions** to make it easier to recruit and retain the right healthcare workforce were identified by general practices in 2025 (GPHNg). The most frequently mentioned areas were:
    - Financial incentives specific to rural areas, often mentioned without details but could include paying bonuses, assistance with costs of relocation, housing and fees related to recruitment. Changes to Medicare items that make it more viable to bulk bill in rural areas were highlighted, including for allied health.
    - Offering additional support was also a key theme. This largely focused on additional support for practices to provide supervision which is limited by finding fellowed GPs to supervise trainees and International Medical Graduates.
    - Example of strategies that can help a general practice recruit and retain relevant workforce include: maintain communication with interested professionals and offer site visits so they can get a sense of the practice culture, maximise the budget and use grant opportunities, encourage Google reviews and promote team culture in the practice.

"… making regional and remote locations desirable and competitive to doctors." (General practice)

Workforce shortages

- Continuing workforce shortages are raised as an issue at every meeting of Gippsland PHN Clinical Councils. They are impacting across professions and the gaps are becoming more severe resulting in pressures on existing staff. This leads to flow on effects such as less capacity to take on quality improvement projects and system reform related work.
- The workforce spread is uneven with the most isolated GP catchments having the most significant challenges in attracting and retaining GPs, including in Omeo and Orbost.
- Some GP catchments are overburdened with wait times of four weeks or more and in some areas clinics are not taking on new patients. This leads to increased presentations to emergency departments.
- Some catchments have a reliance on locums, further exacerbating workforce shortages in areas of greatest needs.
- Gippsland also experiences a lack of non-GP health workforce and restricted access to specialists which limits self-management and support of chronic disease and complex conditions, leading to

disease progression and a greater burden on the GP workforce who are at risk of overload and burnout.

- A lack of access to bulk billing GP services results in higher presentations at hospital ED, often with increased complexity of issues.
- Many service gaps identified in stakeholder consultations are affected by workforce limitations. We heard that in some cases, especially away from metro and regional centres, there may be funded services, but it is not possible to recruit staff.
- **The main areas where health workforce limits referral options** were identified by general practices in 2025 (GPHNg). The most mentioned areas were:
    - Mental health, particularly for psychiatrists. Psychologists and mental health nurses were also identified frequently.
    - Medical specialists were identified consistently, in particular paediatricians, cardiologists and dermatologists.
    - Among the allied health professions, podiatrists were the most common profession identified. Speech therapists were also mentioned multiple times.

"Our remote location makes accessing services challenging across a wide range of services. We do rely heavily on telehealth services." (General practice)

"…especially all mental health supports – very limited and affecting community and families of clients extensively." (General practice)

Place based solutions

Based on stakeholder engagement to inform general practice workforce planning some suggested place-based solutions were identified for East Gippsland and Latrobe Valley (GPHN 2025c):

East Gippsland Bairnsdale, Lakes Entrance, Mallacoota, Omeo and Orbost GP catchments	*"The increasing as well as ageing population in East Gippsland will become more of a drain on GP services and the flow on effect for hospital services. Locum reliance at the hospital and outlying hospitals is cost prohibitive, and reduces efficiency and effectiveness of care due to them not being aware of local referral pathways, challenges, processes, etc."* **A collaborative supervision model** • Multiple supervisors support the registrars in the area, with principal supervisors being supported by additional supervisors who can contribute without all the administrative requirements. • Improves the ability for supervisors to meet other commitments (additional supervision requirements, multi-site work, etc) and to take leave without interrupted supervision for registrars.

	• Improved ability to support remote catchments such as Omeo and Orbost which experience some of the most severe and ongoing health workforce shortages in the State. • Increased access to remote supervision models which could include a hybrid of remote and in-clinic supervision. **Registrar placements of 12 or more months duration** • Longer placements, ideally with links to prevocational pathways offering end to end training for GPs and supported by a Single Employer Model. Accommodation support to enable families to settle in allowing registrars to build connections in the community. Families of registrars would be more likely to relocate, allowing improved social support and integration into the community. This would encourage long-term retention of doctors in the local community.
Latrobe Valley Churchill, Moe-Newborough, Morwell and Traralgon GP catchments	*"…a Collaborative [supervision] approach may be more practical…"* *"We need a supportive multidisciplinary team."* *"Other funding models for after hours, extended visits, specialist GPs, opportunities for nurse practitioners."* **A collaborative supervision model** • A collaborative supervision model as described above. • In this region, this model could enable single GP practices to contribute to supervision of registrars. Ideally, this would be combined with placements of a longer duration to encourage relocation and long-term retention. **Multidisciplinary team based care** • Multidisciplinary team-based care enabled by a collaborative supervision model, with a focus on improved support for the complex needs experienced in the community through person-centred and holistic care. • Greater involvement by nursing and allied health workforce enables flexible workforce arrangement and improved education and training opportunities and professional support.

Community, Consumer and Carer Perspective

Insights from the Tell Gippsland PHN ongoing consultations (2024c, 2024d, 2024e and 2025b) include:

- The Gippsland PHN Community Advisory Committee and others in the community have noted that workforce shortages are impacting on patient safety and quality of care.

  "The population is ageing, and the workforce is not keeping up." (Community member)

- A lack of health workforce causes pressure that are noticed by consumers. Community members are aware of how busy healthcare professionals are and this can lead to not seeking help or delaying help seeking.

  "Less overworked and stressed staff means better health outcomes for patients" (Community member)

- Reports of GPs who are unaware of some conditions and where people can be referred, for example autism and self-harm.

- Many consumers were aware of issues impacting workforce in their communities. At times these were discussed at a high level, as community members were aware of the intricacies of health workforces in rural areas:
  - Challenges of roles in the health sector, including burnout.

    "You know, doctors are under the pump. You've got people in aged care. Like that's a hard job." (Community member)

    "Mate, I would give – I would give the nurses – because I – they're the underdogs, as far as I'm concerned… especially nowadays, the pressure they're under. They are so undervalued and so underpaid." (Community member)
  - Continuity of services and workforce are impacted by short funding cycles.
  - The holiday season impacts needs and services, often resulting in an increased demand on services still operating due to tourists.
  - A lack of childcare is often reported with an impact on the ability to attract and retain workforce in the region, especially in smaller towns and communities where there are no long day care facilities.

Chapter 6: Connected Care

Connected care is a model of healthcare that embraces technology to integrate different parts of the healthcare system. It connects healthcare professionals, patients and data by leveraging tools such as electronic health records (EHRs), telehealth, and wearable devices.

Connected care enables a patient-centred approach to healthcare, granting greater access, improved information sharing, and more precise and effective treatment. This model enhances patient engagement, giving individuals more access and control over their health information, and fosters communication with their care team. Connected care improves healthcare quality, efficiency, and health outcomes, especially for those with chronic or complex conditions requiring ongoing management across different healthcare services.

Summary

Gippsland health insights

- Australian Digital Inclusion Index scores are increasing for all Gippsland local government areas but remain some of the lowest in the country.
- Infrastructure remains a barrier for Gippsland, with issues such as fixed broadband quality and poor mobile coverage.
- A range of digital tools are in use in Gippsland and their use is growing:
  - In July 2024, there were 268 organisations in Gippsland using My Health Record, an increase of 32% from July 2022.
  - In 2023-24, there were 2,732,640 regular uploads to My Health Record, an 18% increase from 2022-23.
- According to Gippsland PHN practice data, only 32% of active patients with chronic kidney disease (CKD) diagnosis had a shared health summary, compared to 13% of patients with an AOD diagnosis.
- Many community members see telehealth as the main form of connected care.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Increased confidence among providers and users to harness digital solutions to streamline services.
- Increased evaluation of services based on patient reported outcomes to drive improvement.
- Increased availability of telehealth to access general practice and specialist services.
- Improved care coordination and continuity of care for complex issues.
- Increased secure sharing of health information across providers.
- Increased digital inclusion for individuals, communities and health services.

Community voices

"I want to be offered telehealth options where services aren't available locally."

"I want communities to be supported to have greater access to digital health services through digital literacy, promotion of and supports in place."

"I want all of my records kept accurately, updated, using My Health Record."

National and Global Context

Connected care includes the planning, promotion and embedding of digital health solutions and connected care models that drive information sharing and health system improvement, supporting capacity building of the primary and acute health sectors to deliver excellent health outcomes in the community (GPHN 2024g).

This includes digital health models such as telehealth and remote patient monitoring, as well as more 'behind the scenes' tools such as secure messaging and in-clinic data analysis tools.

The **National Digital Health Strategy 2023-2028** (Australian Digital Health Agency 2023) outlines four health system outcomes enhanced by digital health:

1. Digitally enabled: Health and wellbeing services are connected, safe, secure and sustainable
2. Person-centred: Australians are empowered to look after their health and wellbeing, equipped with the right information and tools
3. Inclusive: Australians have equitable access to health services when and where they need them
4. Data-driven: Readily available data informs decision making at the individual, community and national levels, contributing to a sustainable health system

It also outlines four change enablers:

- Policy and regulatory settings that cultivate digital health adoption, use and innovation
- Secure, fit-for-purpose and connected digital solutions
- Digitally ready and enabled health and wellbeing workforce
- Informed, confident consumers and carers with strong digital health literacy

In Australia and globally, health is facing shifts due to ageing populations, increasing chronic disease, widening health disparities and technology advances. The COVID-19 pandemic revealed the potential and scalability of digital health solutions to support access, transform health care services to meet changing need, and improve digital and health literacy gaps. Improving digital inclusion is critical to achieving the 2025 vision of the World Economic Forum in their Global Health and Healthcare Strategic Outlook "Shaping the Future of Health and Healthcare" for equitable and innovative health systems that leverage and utilise technology for the benefit of all (WEF 2023).

The Strategic Outlook (WEF 2023) has helped provide a roadmap for the Gippsland PHN Digital Health Strategy 2025-28 (GPHN 2024j), and the activities within that are focussed on digital health adoption and literacy in rural and regional areas.

To align with the global goals, the Gippsland PHN strategy focusses on sustainable and equitable access to digital health. This is to be achieved through coordination and collaboration with governments, regional, state and national partners, health software providers, community organisations, and the Gippsland community to support digital literacy, access to care, health system transformation and information sharing that support an efficient and well-functioning health system. The investment into infrastructure, and improved health literacy through greater information sharing Gippsland can be well positioned to adapt to changing health system needs.

Regional Context

Regional communities stand to see real benefits to health and wellbeing with the use of connected care models (ACRRM n.d). However, there are challenges to the implementation of connected care.

A significant issue for much of Gippsland is digital connectivity. The Gippsland Regional Partnership (2019) identifies six common issues affecting the region:

- **Fixed broadband:** Ensuring NBN service quality is sufficient to meet resident and business needs.
- **Mobile coverage:** Addressing the prevalence of blackspots.
- **Internet of Things (IoT) networks:** Availability of low-bandwidth networks to support the uptake of next generation technologies.
- **Public Wi-Fi:** Availability of free public WiFi for disadvantaged residents and tourists.
- **Access:** Access to government assets to improve services locally.
- **Digital skills:** Improving digital literacy, supply of IT professionals, and workforce preparedness for the future.

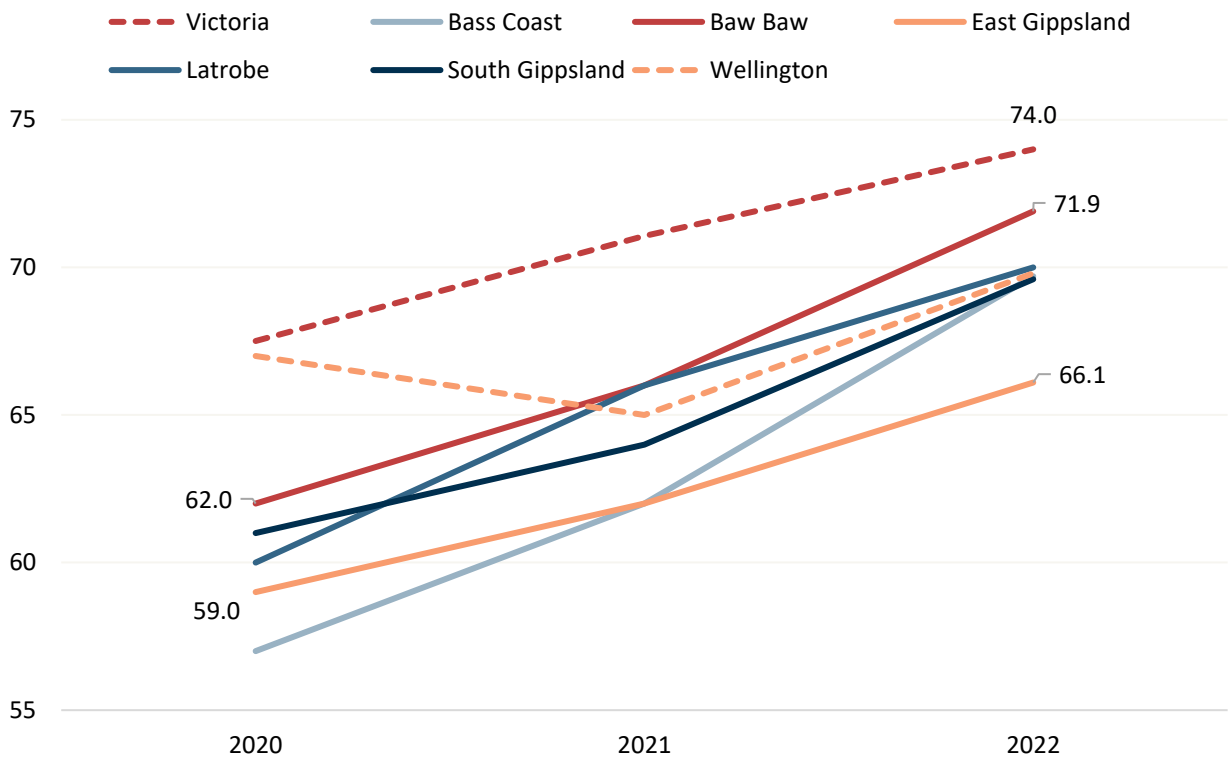
It is important to note that this final point, digital skills, refers to digital literacy overall, but also workforce preparedness. For connected care, digital skills are not only necessary in the community, but also in the health workforce (GPHN 2024e). Achieving a connected health system will require attention to all elements.

The Australian Digital Inclusion Index tracks and reports on digital inclusion in Australia (Australian Digital Inclusion Index (ADII 2023). This measure uses three dimensions of digital inclusion:

- **Access** – the ability to gain a reliable internet connection and use various digital devices, including frequency of online access.
- **Affordability** – the percentage of household income required to gain a good quality service with uninterrupted connectivity.
- **Digital Ability** – the skill level of people, including what they are able to do online and their confidence of doing it.

While Gippsland LGAs experience lower levels of digital inclusion than elsewhere in Victoria, the region has seen substantial increases since 2020 (**Figure 85**) (ADII 2023). Baw Baw currently experiences the highest levels of digital inclusion in Gippsland, with an index score of 71.9, and East Gippsland experiences the lowest levels of digital inclusion, with a score of 66.1 (ADII 2023).

Figure 85. Australian Digital Inclusion Index over time, 2020 to 2022 (ADII 2023).

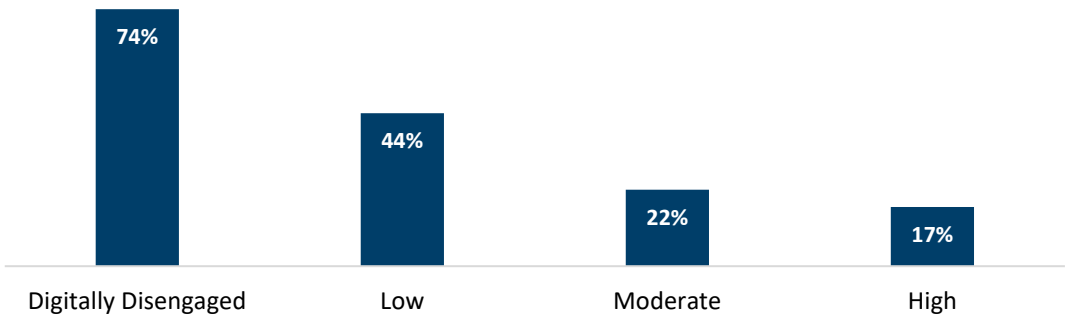


Access to digital connectivity is unequal. People with low socioeconomic status and younger people are more likely to use mobile devices rather than stationary devices in the home (GPHN 2019). Older people are more likely to have lower levels of digital literacy (**Figure 86**) (Office of the eSafety Commissioner 2018). Some older migrants, including those with lower English skills face a digital divide (Office of the eSafety Commissioner 2023), and some people in refugee communities may have never used a computer before (Multicultural Australia n.d).

However, it is important to ensure that digital options are not removed from everyone, or from entire cohorts. Some engagement participants with disabilities discussed the benefits of telehealth for accessing services (GPHN 2024e), and many migrant communities are highly digitally connected (Office of the eSafety Commissioner 2023).

Although older people were more likely to have low digital literacy, a study by the Australian eSafety Commissioner found people aged over 70 made up 17% of the high digital literacy cohort (Office of the eSafety Commissioner 2018). It is reasonable to expect that the cohort of individuals over 70 with high digital literacy will rise over time in Gippsland. This projection is based on demographic shifts, with the ageing of the Gippsland population. Additionally, new entrants to this age group are anticipated to be more digitally literate over time.

Figure 86. Proportion of people aged over 70 years that make up each level of digital literacy (Office of the eSafety Commissioner 2018)

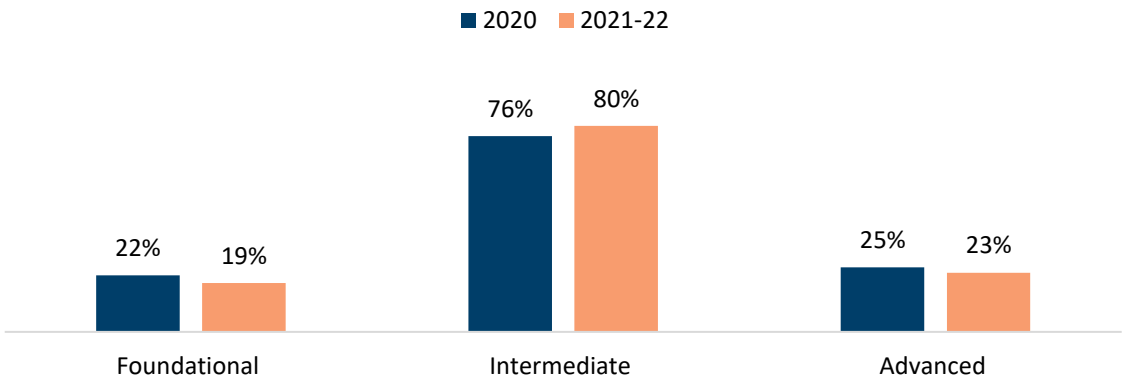


Additionally, it is important to note that people do not need strong digital literacy skills to benefit from connected care models. For example, patients may benefit from their health service utilising data analysis software to identify when they are eligible for a range of services, or from clinical software that can provide decision support to improve care. This further highlights the importance of digital infrastructure in health services and staff digital health skills and knowledge.

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 2021b). This was during the initial stage of the Covid-19 Pandemic in Victoria. The digital health maturity assessment covered a range of topics or domains that include practice context, infrastructure, capabilities, readiness to change, willingness to adopt new models of care and digital literacy (GPHN 2023b). Assessment results are shown in **Figure 87**. General practices were categorised into three tiers: Foundational, Intermediate and Advanced. Follow up results from a second assessment completed in 2022-23 showed that small changes occurred, with a decrease in the proportion of both foundational and advanced clinics, but an increase in the proportion of intermediate clinics.

Figure 87. Digital Health Maturity Assessment results, 2020 to 2022-2023 (GPHN 2021b & GPHN 2023b).



Key findings of the 2022-2023 Digital Health Maturity Assessment include:

- In 2022-23 general practices ranked higher in all assessed digital health domains except infrastructure, which was lower compared to 2020.
- Most of the practices that completed the assessment still use a fax machine in some way.
- There was a 12% increase in practices using a third-party booking service in 2022-23 (80%).
- In 2022-23, 100% of participating practices stated that they did receive hospital discharge summaries.
- 25% of practices reported general practitioners using My Health Record between 50-75% in 2022-23, an increase from 2020.
- In the 2022-23, assessment 50% of practitioners were using My Health Record greater than 50% of the time, an increase from 36% in 2020.
- In 2020, 90% of participating practices used some form of telehealth and in 2022-23, this had increased to 100%.
- In 2022-23, an additional field was added to differentiate between telephone and video consults. Telephone consults appear to be the preferred telehealth method in general practice.
- 70% of Gippsland PHN practice support staff agreed that the practice was ready to implement new models of care using digital health, compared to 2020 when 32% neither agreed or disagreed and 21% disagreed.
- In 2022/23, 83% of practices agree or strongly agree that practice staff have the skills to use digital health technologies.
- In 2022/23, 87% of participating practices (responding agree or strongly agree) reported they require support when using new digital technologies.

While there was no significant change in digital maturity over time, it is noteworthy that the proportion of general practices self-assessing as advanced slightly decreased. Conversely, the proportion of those self-assessing as foundational also decreased, while there was an increase in the proportion of practices self-assessing as intermediate. This shift to the middle is notable in the context of the maturity assessment being conducted across the time of the COVID-19 pandemic where a significant transition occurred that resulted in increased adoption and use of digital models of care to facilitate health care delivery in Gippsland.

Digital Health Tools

Digital tools are an essential part of connected care. See **Table 18** for an overview of selected digital tools utilised in Gippsland, and an estimate of the number of general practices and other providers using them.

Table 18. Digital health tools and their use in Gippsland, 2023-24 (GPHN 2024g).

Tool	Users	Description
POLAR GP	81 practices sharing data (out of 87 = 93% of accredited practices)	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.
My Health Record	268 Gippsland organisations registered for My Health Record; 88 general practices (up from 69 in 2021) 83 retail pharmacies 12 public hospitals and health services 23 aged care residential services Gippsland providers uploaded 2,732,640 (2023-24FY) clinical documents to My Health Record in 2023-24FY, a 17.5% increase from the previous year 2,326,494 (2022-23FY).	My Health Record allows secure storage and sharing of information between healthcare professionals and with the consumer, carer or family member. Rate of regular uploads to My Health Record = 2,732,640 (per 100,000 population = 910,880) Rate of discharge summaries uploaded to My Health Record = 62,835 (per 100,000 population = 20,945) Documents viewed which were uploaded by other health organisations = 124,763 (per 100,000 population = 41,588) Documents uploaded which were viewed by other health oraganisations = 137,962 (per 100,000 population = 45,987) Total cross views = 262,725 (per 100,000 population = 87,575)

e-prescribing	68 retail pharmacies have ePrescribing conformant software and utilising the functionality. 34 of these pharmacies have listed as electronic prescription capable on the National Health Service Directory.	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	87% of General Practices in Gippsland (85/98) are registered with HealthLink for secure messaging between health organisations. 90% of General Practices in Gippsland (88/98) are utilising Medical Objects for secure messaging between health providers.	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.
Gippsland Pathways	257 registered users 538 formal referral pathways 13064 page views	Gippsland Pathways is for use by primary care professionals in the Gippsland PHN region, providing information on local referral pathways and access to resources.
Remote Patient Monitoring - using Lifeguard	11 Gippsland general practices actively monitoring patients for chronic disease. 143 patients registered.	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). Hypertension was the most common condition to be monitored, with 58 patients monitored. In 2023/24, patients registered a total of 44,758 Patient Recorded Outcome Measures (PROMs). Healthcare providers viewed 2,733 PROMs.
Telehealth	54 general practices are listed as telehealth capable on the National Health Services Directory. 38 general practices are registered with Healthdirect Videocall service through Gippsland PHN.	Telehealth allows patients to consult a healthcare provider by phone or a video call

	PHN general practice data showed: - 61 out of 62 general practices sharing data with PHN have conducted a telehealth phone call. - 59 out of 62 general practices have conducted a video-telehealth call.	
Smart forms	87% of General Practices in Gippsland (85/98) are registered with HealthLink for streamlined referrals between health organisations. 90% of General Practices in Gippsland (88/98) are utilising Medical Objects for streamlined referrals between health providers.	Smart forms is a system that streamlines referral processes using clinical software.

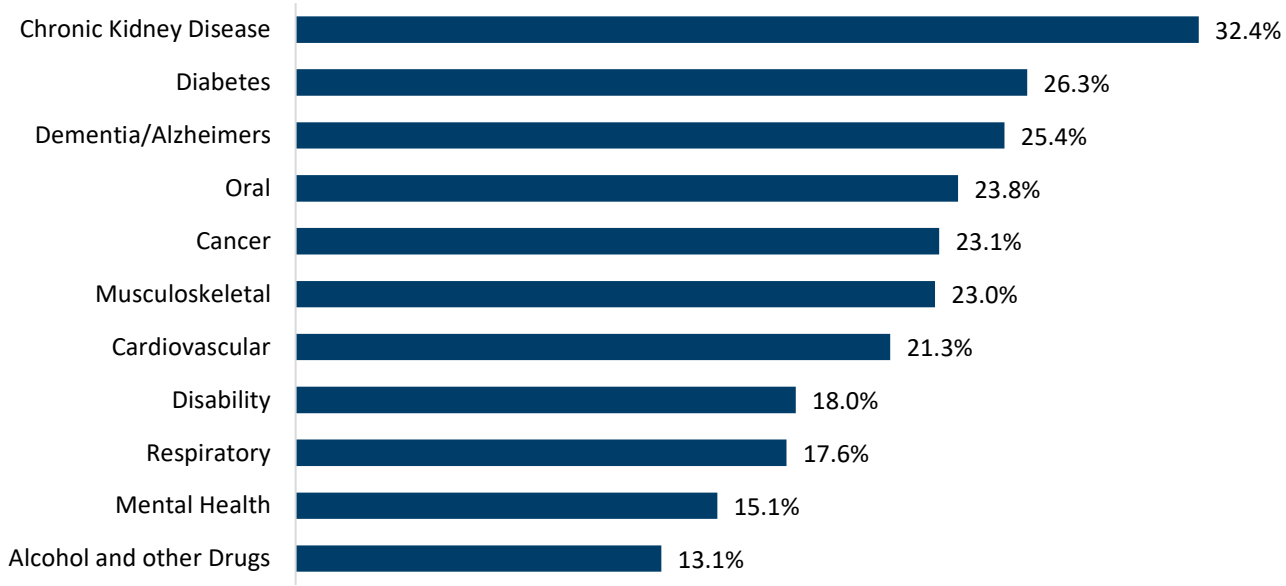
Service Use

General practice data

A Shared Health Summary (SHS) provides a summary of a patient's health status and is typically created and uploaded by a patient's regular GP. It contains essential health information and supports continuity of care, enhances patient empowerment, and improves health outcomes through connecting care. Uploads are incentivised through an MBS item number associated with creating or updating a Shared Health Summary.

The proportion of active patients presenting to Gippsland general practices with a Shared Health Summary (SHS) uploaded to My Health Record was 12.9% (GPHN 2024b), with a total of 29,657 SHSs uploaded. Breakdown by chronic disease type is shown in **Figure 88**.

Figure 88. Proportion of active patients with a chronic disease with a Shared Health Summary (12.9% of total population) (GPHN 2024b).



Professional Stakeholder Perspective

Insights from Gippsland PHN consultations (2024e) include:

- The digital technology health professionals were most likely to discuss during interviews and workshops was telehealth.
- Professionals were more accepting of the term “hybrid telehealth”, even if this was used to describe existing telehealth models. In these discussions, emphasis was placed on a person-centred approach where community members are supported in some way to use digital tools.
- Some professionals highlighted that there is danger in allowing telehealth to shift the responsibility for access to patients, especially when internet doesn’t work for some.
- Professionals were often hesitant about the ability of their older patients, a significant cohort, to be able to use digital health tools.
- Professionals highlighted digital infrastructure limitations in their regions, such as phone service and access to internet.

Community, Consumer and Carer Perspective

Insights from Gippsland PHN consultations (2024c, 2024d and 2024e) include:

Telehealth

- Community members were more accepting of the term “hybrid telehealth”, even if this was used to describe existing telehealth models. In these discussions, emphasis was placed on a person-centred approach where community members are supported in some way to use digital tools.
- Telehealth appointments can be harder to access following changes to MBS item number requirements.
- Some patients were positive about telehealth options but expressed concerns that telehealth would replace face to face consultations.

Appropriateness

- Community members raised differences in suitability for digital tool depending on age, service type and location. However, it was noted it is essential that this does not result in making assumptions about someone’s capacity to access these services

  “Health system strengthening including workforce, digital health, equity of access and person-centred care; focus on building a stronger, more accessible, and patient-focused healthcare system. Avoid siloing health challenges, it’s crucial to adopt a holistic, integrated approach.” (Community member)

“Digital health provides the greatest possibility to bridge the gap between need and access.” (Community member)

- Participants were positive about the convenience of accessing digital services, whether to fit around work or to save significant travel time or costs.
  "You have to travel from one place to the other just to get access to that. And then you go there, you sit with them for five minutes and your appointment’s over. Like, I drove all the way. I drove two, three hours just to come and get this five-minute opinion."
  (community member)

  "I also have ADHD and I find it really, really hard to make appointments and to keep them because I either lose track of the time or I just feel like weird about going and talking to my doctor about something. So, I find telehealth really useful." (community member)

  "I mean, I literally live around the corner from the doctor but sometimes my work schedule doesn't allow me to do things like that. So, it's handy to just be able to go online and talk to a doctor at like six in the afternoon or whatever else and get your prescription in quickly and get all the things to be done." (community member)

- Young people as a cohort were less likely to discuss low digital literacy, and many discussed seeking health information through sources such as podcasts and YouTube.

Support to use digital tools

- More promotion and support is needed to allow as many people as possible to benefit from digital health solutions; this includes improving access to technology, improving digital literacy through education and training, promotion and ongoing supports in place. This applies to health services, health professionals and the community receiving care.

Engagement participants expressed a desire to be supported to use digital options when they faced challenges such as digital literacy.

Chapter 7: Growing Up Healthy (0-25 years)

This priority refers to the health and wellbeing of people aged 0 to 25 years. Data in this priority is occasionally split into children and young people, as these groups can have different health needs. There are different definitions of children and young people, but in this report, children are described as aged 0 to 11 years, and young people as aged 12 to 25 years, to align with the Australian Institute of Health and Welfare definition. In some cases, datasets that split children and young people in this way have not been available, so other groupings of age ranges have been used.

The foundations for good health start early in life, and development of positive health-related behaviours can impact health and wellbeing in later life.

Summary

Gippsland health insights

- Children aged 0-11 make up 14.4% and young people aged 12-25 make up 14.5% of the Gippsland population.
- Approximately 15% of children aged under 16 years live in low-income families in Gippsland.
- Childhood vaccination in Gippsland has decreased between 2018-19 and 2023-24.
- In 2023-24, there were 1,419 clients accessing headspace services (up from 1,153 in 2022-23).
- There were 3,418 admissions for newborns and other neonates in Gippsland in 2023-24, up from 3,227 in 2019-20.
- There was a total of 20,589 Emergency Department presentations for people aged 0-14 years in 2023-24. A total of 13,352 people aged 15-24 years presented to the Emergency Department in 2023-24.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Improved identification and support for vulnerable children/families to access affordable and holistic support services.
- Improved health service capacity and capability to intervene early and reduce and prevent further harm.
- Improved access and coordination of specialist services and supports for children.
- Improved access to paediatricians and paediatric-specialised allied health professionals.
- Increased access to affordable child and adolescent mental health services that meet population needs.
- Increased access to appropriate care and connections for vulnerable young people.
- Improved support for the perinatal period.
- Increase childhood immunisation rates to meet the 95% target, including for Aboriginal and/or Torres Strait Islander children.
- Reduce the proportion of children who are developmentally vulnerable when they start school.

Community voices

“I don't want my children's access to health services to be compromised because of where we live.”

“I want to see all children commencing school with no vulnerabilities.”

"I want health professionals to take me seriously, even though I'm young."

"I want to understand the health system better, so I can start to navigate it as a young adult."

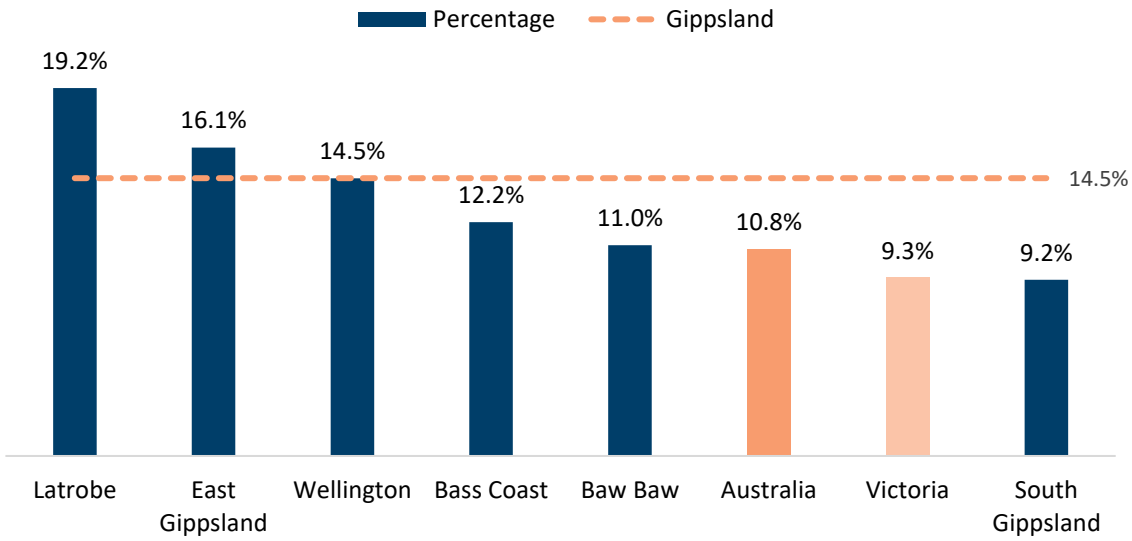
Health Status

Child health

Children aged 0 to 11 years make up 14.4% of the Gippsland population (40,063 people) (GPHN 2024a). Child health is closely linked to maternal health, and socioeconomic factors including poverty, housing and employment status, exposure to family violence or living in Out of Home Care. Other social determinants of health, such as whether a person is from a rural or remote area, is of Aboriginal and/or Torres Strait Islander or culturally diverse descent, can impact child health. See also **Social Determinants of Health**.

In Gippsland, nearly 15% of children under 16 years live in low-income families receiving income support (**Figure 89**) (GPHN 2024a). Notably, all LGAs in Gippsland, except South Gippsland, exceed both the state and national averages. Latrobe has the highest proportion, with 19.2% of children living in low-income families receiving income support (GPHN 2024a).

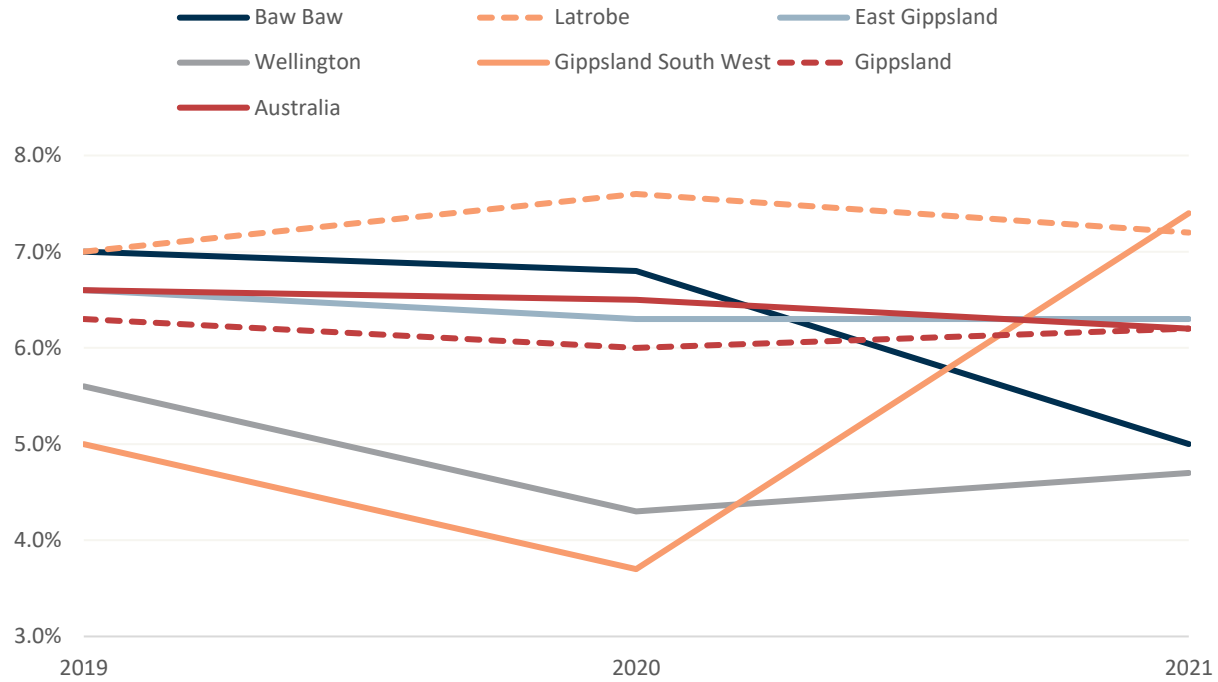
Figure 89. Children (under 16 years) in low-income families receiving income support (GPHN 2024a).



Births

Most Gippsland LGAs saw a small decrease in the proportion of low-birth-weight babies between 2019 and 2021, consistent with the national trend, however, Baw Baw had a substantial reduction. Latrobe saw a minor increase, and Gippsland Southwest saw a sizable increase in low-birth-weight babies during this period (**Figure 90**) (GPHN 2024a).

Figure 90. Low birth weight babies (<2,500 grams at birth) over time, 2019- 21(GPHN 2024a).



Mortality

The average annual infant mortality rate in Gippsland was 2.4 per 1,000 live births in 2018-2022**,** lower than 3.2 in Australia. (PHIDU 2024b). The highest rate was in Latrobe, with a rate of 3.6 infant deaths per 1,000 live births.

Development

The first 1000 days of life are critical for health child development. A growing body of evidence suggests that maternal mental health and wellbeing can influence pregnancy, foetal and infant development, as well as parenting (Lee & Newman 2018).

The Australian Early Development Census (AEDC) measures children's development as they enter primary school (AIHW 2022b). The five AEDC domains are:

- Physical health and wellbeing,
- Social competence,
- Emotional maturity,
- Language and cognitive skills (school-based), and;
- Communication skills and general knowledge.

Between 2012 and 2021, the percentage of children in Gippsland likely to be developmentally vulnerable at school entry was consistently higher than the Victorian average (**Figure 91**) (GPHN 2024a). This trend was true for children vulnerable at one or more, and two or more developmental domains. A breakdown of the percentage of children in Gippsland likely to be developmentally vulnerable at school entry per LGA is shown in **Table 19**, noting Latrobe has the highest proportion of developmentally vulnerable children and is within the top 25% of LGA's nationally (GPHN 2024a).

Figure 91. Children who are developmentally vulnerable at school entry over time, 2012 to 2021 (GPHN 2024a).

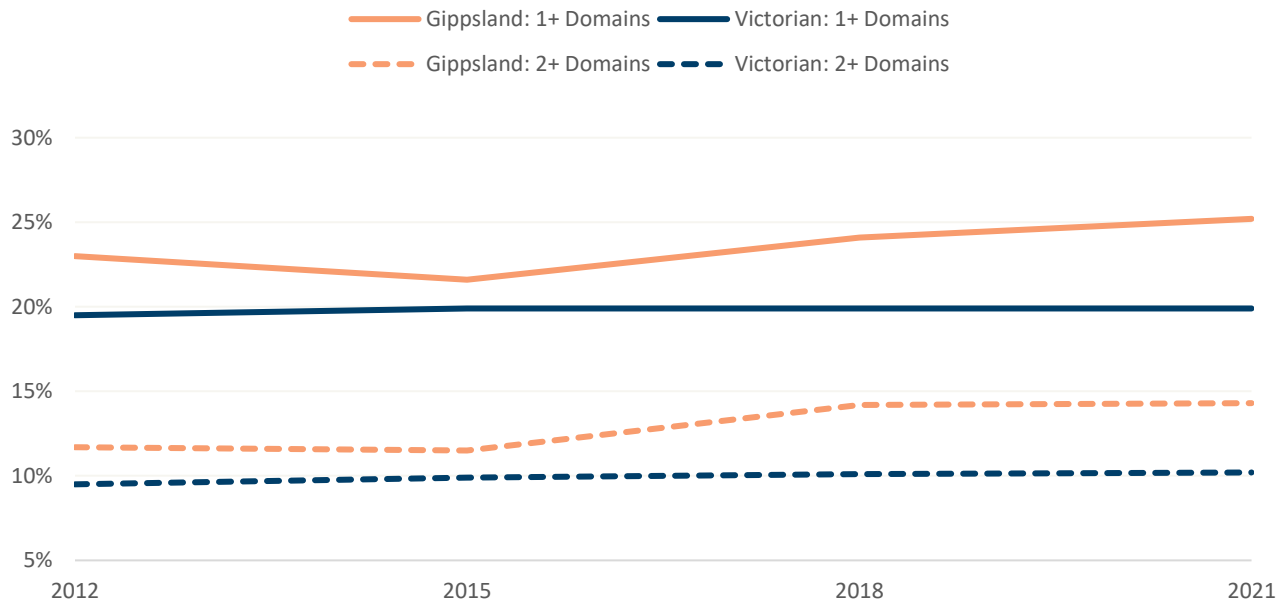


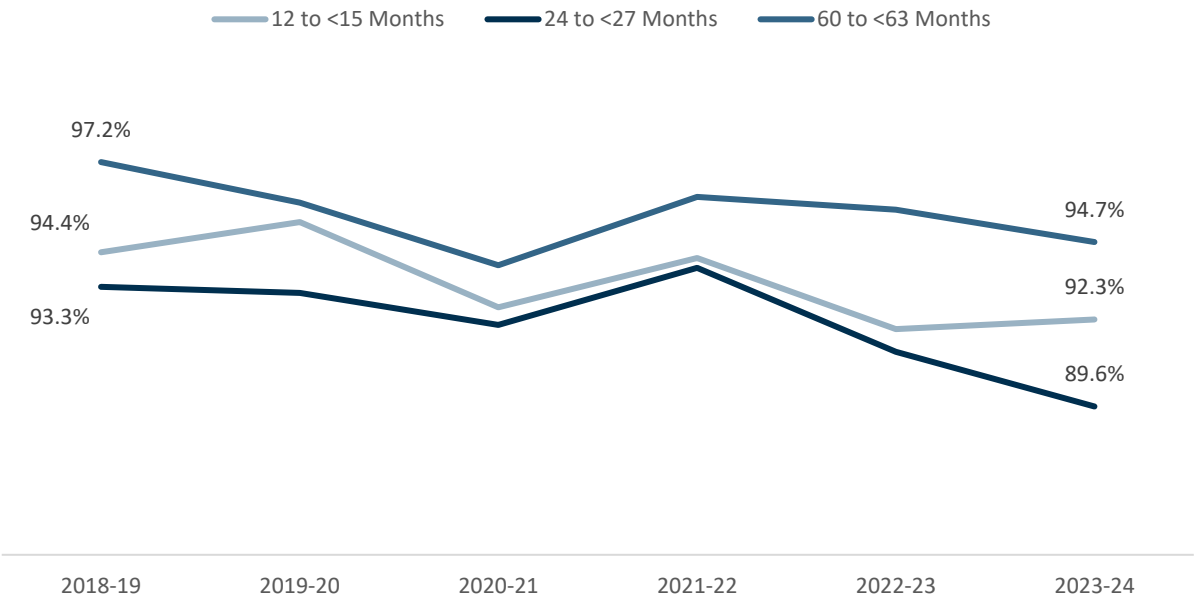
Table 19. Children who are developmentally vulnerable at school entry, 2021 (GPHN 2024a).

Region	One or more domains at school entry	Two or more domains at school entry
Bass Coast	26.8%	13.0%
South Gippsland	27.3%	13.6%
Baw Baw	24.0%	13.8%
Latrobe	26.0%	16.8%
East Gippsland	24.1%	12.7%
Wellington	24.0%	13.3%
Gippsland	25.2%	14.3%
Victoria	19.9%	10.2%
Australia	22.0%	11.4%

Immunisations

Over time, the rate of children fully vaccinated in Gippsland has been relatively high, although is starting to trend downwards as per **Figure 92**. The National Centre for Immunisation Research and Surveillance (NCIRS) has noted coverage rates among children in Australia have declined for the third consecutive year (NCIRS 2024). Prior to the start of the COVID-19 pandemic, these rates had been increasing for eight years. Immunisation experts say a deeper understanding of the reasons for partial and under-vaccination in Australia is needed.

Figure 92. Rate of children in Gippsland fully vaccinated at ages one, two, and five over time, 2018-19 to 2023-24 (GPHN 2024a).



In 2023-24, Gippsland and every SA3 in the region was within the lowest 25% of SA3s Australia wide for 2-year-old children fully immunised (GPHN 2024a). Notably, Baw Baw and Wellington were the 2nd and 5th lowest ranked SA3's in Victoria, respectively. Baw Baw is also in the lowest 25% of SA3's nationally for 1-year-old and 5-year-old children fully immunised, whilst Wellington was the lowest ranked SA3 in Gippsland for 1-year-old immunisations, the 6th lowest in Victoria. For further details see **Appendix 13**.

Young people

In 2021, young people aged 12 to 25 years made up 14.5% of the Gippsland population (43,551 people) (GPHN 2024a).

In 2023, the Mission Australia Youth Survey (Mission Australia 2023) reported the following issues to be the most important to young people nationally:

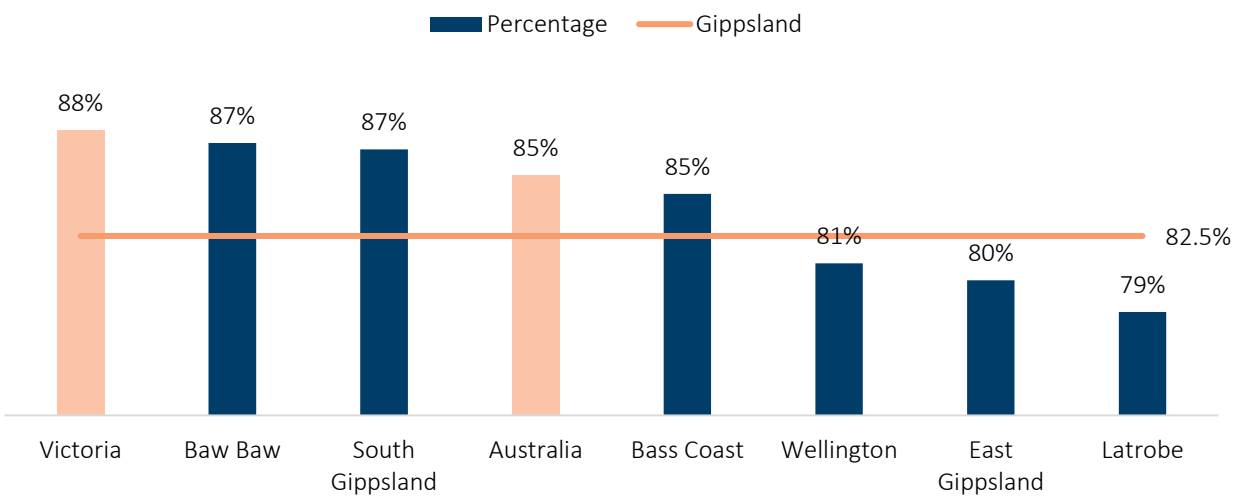
1. The environment: 44% said this was one of the most important issues in Australia.
2. Equity and discrimination: 31% said this was one of the most important issues in Australia.
3. The economy and financial matters: 31% said this was one of the most important issues in Australia.
4. Mental health: 30% said this was one of the most important issues in Australia.
5. Homelessness and housing: 19% said this was one of the most important issues in Australia.
6. Crime safety and violence: 18% said this was one of the most important issues in Australia.

Employment

In Gippsland, 82.5% of young people aged 15 to 24 years are either studying or employed (**Figure 93**) (GPHN 2024a). However, this varies by LGA, being highest in Baw Baw (86.9%), and lowest in Latrobe (78.9%) (GPHN 2024a).

In Gippsland, 81.2% of 16 years olds were studying full time at secondary school in 2021, compared to 88.5% in Victoria (GPHN 2024a). Notably, 26.7% of Gippsland school leavers aged 17 were participating in higher education in 2023, which is nearly half of the 45.4% participation rate in Victoria (GPHN 2024a).

Figure 93. Learning or Earning at ages 15 to 24 years, 2021 (GPHN 2024a).



Mortality

The youth mortality rates in Gippsland, Victoria, and Australia have remained relatively stable between 2015-2019 and 2017-2021 (**Table 20**). In 2015-19 and 2016-20 East Gippsland was in the top 25% of Victorian LGA's, with South Gippsland in the top 25% in 2016-20 and 2017-21.

Table 20. Youth mortality (15-24 years) - average annual age-standardised rate (per 100,000), 2015-19 to 2017-21 (GPHN 2024a).

Region	2015-2019	2016-2020	2017-2021
Bass Coast	42.7	53.1	31.9
South Gippsland	45.7	66.3	57.1
Baw Baw	45.7	51.9	42.4
Latrobe	37.3	47.0	38.9
East Gippsland	64.4	67.6	47.5
Wellington	25.2	36.5	33.0
Gippsland	41.4	40.7	40.8
Victoria	31.9	30.1	30.2
Australia	38.9	36.8	37.3

Immunisations

For rates of young people fully immunised against HPV at 15 years, Gippsland performed well, with 80.4% coverage for boys and 85.7% coverage for girls in 2017 (**Table 21**) (GPHN 2024a). East Gippsland performed notably well, while rates in Baw Baw were in the lowest 25% in Victoria (GPHN 2024a).
Note: 2017 data is the most current data available for this measure.

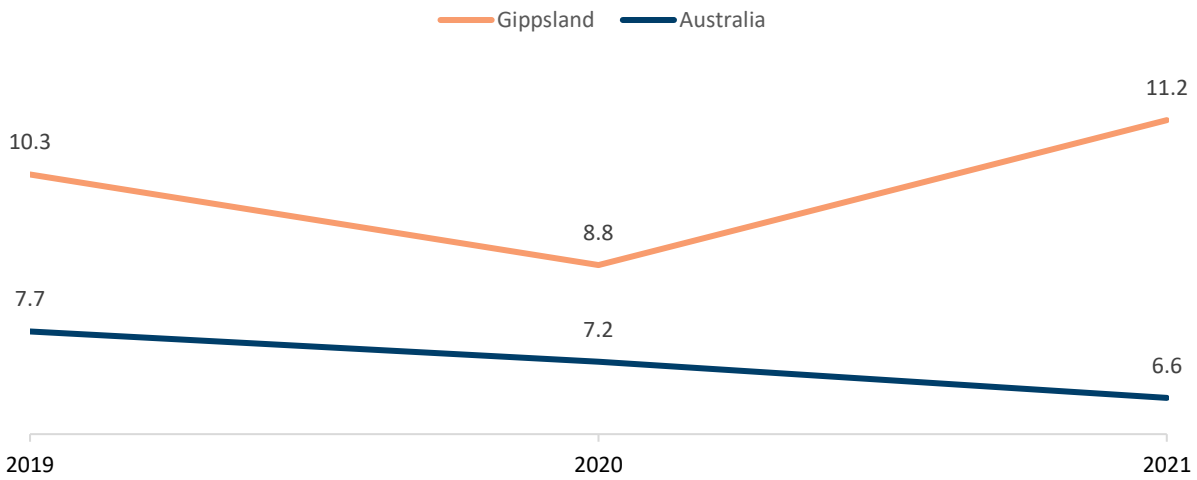
Table 21. Proportion of 15-year-old boys and girls who were fully immunised against HPV, 2017 (GPHN 2024a).

Region	Proportion of 15-year-old boys who were fully immunised against HPV	Proportion of 15-year-old girls who were fully immunised against HPV
Bass Coast	74.1%	90.4%
South Gippsland	86.8%	85.3%
Baw Baw	65.0%	73.1%
Latrobe	87.7%	94.3%
East Gippsland	96.1%	91.7%
Wellington	73.9%	78.0%
GIPPSLAND	80.4%	85.7%
VICTORIA	76.5%	80.0%
Australia	76.1%	80.5%

Young mothers

While the number of live births to mothers aged 15 to 19 years per 1,000 people decreased in Australia between 2019 and 2021, this figure has increased in Gippsland (**Figure 94**). In 2021, the highest rate of teenage births was in Latrobe (18.4 per 1,000 people) and East Gippsland (16.4 per 1,000 people) (GPHN 2024a). Over time this figure has decreased in Latrobe and increased in East Gippsland (GPHN 2024a). It is also important to note that data is not available on the rates of live births to fathers aged 15 to 19, an essential part of health planning for births to teenage parents.

Figure 94. Number of live births to mothers aged 15-19 years per 1,000 people between 2019-21 (GPHN 2024a).



Service System

Key services for children and young people include maternal and child health services, provided through local government, early intervention services, and 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.

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 locations: Bairnsdale, Sale, Morwell and Wonthaggi.
    - Satellite centres in Korumburra, Leongatha, Foster, Cowes.
    - Youth Advisory Groups are established across three headspace sites.
- Primary Mental Health Care commissioned services:
    - Psychological therapies delivered by a 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.
- The Youth Enhanced Service provides enhanced support to young people aged 12-25 years who are living with, or at risk of severe and complex mental health issues.
- 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) is 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 centre or school. Schools more than 80km from their closest headspace center can access telephone counselling via the Regional Telephone Service.
- A Family Support Program 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.
- Community Led Integrated Health Care (CLIHC) is a clinic for children from disadvantaged backgrounds that provides care coordination, transport assistance and a multi-disciplinary approach to address family needs. The service also supports families experiencing violence, new parents and young children by identifying patients at risk. CLIHC is delivered in the Latrobe region by Latrobe Community Health Service, in collaboration with Berry Street Victoria.
- Gippsland Pathways has localised referral pages to support child mental health referrals, and child health pathways more broadly which consist of clinical pathways to support patient care in Gippsland.

Service Utilisation

Children and young people in Gippsland were less likely to access a range of Medicare-subsidised services when compared to children and young people in Australia (**Figure 95** and **Figure 96**). This may suggest poorer access to services in the region.

In 2022-23, children aged 0-14 in Gippsland received speech pathology and physiotherapy Medicare-subsidised services at less than half the rate of the Australian average, with access to Psychiatry and Psychology also substantially lower. This difference appears to largely disappear for young people aged 15-24, with Gippsland still below the national average.

Figure 95. Proportion of children aged 0-14 receiving Medicare-subsidised services, 2022-23 (AIHW 2024f).

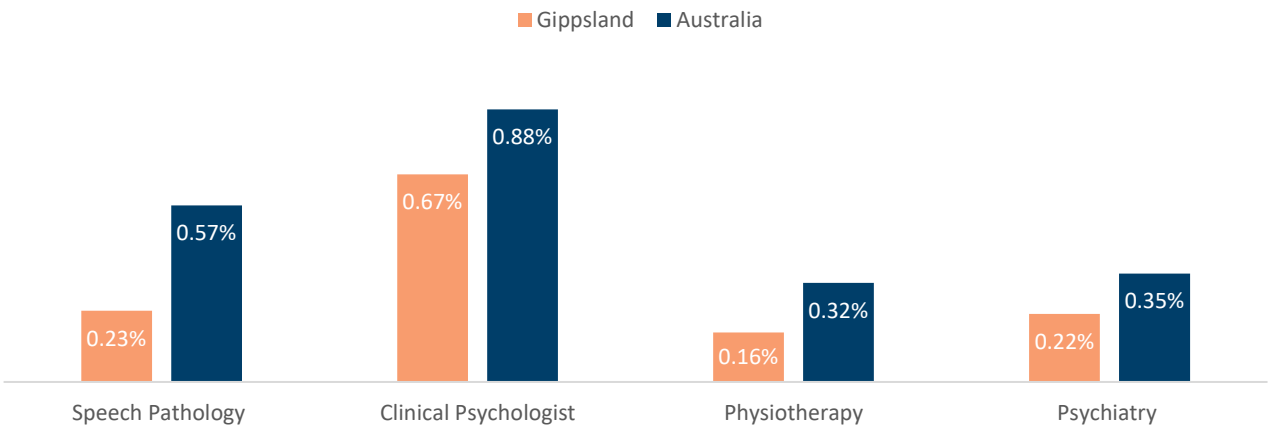
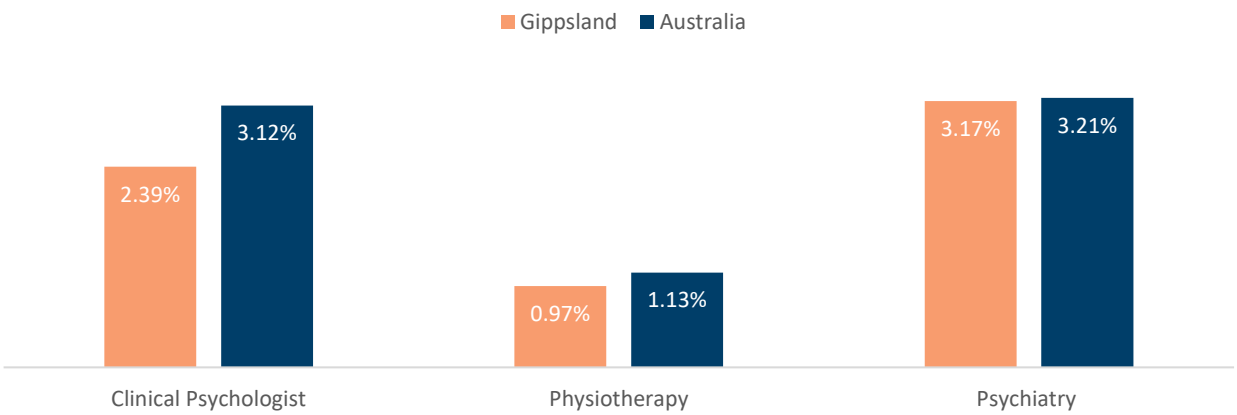


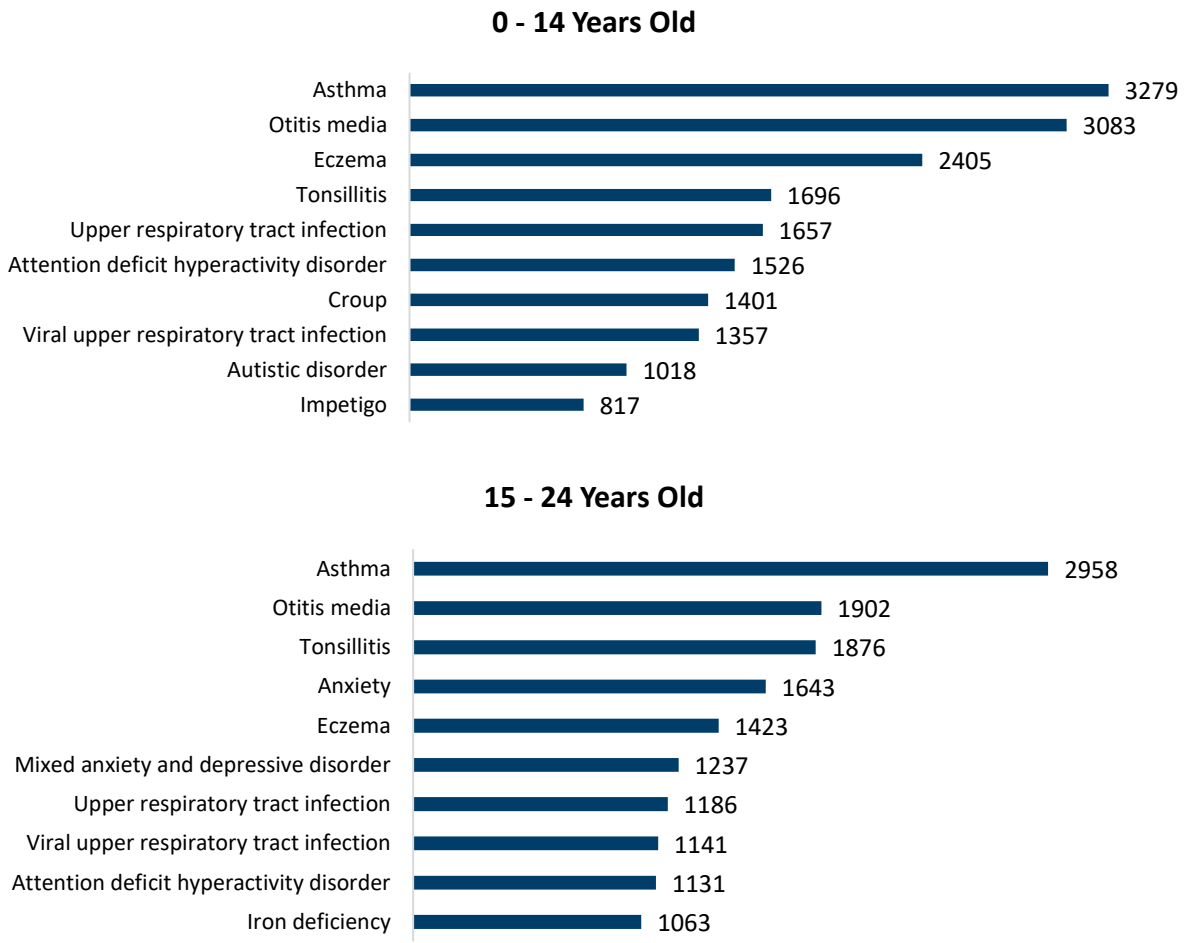
Figure 96. Proportion of young people aged 15-24 receiving Medicare-subsidised services, 2022-23 (AIHW 2024f).



General practice

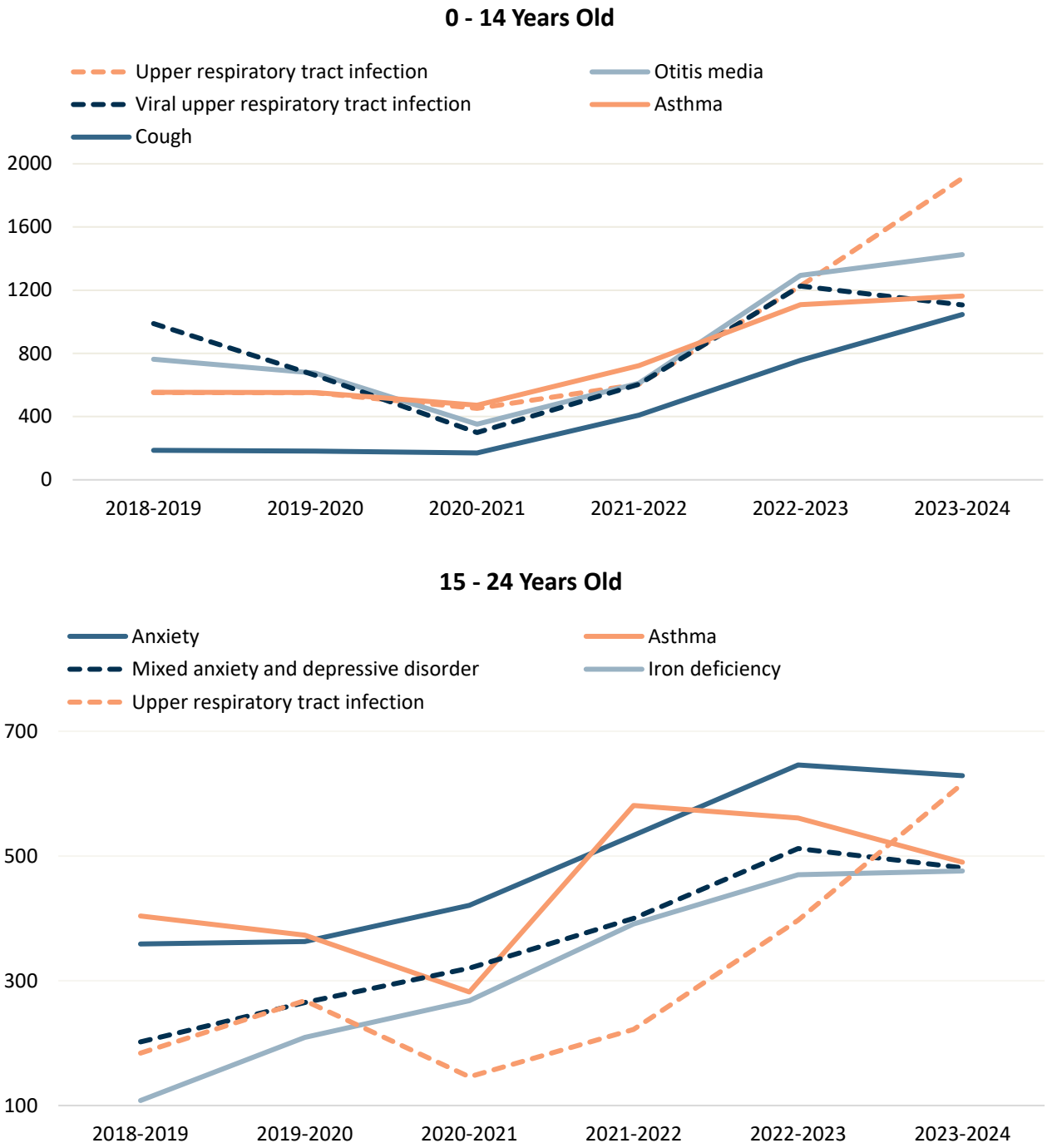
Asthma was the most common diagnosis seen among both 0–14-year-olds and 15–24-year-olds in general practice in Gippsland in 2023-24 (**Figure 97**) (GPHN 2024f).

Figure 97. Top 10 active diagnoses for active patients aged 0-14 years & 15-24 years, 2023-24 (GPHN 2024f).



The top new diagnoses by year show a decrease in new diagnoses for many conditions in 2019-20 and 2020-21 (**Figure 98**). As some of these conditions comprise communicable diseases, such as upper respiratory tract infections, this could be because of COVID-19 lockdowns and other infection control practices limiting the spread of communicable diseases. For non-communicable diseases, such as asthma, this may indicate that children and young people were less likely to be diagnosed during this time.

Figure 98. Top new diagnoses for patients aged 0-14 years, 15-24 years in Gippsland by year (GPHN 2024f).



Gippsland PHN commissioned services data

Mental health services provided for young people, reported via national PMHC-MDS reporting (GPHN 2024k) show that:

- In 2023-24, there were 1,419 active clients accessing headspace services (up from 1,153 in 2022-23) across Gippsland (GPHN 2024i).
- There were 7,612 occasions of services provided in 2023-24 (an increase from 5,363 in 2022-23); average of 5.3 occasions of service per person in 2022-24, (4.6 in 2022-23).
- Mode of service delivery returned to pre-pandemic numbers, with 84% face to face in 2023-24 up from 34% in 2020-21; telephone and video calls reduced substantially and are now lower than pre pandemic (**Table 22**).

Table 22. Mode of delivery of headspace services 2019-20 to 2023-24, Gippsland (GPHN 2024k).

Mode	2019-20	2020-21	2021-22	2022-23	2023-24
Face to face	76.9%	33.8%	55.7%	84.6%	83.7%
Telephone	16.9%	50.0%	30.5%	12.0%	13.9%
Video call	6.1%	15.5%	13.8%	3.4%	2.4%

Client characteristics for service contacts (GPHN 2024k):

- Gender: females (56.2%), males (36.4%) and 'other' (7.3%)
- Age: 12-17 years (69.1) and 18-24 years (30.7%)
- Indigenous status: 7.0% were Indigenous
- Preferred language: 96.8% spoke English as the main language at home

Service contact characteristics (GPHN 2024k):

- Healthcare card holders: 35.4%
- NDIS participant: 5%
- Had a GP mental health care plan: 18.8%
- Appointment types: structured psychological intervention (71.2%), assessment (19.2%) and clinical care coordination/liaison (5.5%)
- Employment status: employed (27.5%), unemployed (18.3%), not in the workforce (18.6%) and note stated (35.6%)
- Referral type: self-referred (62.8%), referred by a GP (11.5%) and other (24.6%)
- Diagnosis: 89.6% of service contacts through Gippsland PHN funded services for this aged cohorts were for a client with a missing or unknown diagnosis (**Table 23**). Anxiety disorders (3.1%) was the most common diagnosed condition, followed by other mental disorders (2.8%).

Table 23. Service contact characteristics by principal diagnosis across all Gippsland PHN Commissioned Services, 2023-24 (GPHN 2024k).

PRINCIPAL DIAGNOSIS: GROUPED	SERVICE CONTACTS	
	Number	Percentage
Anxiety disorders	236	3.1%
Affective (mood) disorders	139	1.8%
Disorders with onset usually occurring in childhood and adolescence not listed elsewhere	85	1.1%
Other mental disorders	213	2.8%
No formal mental disorder but subsyndromal problems	118	1.6%
Missing or unknown	7,612	89.6%

headspace – analysis of young people serviced

An analysis of the number of young people serviced by financial year was done using the headspace reporting platform (GPHN 2024i):

- The number of young people serviced by financial year and LGA is shown in **Figure 99**. The number of young people receiving a service has remained relatively stable over this time, except for Wellington in 2021-22.

- An estimated 3.8% of young people in Gippsland aged 12-25 years received a headspace service in 2023-24. This is a slight increase from 3.6% in 2020-21 (**Table 24**).
    - Latrobe continues to have the lowest coverage, steady at 2.9%
    - Baw Baw had the second lowest coverage at 3.4%, a decrease since 2020-21 (noting this LGA is serviced from the headspace site in Latrobe)
    - East Gippsland had the highest rate at 5.7%, a slight increase since 2020-21
    - Bass Coast saw a decrease
    - Wellington coverage has improved after a satellite site opened in July 2020
- Wait times for first appointment in the six months to June 2024 by center:
    - Bairnsdale: 12% thought the wait was too long (62% were seen within two weeks)
    - Morwell: 15% thought the wait was too long (57% seen within two weeks)
    - Sale: no-one thought the wait was too long (72% seen within two weeks)
    - Wonthaggi: 15% thought the wait was too long (51% were seen within two weeks)

Figure 99. Headspace throughput by Gippsland LGA, 2020-21 to 2023-24 (GPHN 2024i).

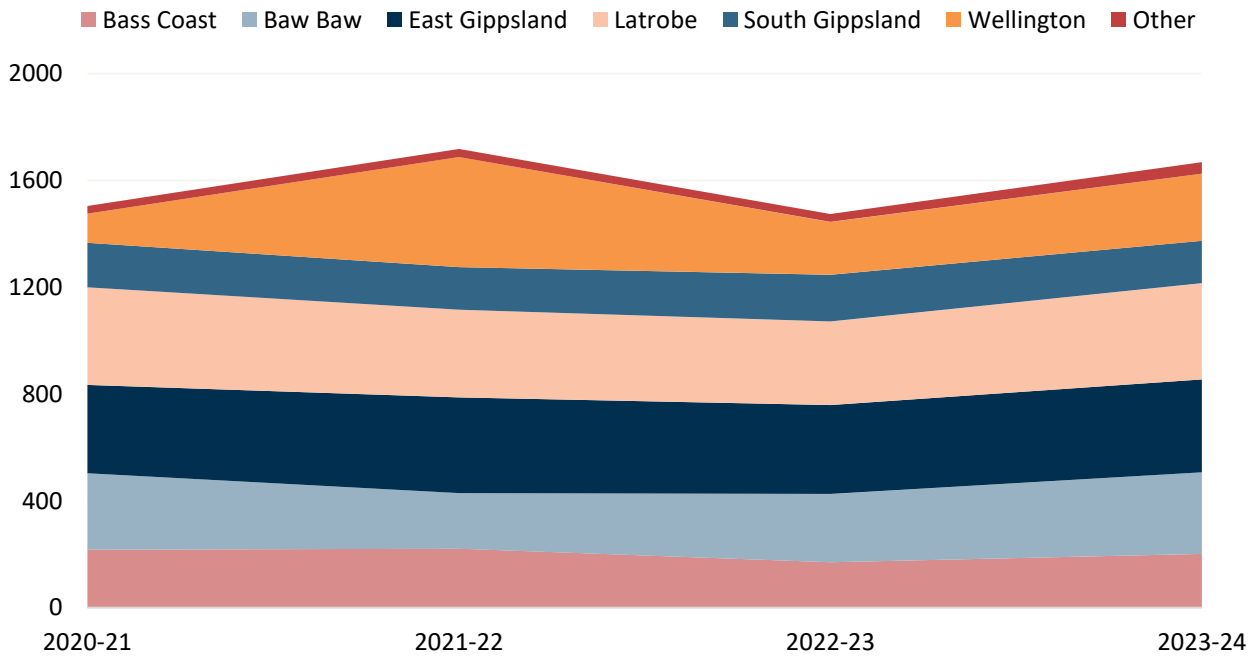


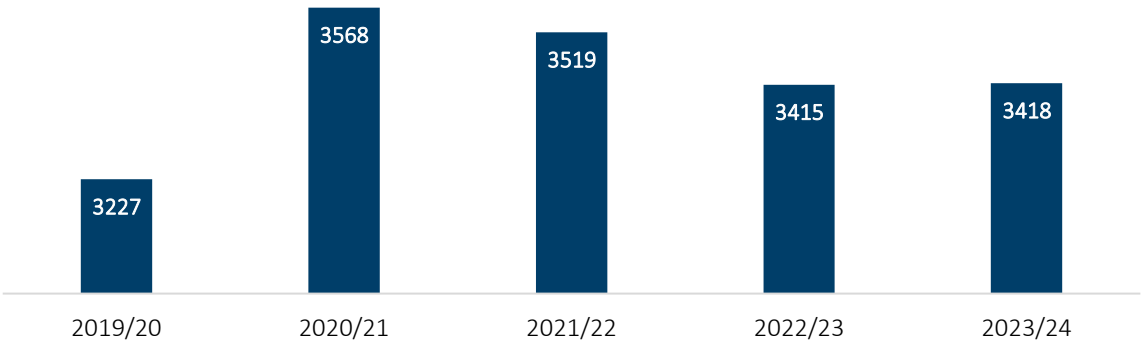
Table 24. Residential LGA of headspace clients and estimated proportion of people aged 12-25 years receiving a service, 2023-24 (GPHN 2024i & ABS 2021a).

LGA	Population 12-25 years (ABS 2021a)	Number of people serviced by a headspace centre	Percent of total population 2023-24
Bass Coast	4,887	201	4.1%
Baw Baw	9,123	306	3.4%
East Gippsland	6,113	348	5.7%
Latrobe	12,362	360	2.9%
South Gippsland	4,172	159	3.8%
Wellington	6,840	252	3.7%

Hospital admissions

There were 3,418 admissions for newborns and other neonates in Gippsland in 2023-24, up from 3,227 in 2019-20 (DH 2024a) (**Figure 100**). The distribution by SA3 sub-region indicates that 29% were Latrobe based, 22% were Baw Baw based, 20% were East Gippsland based, 15% were Wellington based and 14% were East Gippsland based residents.

Figure 100. Hospital admissions for newborns and other neonates residing in Gippsland 2019-20 to 2023-24 (DH 2024a).



Emergency Department presentations

In 2023-24, there were 20,589 emergency department (ED) presentations for people aged 0-14 years, accounting for 16% of all presentations. Top diagnoses are shown in **Table 25**. Key insights include:

- **Injuries:** 33% of these presentations were due to injuries, with "Fall <1 metre or no height information" the top cause, making up 12% of all presentations in this age group (2,527 presentations in 2023-24)
- **Lower urgency:** 49% of all presentations were lower urgency in 2023-24, down from 59% in 2019-20
- **Top diagnosis:** The top diagnosis for lower urgency presentations was viral infection unspecified, with 5% of diagnoses **Table 25**.

There was a total of 13,352 Emergency Department presentations for people aged 15-24 years in 2023-24 (11% of all presentations). Top diagnoses are shown in **Table 26**. Key insights include:

- **Injuries:** 34% of these presentations were due to injuries, with "Fall <1 metre or no height information" the top cause, making up 6% of all presentations in this age group (789 presentations in 2023-24)
- **Lower urgency:** 48% of all presentations were lower urgency presentations, down from 53% in 2019-20
- **Top diagnosis:** Top diagnosis for lower urgency presentations was other and unspecified abdominal pain, with 6% of diagnoses. **Table 26**

Table 25. Top diagnoses (ICD-10 descriptions) among lower urgency presentations for people aged 0-14 years, 2023-24, total of 10,081 presentations (DH 2024b).

Description	Percentage	Number
Viral infection unspecified	5%	525
Fracture other & unspecified parts wrist & hand	4%	433
Issue of repeat prescription	4%	395
Other and unspecified abdominal pain	3%	318
Open wound of head part unspecified	3%	269
Superficial injury head unspecified part unspecified	2%	243
Sprain and strain of ankle part unspecified	2%	221
Acute URTI unspecified	2%	217
Otitis media unspecified	2%	189
Unknown & unspecified causes of morbidity	2%	179
Sprain and strain of other parts of wrist	2%	178
F/U exam after unspecified Rx for other condition	2%	161
Acute obstructive laryngitis [croup]	2%	158

* Including all affecting 150 or more presentations

Table 26. Top diagnoses (ICD-10 descriptions) among lower urgency presentations for people aged 15-24 years, 2023-24, total of 6,406 presentations (DH 2024b).

Short Description	Percentage	Number
Other and unspecified abdominal pain	6%	815
Issue of repeat prescription	4%	585
Suicidal ideation	3%	460
Open wound of wrist & hand part unspecified	3%	390
Chest pain unspecified	2%	332
Sprain and strain of ankle part unspecified	2%	324
Unknown & unspecified causes of morbidity	2%	258
Fracture other & unspecified parts wrist & hand	2%	235
Abnormal uterine & vaginal bleeding unspecified	2%	213
Acute tonsillitis unspecified	2%	209
Urinary tract infection site not spec	1%	205
Viral infection unspecified	1%	167
Superficial injury of wrist & hand unspecified	1%	161

* Including all affecting 150 or more presentations

Professional Stakeholder Perspective

The health of children and young people continue to be reported as a highly rated priority area by professional stakeholders. Insights from Gippsland PHN ongoing consultations (2024e) include:

Social determinants of health

- There is a need to focus on vulnerable young children (0-5 age group) to make sure they are protected; including children in out of home care, children impacted by family violence and other trauma, parental mental health issues and/or alcohol and other drug use. The causes of vulnerability are frequently related to social determinants of health such as poverty, housing and homelessness issues and food insecurity.
- Young people have many barriers to accessing healthcare, including experiences of trauma and a higher reliance on bulk billing. They need doctors to explain things in youth-friendly way so they can become more health literate.

Service system

- Specialist health care for children; service gaps across many professions / service types, including:
    - Early assessment and intervention for children can be exceedingly difficult to access or are not available in many areas of Gippsland, leading to a need to travel and pay gap fees for private providers
    - Lack of access to diagnostic services, rehabilitation, paediatric allied health and audiology and speech therapy
    - Lack of knowledge of specific conditions including autism spectrum disorders and ADHD
    - The gaps have been described as most pronounced in East Gippsland
- A stable clinical workforce supporting the delivery of youth mental health services remains a challenge.
- The youth mental health service system in Gippsland has improved in recent years with some good examples of school programs, co-designed resources, improved access to headspace services and an Enhanced Youth Service. However, this can be patchy and there is a lack of capacity for ongoing management of more complex cases.

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

Health issues

- Opportunities to improve immunisation rates include:
    - Address declining immunisation coverage rates through implementation of the soon to be released National Immunisation Strategy

    - Work with maternal and child health nurses to support children aged 0-5 years, including with immunisation
    - Stronger links between general practice, schools and local councils to support adolescent vaccination
- Services stressed the need for early intervention strategies for self-harm and suicide, eating disorders and body image issues among young people.
- Poor mental health impacts every other area of wellbeing and health. Especially true for young people.

Community, Consumer and Carer Perspective

Insights from the Gippsland PHN consultations (2024d and 2024e) include:

- Children are the future, and we know how important it is to get a good start in life; we need to disrupt the cycle of disadvantage. This focus will improve the whole community.
- Looking after the health and wellbeing of children and young people is an investment in healthy futures. If we do not support children, these will be the future problems.

  "Early intervention is key… still so many children who need early intervention." (Community member)
- High teacher turnover is impacting students' mental health.
- Concerns about exposure to online pornography. Support and education are needed for young people exposed to pornography and dangerous sexual practices, and/or experiencing addiction to pornography.
- Many families are moving to Gippsland, especially Baw Baw, and there is a need for:
    - early intervention in schools for equity of access, including for neurodivergence.
    - social activities for young people; including to limit risks of using drugs.

Insights from young people include:

Accessing services

- Young people value person centred care and expressed how grateful they were for health professionals who listened to them, explained things clearly, and built trust.
- Mental health was a common theme, with young people talking about positive experiences with mental health providers, but long wait times to be seen.

  "And, there's only two places that have those specialists… So, like, I can understand that the waiting list over there is long." (Community member)

- Young people spoke about not being taken seriously or believed by health professionals due to their age. Several girls and young women spoke about having menstrual concerns dismissed by doctors.

  "Not that they don't prioritise young people. It's like, they don't believe them." (Community member)

  "So, he was like, "Oh, you're young, so your options are either birth control or just wait it out." I'm like, "What?" (Community member)

- Young people who were homeless spoke about the importance of community organisations such as neighbourhood houses. Some highlighted how happy they were when finding organisations with facilities such as washing machines and showers.

  "Like if I needed to shower desperately sometimes, I'd have to sneak into like caravan parks and stuff. I don't want to do it but I just, it's better than not showering." (Community member)

Managing health and wellbeing

- Young people also spoke about learning to be in charge of their own health and learning to navigate the system. This often-meant learning about healthcare basics like bulk billing.

  "That's when I went to a psychologist and then learned, no, I need to see a psychiatrist. Yeah. Learning the difference between the two of them." (Community member)

- The cost of services, and transport were barriers to accessing healthcare.

  "Having to get their parents to take them and everything is huge. Like I think that was the biggest barrier is just the transport and cost." (Community member)

- Multicultural young people spoke about managing differences in culture around health issues, especially mental health.

  "It's like, um, your kid comes to you saying, "I'm getting bullied at school." And it's like, "Oh, you didn't go to war." And it's like, "Ah, well, it's still an issue."" (Community member)

- Young people had high digital literacy and talked about using technology to manage their health. Some found telehealth impersonal, while others spoke about its convenience. They also spoke about social media contributing to poor mental health. A common theme was using online resources to seek health information, including YouTube and podcasts.

  "I like watching a lot ofvideos or listening to podcasts about, like, mental health and, like, meditation and, like, reflecting, and like, writing on your journal." (Community member)

Chapter 8: Chronic Conditions

Chronic conditions, also referred to as chronic diseases or non-communicable diseases, refer to long-term health conditions that can have significant individual and societal-level consequences. Multimorbidity refers to the presence of two or more chronic conditions in a person at the same time. Chronic conditions can reduce a person's quality of life and may result in disability and even premature death.

Chronic condition prevention and management is complex, with biological, environmental and social determinants of health impacting an individual's likelihood of developing and successfully managing a chronic condition. Chronic conditions are a particular public health concern due to the fiscal impact on Australia's healthcare system.

Examples of common chronic conditions include hypertension, asthma, diabetes, osteoarthritis, hypercholesterolaemia, chronic pain, chronic obstructive pulmonary disease, anxiety and depression. Many chronic conditions are appropriate for management in the primary healthcare setting.

Summary

Gippsland health insights

- In Gippsland, the top five chronic condition-related hospital admissions were for diabetes & obesity, cardiovascular disease & stroke, chronic obstructive pulmonary disease, chronic kidney disease and back problems.
- Across Gippsland, 65% of all active general practice patients have one or more chronic condition diagnosis and the most common chronic conditions among general practice patients are cardiovascular disease, mental health, and musculoskeletal conditions.
- Four out of six Gippsland LGAs have larger proportions of the population categorised as overweight and/or obese compared to the Australian average.
- Gippsland has the second lowest uptake of GP Management Plan items and Team Care Arrangement service use compared to all PHN regions nationally, as per age-standardised rates.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Improved early detection and intervention for chronic conditions and risk factors.
- Increased use of multidisciplinary care for improved patient outcomes.
- Improved care coordination, especially for complex presentations, including better linkage between primary, secondary and tertiary care.
- Increased use of chronic conditions management Medicare Benefits Schedule items that support patients.
- Reduced Potentially Preventable Hospitalisations due to chronic conditions, particularly iron deficiency anaemia, diabetes complications, congestive cardiac failure and chronic obstructive pulmonary disease (COPD).
- Reduced avoidable deaths due to cancer, cardiovascular disease, diabetes and COPD.

Community voices

"As a chronic disease patient – I don't want to tell my story more than once."

"I want to have preventive health advice as an important part of my holistic care."

"I do not want to be judged when I seek treatment for my chronic conditions and chronic pain."

"I want comprehensive care for chronic disease."

Health Status

National Data

For all persons, the top self-reported chronic conditions nationally are anxiety, back problems, depression and asthma (AIHW 2024u). Among people of all ages, approximately 61% of the Australian population live with at least one long-term health condition (AIHW 2024u). This increases to 94% of individuals aged 85, whilst only 28% of people aged 0–14 have a chronic condition (AIHW 2024u). National Health Survey data estimates than more than 1 in 5 Australians are living with multimorbidity, that is, they have two or more chronic conditions at the same time and this proportion has increased between 2007-2008 and 2022 (AIHW 2024v).

Nationally, data from the Royal Australasian College of General Practitioners suggests that the most common chronic conditions presenting to general practice in 2023 were (RACGP 2023):

- Psychological factors (including depression and anxiety),
- Musculoskeletal conditions (including arthritis), and;
- Endocrine and metabolic conditions (including diabetes).

For further information on anxiety and depression, see **Chapter 4 – Mental Health and Wellbeing.**

Burden of disease

The large majority of Australia's fatal and non-fatal burden of disease is due to chronic conditions (AIHW 2024v). The population distribution of chronic conditions often follows certain trends: they generally become more common with age, are more common among people living in lower socioeconomic areas and are more common in people living outside major cities (AIHW 2024u).

For further information on burden of disease, see **Gippsland Main Health Issues: Burden of Disease.**

Risk factors

Many chronic diseases have been shown to be related to one or several behavioural risk factors (AIHW 2016). Behavioural risk factors may also be referred to as avoidable or modifiable risk factors as are often influenced by health behaviours (AIHW 2016). They are distinctly different from other types of risks including genetic pre-dispositions, which are generally not modifiable (AIHW 2022c). Examples of avoidable risk factors with established links to chronic conditions include excessive alcohol consumption, dietary risks, obesity, physical inactivity and tobacco use (AIHW 2016).

It is estimated that up to 38% of the total burden of disease in Australia can be prevented by addressing modifiable risk factors (AIHW 2021a). ABS data suggests the following prevalence of chronic condition-related modifiable risk factors nationally (ABS 2024c):

- Approximately one in four (23.9%) people aged 15 years and over met the physical activity guidelines in 2023.
- One in ten (10.6%) of adults were daily smokers in 2022.
- More than one if four (26.8%) of adults exceed the Australian Adult Alcohol Guidelines in 2022 (males more commonly than females).
- One in three (33.9%) of people with asthma used asthma medication daily.
- Two in five (38.1%) of people aged 15 years and over used sunscreen (SPF30 or higher) on most days in the spring/summer of 2023-24.

Health system spending on modifiable risk factors

The true value of health system spending on conditions influenced by modifiable risk factors is unknown (AIHW 2022c). However, for conditions which attribution to modifiable risk factors, $24 billion (39%) of the estimated health system spending in 2018–19 was attributable to potentially modifiable risk factors (AIHW 2022c).

The risk factor that contributed the highest share of this spending in 2018-19 is overweight (including obesity), costing $4.3 billion nationally (AIHW 2022c). Recent research has also shown that reducing childhood overweight and obesity measures by a mere 5% could save $7.44 billion nationally through reductions in lifetime obesity-related healthcare costs and premature mortality (Carrello, Lung, Baur & Hayes 2024).

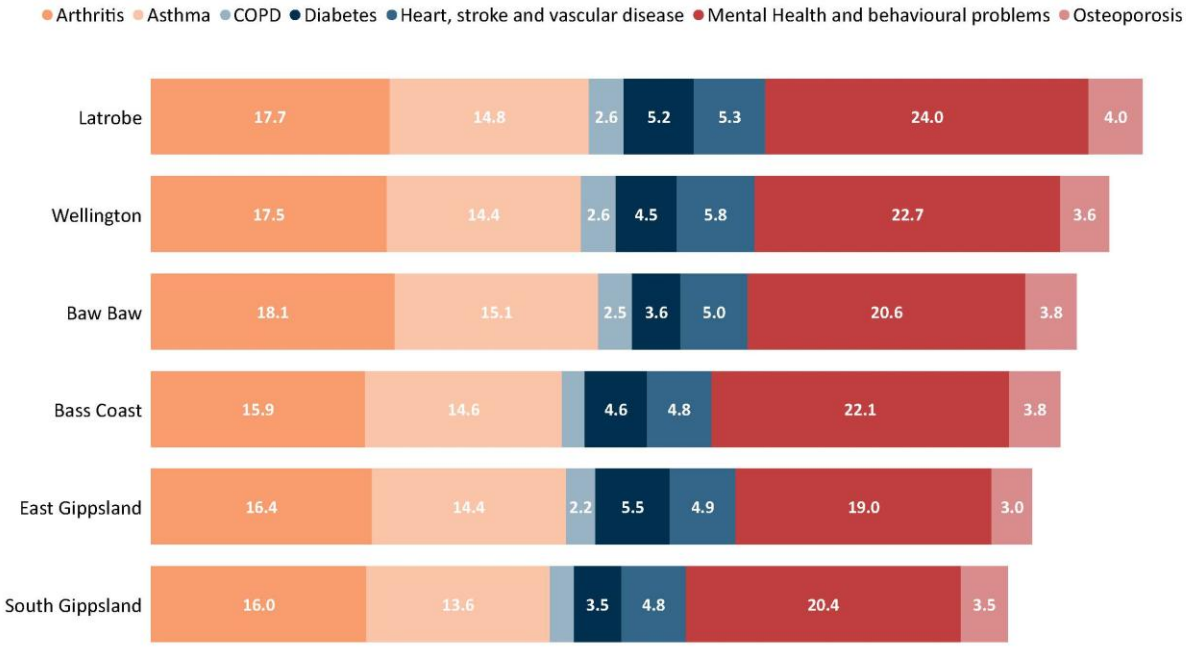
Additionally, approximately half (50%) of the estimated spending for bowel cancer can be attributed to modifiable risk factors and two-thirds (66%) of the estimated spending on chronic obstructive pulmonary disease (COPD) can be attributed to tobacco use (AIHW 2022c).

Gippsland Data

Chronic condition prevalence estimates

The estimated number of people in each Gippsland LGA (aged-standardised rate per 100) across several chronic conditions (based on the latest available data) is shown in **Figure 101** (PHIDU 2024b). Mental health and behavioural problems appear the most common chronic conditions across all LGAs, followed by arthritis and asthma, whilst COPD, osteoporosis and diabetes are less prevalent (PHIDU 2024b). The LGA with the largest estimated prevalence of mental health and behaviour problems is Latrobe (PHIDU 2024b).

Figure 101. Estimated number of persons with chronic conditions in Gippsland LGAs (2017-18), age-standardised rate per 100 (PHIDU 2024b).



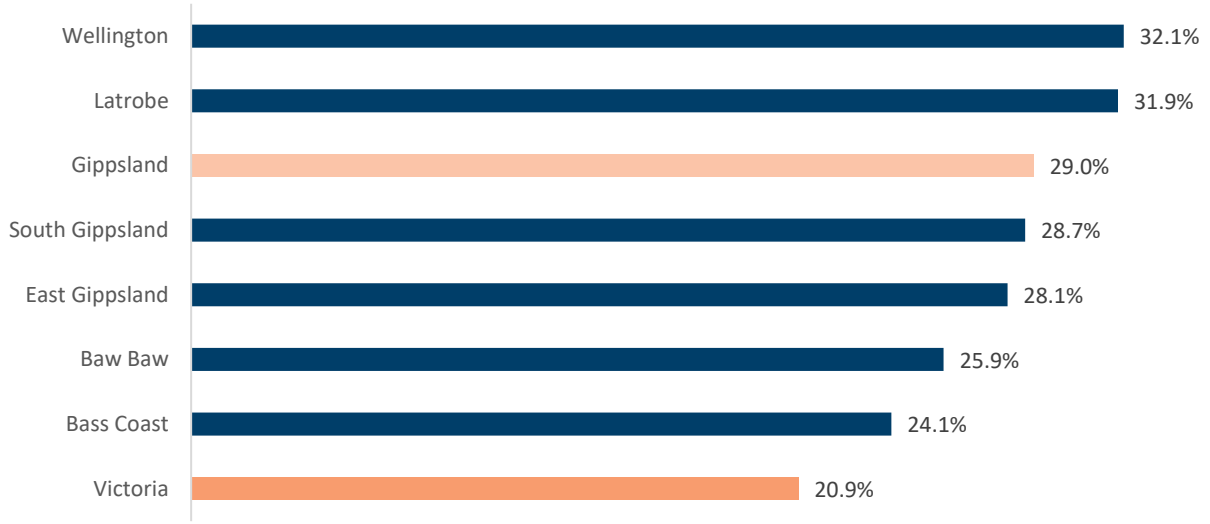
Chronic condition-related risk factors

Data below presents findings from the 2020 Victorian Population Health Survey on risk factors related to chronic conditions by Gippsland LGA (VAHI 2022). The Victorian Population Health Survey assessed prevalence of factors affecting health including smoking, perceived mental health and wellbeing status, social capital and poverty. In summary:

- **Smoking:** Gippsland LGAs were above the Victorian average for rates of current smokers with Latrobe and Wellington the highest rates.
- **Mental Health and Wellbeing:** Reported rates of people categorising their self-reported mental health status as fair/poor was higher in Latrobe than the Victorian average.
- **Social Capital:** Reported rates of people feeling never or not often feeling valued by society was higher in Latrobe than the Victorian average.
- **Poverty:** Reported rates of people stating that they had run out of money to buy food in the last 12 months was higher in Latrobe than the Victorian average.

In addition, Gippsland experiences high rates of obesity compared to Victoria (**Figure 102**).

Figure 102. Age-standardised proportion of persons who are obese (BMI 30.0 or greater - adults) (GPHN 2024a).



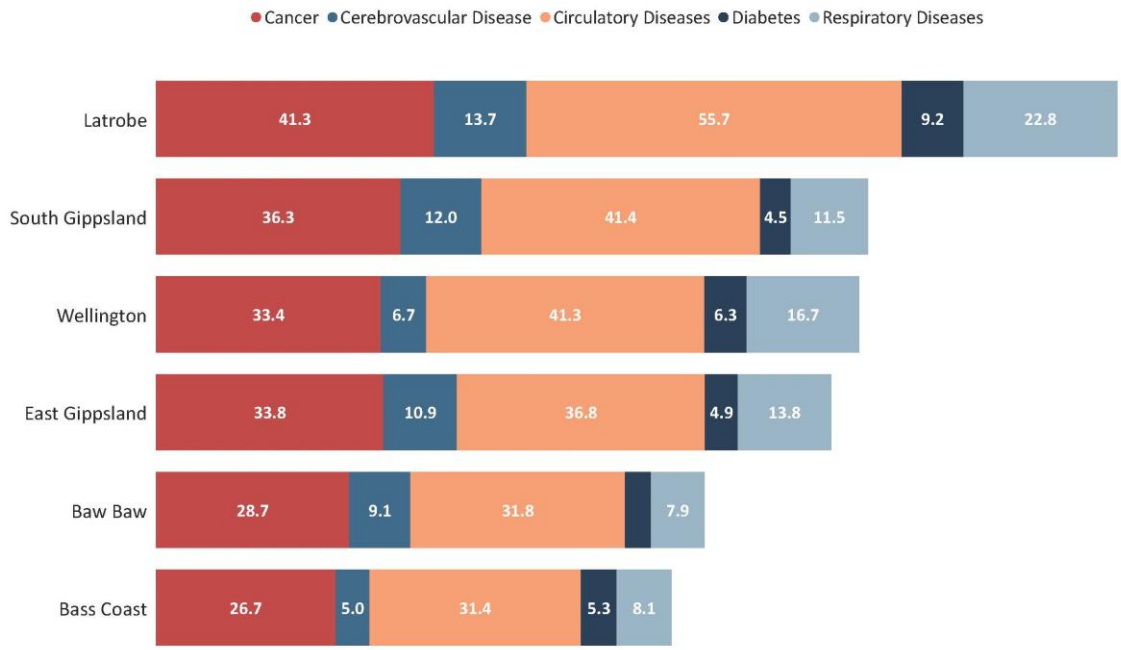
Chronic condition-related mortality

Out of the ten leading causes of mortality in Gippsland by aged-standardised rate per 100,000 between 2018-2022, nine may be associated with chronic conditions (AIHW 2024u) (see **Gippsland Main Health Issues: Mortality** for further details).

Chronic condition-related avoidable deaths

Avoidable deaths related to chronic conditions (average annual age-standardised rate per 100,000) in Gippsland between 2018-22 are shown in **Figure 103** (PHIDU 2024b). Latrobe has the largest number of total chronic condition-related avoidable deaths, followed by Wellington, South Gippsland and East Gippsland (PHIDU 2024b). The chronic conditions resulting in the largest number of avoidable deaths appear to be circulating system diseases, cancer and respiratory system disease (PHIDU 2024b).

Figure 103. Avoidable deaths (average annual age-standardised rate per 100,000) related to chronic conditions across Gippsland LGAs between 2018-22 (PHIDU 2024b).



Spotlight on Chronic Pain

Although recognised increasingly as a **national public health concern**, with publication of a National Strategic Action Plan for Pain Management in 2021 (DoHAC 2021), Gippsland-specific data on chronic pain is limited.

Chronic pain refers to pain that persists beyond the normal healing timeframes for an injury or illness (usually 3-6 months). Chronic pain can have profound impact on an individual's quality of life, affecting employment opportunities, social interactions, physical capacity, mental health and independence. Nationally, it is estimated that **1 in 5 Australians** aged 45 years and over are living with chronic pain (AIHW 2020).

Nationally, **general practitioner patient encounters** for chronic pain **increased by 67%** between 2010-2020 (AIHW 2020) and it is estimated that the annual cost of chronic pain in Australia will rise from $139.3 billion to approximately $215.6 billion by 2025 if health related policies and practices do not change (Deloitte 2019).

From available data we know that in Gippsland, between 2020-21 and 2022-23, back problems were one of the top five chronic conditions that resulted in presentations to ED and hospital admissions (DH 2024a) (see **Hospital Activity** for further details).

Furthermore, in Gippsland, musculoskeletal conditions were the third most common chronic condition among general practice patients in 2023-24 (GPHN 2024f) (**Figure 104**) see **General Practice** for further details). In addition, the estimated number of people with arthritis is all six Gippsland LGAs (aged-standardised rate per 100) is higher than the Australian average (PHIDU 2024b).

These findings highlight the need to improve chronic pain related data collection at a regional level and present opportunities to improve multidisciplinary pain management in primary healthcare settings.

Service System

Many chronic conditions can be successfully managed in primary or community care settings by multidisciplinary teams incorporating general practitioners, nurses and allied health professionals. In recent years, the Australian Government has responded to the recommendations of the Strengthening Medicare Taskforce and invested through the 2022, 2023 and 2024 budgets to lay foundations for a stronger Medicare system (DoHAC 2024e). These Strengthening Medicare initiatives aim to have an increasing impact on care of chronic disease in the community through improved access to primary care, encouraging multi-disciplinary team-based care, modernising primary care and supporting change management (DoHAC 2024e).

General practice

Across Gippsland, 65.2% of all patients with activity in a general practice had one or more chronic conditions diagnosis (**Table 27**)**.** Bass Coast has the highest proportion of patients with chronic conditions (71.5%), while Baw Baw has the lowest (60.1%) (GPHN 2024f).

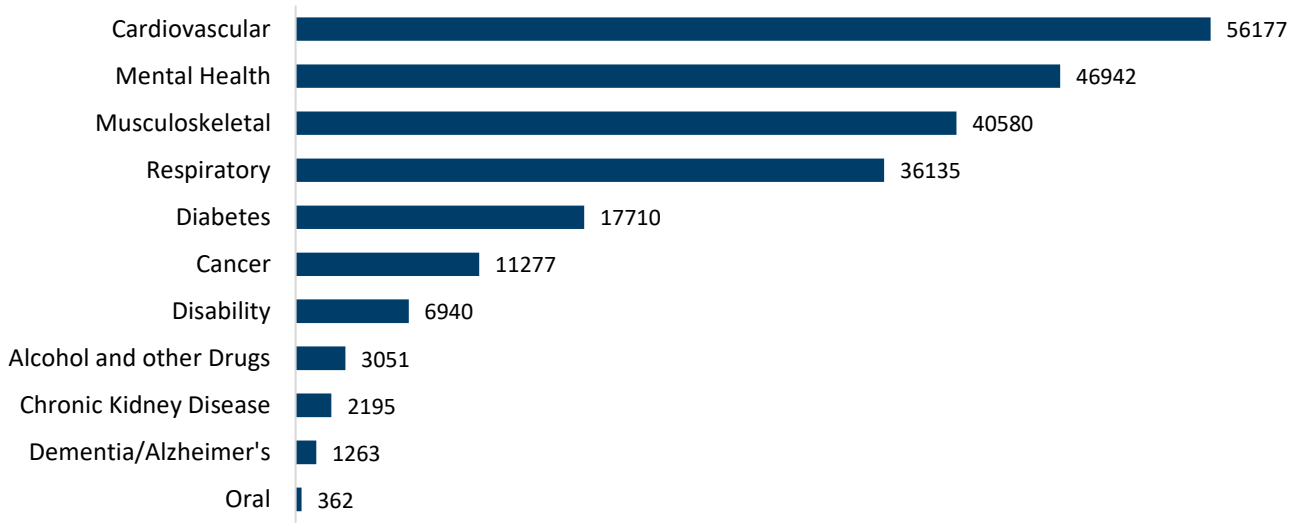
Table 27. Prevalence of active patients with an active chronic condition diagnosis in 2023-24 by Gippsland LGA (GPHN 2024f).

LGA	Number of patients with chronic condition	Total general practice population	Proportion of all active patients
Bass Coast	10,673	14,927	71.5%
Baw Baw	24,653	41,014	60.1%
East Gippsland	26,012	38,387	67.8%
Latrobe	30,482	47,188	64.6%
South Gippsland	11,589	16,883	68.6%
Wellington	18,310	28,423	64.4%
Total	**121,053**	**185,621**	**65.2%**

Males and females appear almost as likely as each other to have at least one chronic condition diagnosis in Gippsland: 65.7% of males and 64.8% had a chronic condition diagnosis (GPHN 2024f). The likelihood of being diagnosed with a chronic disease appears to increase with age among general practice patients: 21.4% of 0–9-year-olds had a chronic condition diagnosis, increasing to 94.3% in those aged 80 years or older (GPHN 2024f).

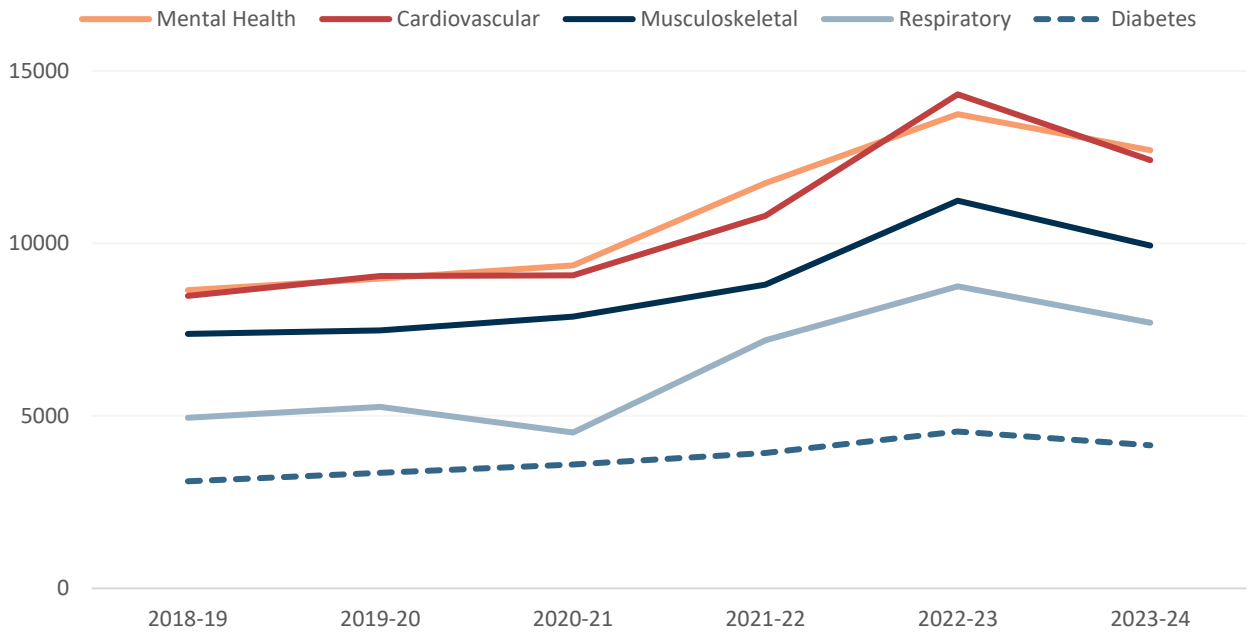
In Gippsland, the most common chronic conditions among general practice patients are cardiovascular disease, mental health, and musculoskeletal conditions (**Figure 104**).

Figure 104. Number of active general practice patients with an active chronic condition diagnosis by category in Gippsland in 2023-24 (GPHN 2024f).



The number of new chronic conditions diagnosed has increased, across all chronic conditions, between 2018-19 and 2023-24 in Gippsland general practices (**Appendix 14**). Of the top 5 new chronic conditions (**Figure 105**) diagnosed during this period, respiratory conditions have increased the fastest, at 9.3% per year, however this may be influenced by the COVID-19 pandemic. The second fastest growth rate in the top five conditions was mental health, growing at 8% per year. Outside the top five conditions, disability has the highest growth rate at 12.6% per year (**Appendix 14**).

Figure 105. Number of patients in Gippsland general practices with a top five new chronic condition diagnosis, by year (GPHN 2024f).



Current use of chronic condition management and allied health Medicare services

Chronic disease General Practitioner Management Plan (GPMP) items are billable by general practitioners for chronic conditions that have been ongoing for greater than six months. Team Care Arrangements (TCAs) allow allied health professionals to bill under the MBS when treating those conditions and allow the public to access five subsidised visits to allied health professionals per calendar year. Nationally, the rate of patients claiming both GPMP and TCAs service was higher for females than males, and rates were highest for patients aged 75-84 years (AIHW 2022a).

In Gippsland, the age-standardised rate of GPMP item use was 73.20 per 1,000 population, the second lowest PHN region nationally (AIHW 2022a). In Gippsland, the age-standardised rate of TCA service use was 63.4 per 1,000 population, the second lowest PHN region nationally (AIHW 2022a). In comparison, the PHN region with the highest GPMP item use had a rate of 145 per 1,000 and TCA service use of 123 per 1,000 (AIHW 2022a).

At an SA3 sub-region level, GPMP item use and TCA service use was lowest in East Gippsland (46.9 per 1,000 population and 49.2 per 1,000 population respectively) and Latrobe (65.7 per 1,000 population and 57.3 per 1,000 population respectively) (AIHW 2022a).

This data highlights a gap in both chronic disease management in general practice and also in the provision of Medicare-subsidised allied health consultations in Gippsland.

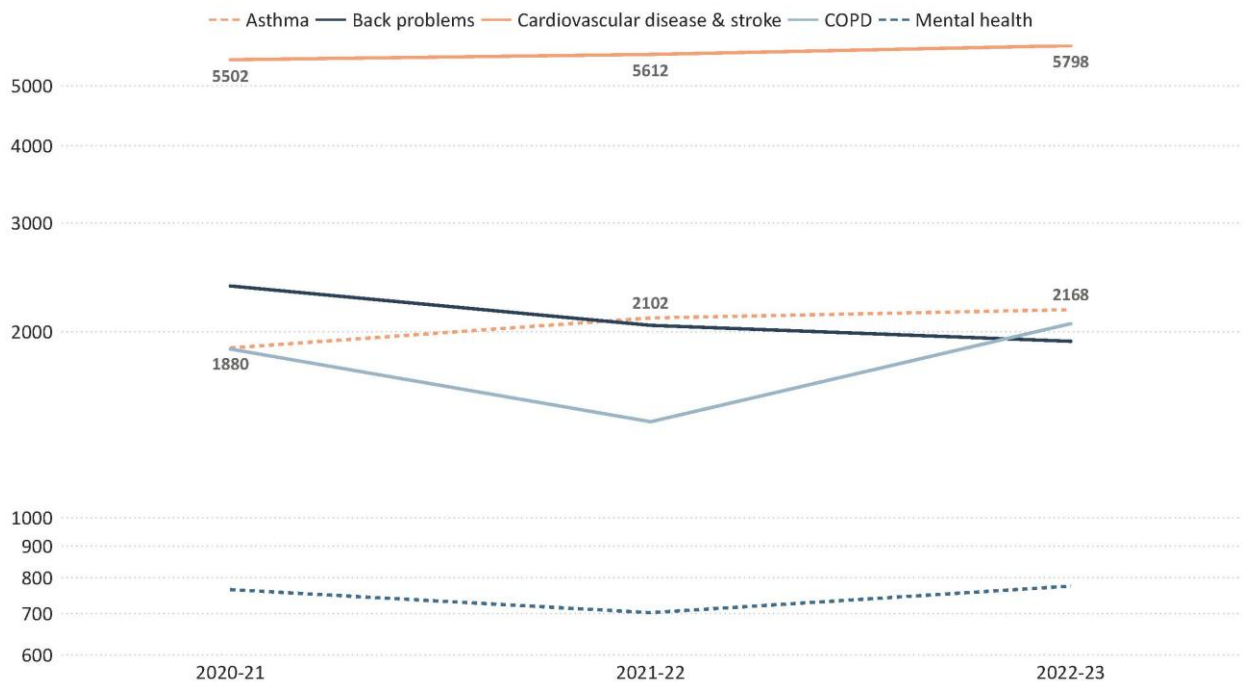
Future state of chronic condition management

From 1 July 2025, Medicare Benefits Schedule (MBS) items will be changing to replace the current GPMP and TCAs with a single GP Chronic Condition Management Plan to support continuity of care by requiring patients registered for MyMedicare (DoHAC 2024d). This will allow patients to access management plans through the practice where they are registered, encourage management plan reviews, formalise referral processes for allied health services so they are more consistent with other referral arrangements and ensure patients do not lose access to their current services through transition arrangements for existing patients with GPMPs and TCAs (DoHAC 2024d).

Chronic condition-related Emergency Department presentations

In Gippsland, between 2020-21 and 2022-23, the top five chronic condition-related Emergency Department presentations were for cardiovascular disease & stroke, back problems, asthma, Chronic Obstructive Pulmonary Disease (COPD) and mental health, see **Figure 106** (DH 2024b). The most common chronic condition-related Emergency Department presentation was for cardiovascular disease & stroke, noting an increase in these episodes between 2020-21 and 2020-23 (DH 2024b). Emergency Department presentations related to asthma have also increased over this period, while episodes related to back problems have decreased slightly (DH 2024b).

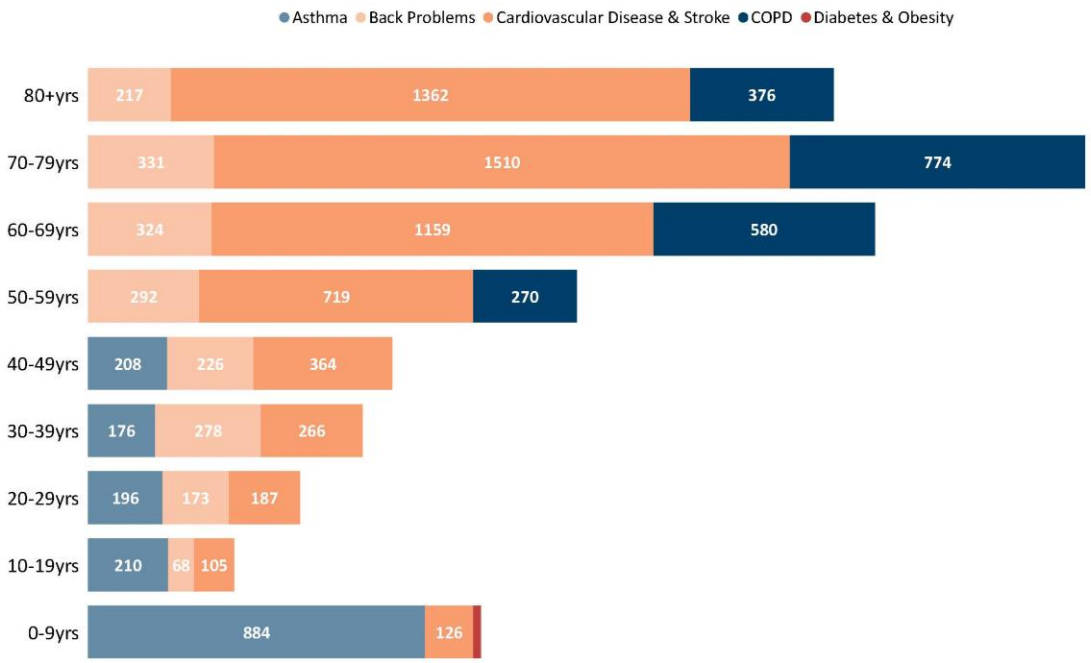
Figure 106. Top five chronic condition groups for Emergency Department presentations in Gippsland between 2020-21 and 2022-23 (DH 2024b).



When considering trends over time between 2020-21 to 2022-23, the number of Emergency Department presentations due to chronic conditions has remained mostly steady in each Gippsland LGA (DH 2024b).

In Gippsland, data from 2022-23 suggests that the top three chronic condition-related Emergency Department presentations vary across the lifespan (**Figure 107**). Emergency Department presentations due to asthma are more common among 0–9-year-olds and continue to be among the top three conditions up to the age of 40-49 years, after which COPD presentations become more common from 50-59 years through to 80+ years of age (DH 2024b). Cardiovascular disease & stroke related ED Emergency Department presentations are within the top three conditions among all age brackets with episodes generally increasing in number in correlation with advancing age (DH 2024b). Back problem related Emergency Department presentations occur frequently among all ages with the exception of 0–9-year-olds (DH 2024b).

Figure 107. Number of Emergency Department presentations for the top three chronic condition groups for each 10-year age group in Gippsland in 2022-23 (DH 2024b).

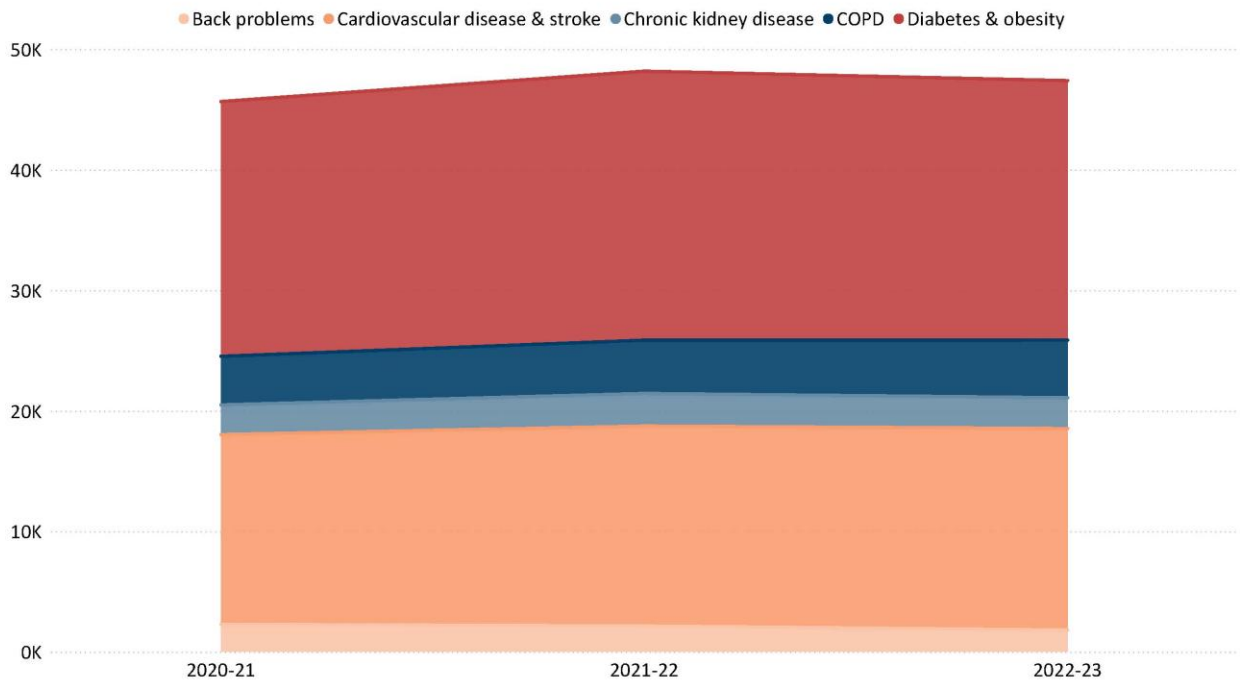


Chronic condition-related hospital admissions

In Gippsland, between 2020-21 and 2022-23, the top five chronic condition-related hospital admissions were for diabetes & obesity, cardiovascular disease & stroke, COPD, chronic kidney disease and back problems (**Figure 108**) (DH 2024a). Of these, diabetes & obesity and cardiovascular disease & stroke are the most common (DH 2024a).

When considering trends over time between 2020-21 to 2022-23, the number of hospital admission episodes due to chronic conditions has remained mostly steady in each Gippsland LGA (DH 2024a).

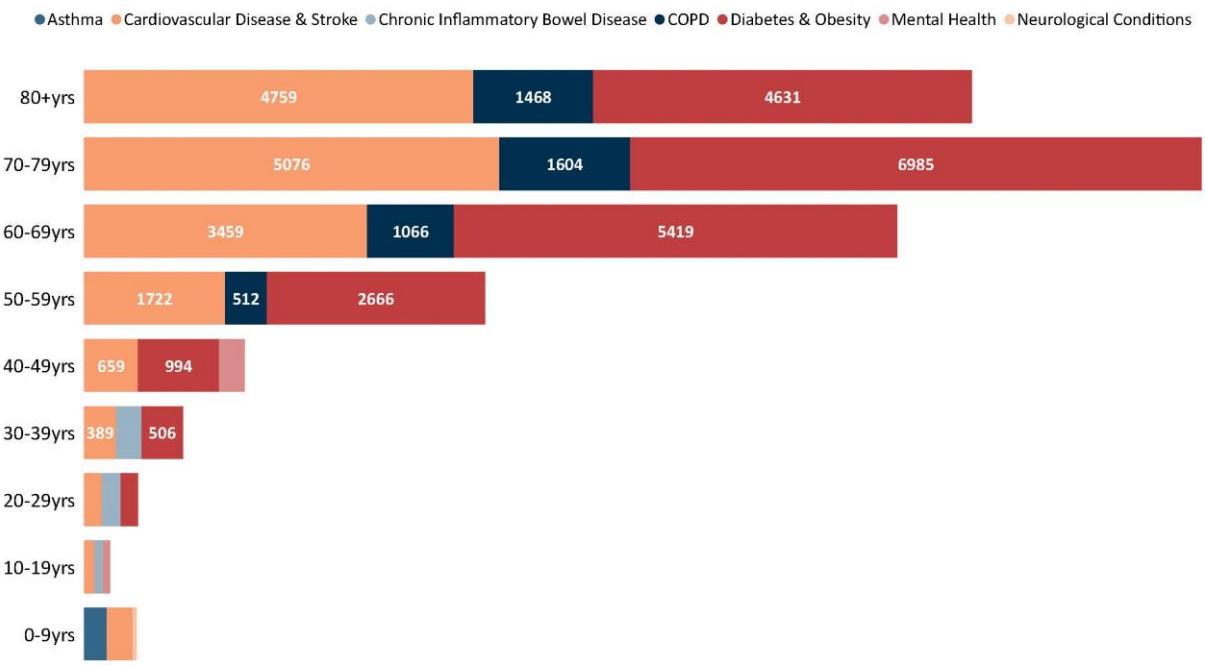
Figure 108. Top five chronic condition-related hospitalisations in Gippsland between 2020-21 and 2022-23 (DH 2024a).



In Gippsland, data from 2022-23 suggests the top three hospitalisation associated with chronic condition also vary across the lifespan (**Figure 109**). Admission episodes related to cardiovascular disease & stroke and diabetes & obesity generally appear to increase with age (DH 2024a). Other general trends seen in 2022-23 include the following (DH 2024a):

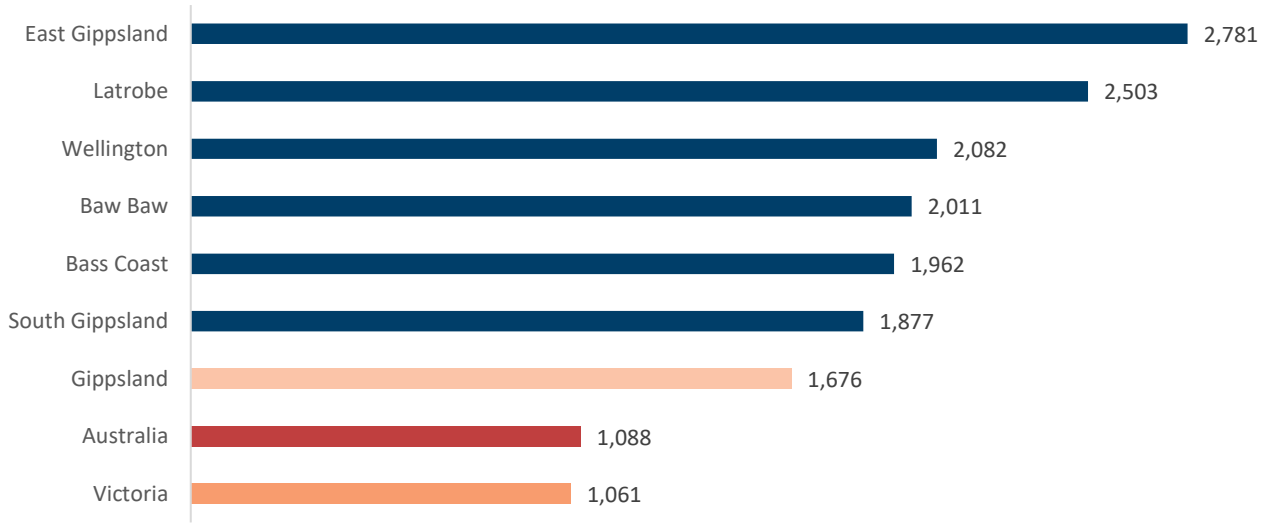
- Hospital admissions for neurological conditions and asthma are more common among 0-9-year-olds.
- Mental health related-admissions are more common among 10–19-year-olds and 40–49-year-olds.
- Chronic inflammatory bowel disease-related admissions are more common among 10–19-year-olds, 20–29-year-olds and 30–39-year-olds.
- COPD-related admissions are more common over the age of 50-59 years.

Figure 109. Number of hospital admissions for the top three chronic conditions for each 10-year age group in Gippsland in 2022-23 (DH 2024a).



Gippsland has a high age standardised rate of public hospital admissions for musculoskeletal conditions; this is the second highest rate for PHN regions in Australia (**Figure 110**). These admissions are higher for women (1,776 age standardised rate per 100,000) than men (1,579 age standardised rate per 100,000).

Figure 110. Age standardised rate public hospital admissions for musculoskeletal system and connective tissue diseases, persons per 100,000, 2020-21 (PHIDU 2024b)



It is estimated that 17% of people in Gippsland have arthritis (GPHN 2024a). Musculoskeletal conditions contribute to 12.8% of the total disease burden, including 23.1% of the non-fatal burden (AIHW 2024k).

Chronic condition related Potentially Preventable Hospitalisations

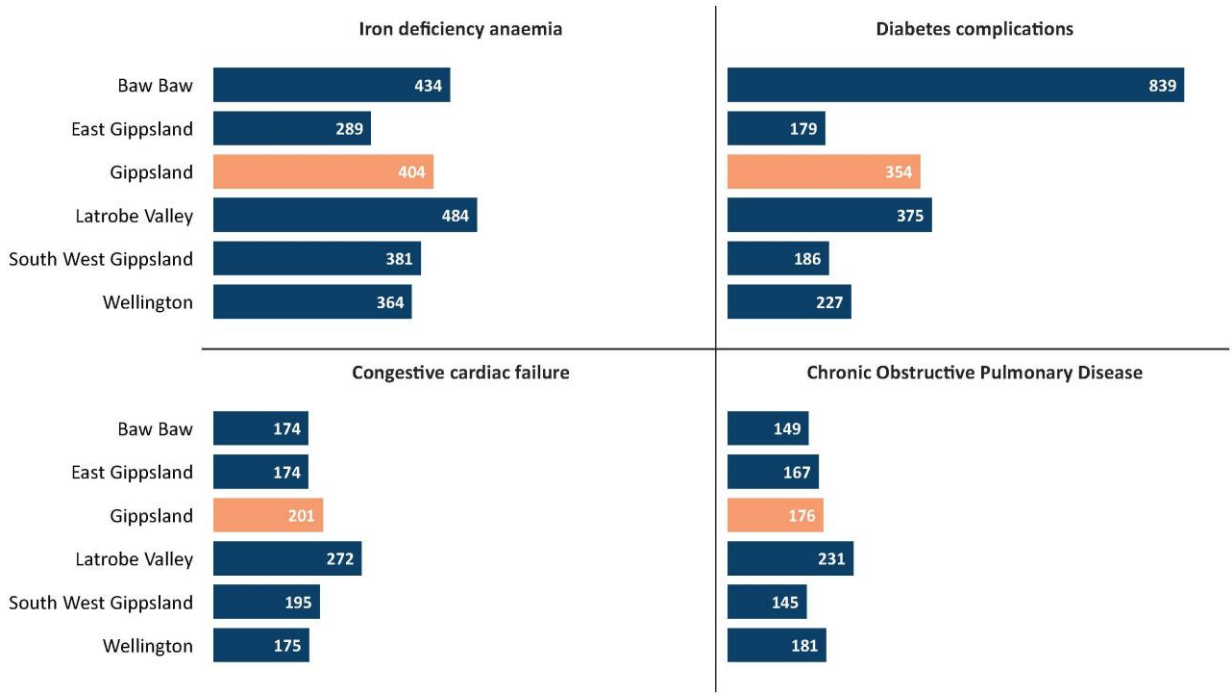
Potentially preventable hospitalisations (PPH) refer to episodes of care that may have been managed in primary and community healthcare settings (AIHW 2024w). PPH can tell us about the effectiveness of health care in the community, as higher rates may suggest a lack of timely, accessible, and adequate primary care (AIHW 2024w).

In 2021–22, there were approximately 2,300 total PPH per 100,000 people in Australia (age-standardised rate) (AIHW 2024w). In Gippsland, this figure was 2,757 PPH per 100,000 people (age-standardised rate). Gippsland has the seventh highest rate of PPH out of the 31 PHN regions Australia-wide (AIHW 2024w).

In 2021-22, of the total PPH in Gippsland, 1,395 per 100,000 people (age-standardised rate) were related to chronic conditions (AIHW 2024w). The top chronic condition-related PPH (based on available data) in Gippsland were for iron deficiency anaemia, diabetes complications, congestive cardiac failure and Chronic Obstructive Pulmonary Disease (COPD) (AIHW 2024w). A breakdown of the age-standardised rate per SA3 sub-region, relative to the Gippsland rate, is shown in **Figure 111** (AIHW 2024w). It can be noted that Baw Baw has substantially higher PPH related to diabetes complications than the other regions (AIHW 2024w). Furthermore, Latrobe Valley has the most PPH related to iron deficiency anaemia, COPD, and congestive cardiac failure (AIHW 2024w).

Additional PPH data can be found in the **Gippsland Main Health Issues: Emergency department (ED) activity** section of this report.

Figure 111. Comparison of chronic condition-related PPH (2021-22), per 100,000 people (age-standardised rate) in Gippsland and SA3 sub-regions (AIHW 2024w).



Professional Stakeholder Perspective

Insights based on Gippsland PHN consultations with clinicians and other professional stakeholders, including Clinical Councils (GPHN 2024e and 2024g):

- A focus on intervening early was noted as a main theme and is an opportunity to save health dollars, for example by screening for cancer.
- Improved coordination of care when many professionals are involved is key to improving outcomes. Co-morbidities require a connected system where professionals work together, including across physical and mental health, to avoid misdiagnoses due to lack of information sharing and holistic understanding.
- Obesity is common in the community and impacts referral pathways.
- Existing health checks are underused.
- Service gaps related to chronic disease were identified and include:
    - respiratory specialists (medical and nursing) across the catchment
    - Some professionals spoke about wanting to see dedicated skin cancer clinics
    - Diabetes education, care coordination and access to endocrinologists

Community, Consumer and Carer Perspective

Insights from Gippsland PHN consultations including the Community Advisory Committee (2024d and 2024e) include:

Identifying and managing conditions

- Early detection and intervention for chronic health conditions is valuable.
- Chronic and complex conditions often require long-term care and management.

  "I'm on that much meds that I rattle when I walk. [laughter] I have hypertension, depression, heart issues, chronic pain. So yeah, a lot of different meds." (community member)

- Resources need to be allocated to improving chronic disease management and care coordination across the region.
- Community members reported instances where chronic disease was not well managed by professionals, frequently as a result of lack of understanding of the person's overall health and impacted by poor communication.

Service gaps

- A general lack of access to affordable medical specialists without a long wait list for all conditions was noted as a key theme
- Access to affordable allied health services / professionals without a need to travel
- Significant needs related to rheumatoid and osteoarthritis, with a need access to specialists locally.

Chronic pain

- Chronic pain is a huge issue, especially among older people, meaning specialist services are needed.

  "And with my hip, I couldn't sit couldn't stand, I couldn't walk, some days I couldn't get out of bed and it was just constant chronic pain." (community member)

Chapter 9: Family Violence

Family violence refers to violence that happens within family relationships, including between parents and children, siblings, intimate partners, or kin. These family relationships may also involve carers, foster carers, and co-residents, such as those in group homes or boarding residences.

Domestic violence is a specific form of family violence that occurs between current or former intimate partners and is often called intimate partner violence. Another example of family violence is elder abuse, committed by adult children against their parents who have age-related dependencies.

Summary

Gippsland health insights

- In the year ending March 2024, East Gippsland had the highest rate of family violence incidents in Victoria, followed by Latrobe with the second highest rate in the state.
- Family violence has a significant impact on health and wellbeing, including physical, mental and financial and economic wellbeing.
- Family violence has a significant impact on children and young people.
- Primary healthcare services, such as general practice, have a key role in responding to family violence. An estimated 20% of women who experience intimate partner violence asked a GP or other health professional for support.
- In 2022-23, the Crime Statistics Agency recorded that the Women and Children's Family Violence services had 611 cases in Inner Gippsland, and 353 in Outer Gippsland.
- In 2022-23, the Crime Statistics Agency recorded 468 Family Violence Perpetrator Interventions cases in Inner Gippsland, and 155 in Outer Gippsland. This includes men's behaviour change programs and perpetrator case management.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Increased awareness of the types of family, domestic and sexual violence and their impact on health.
- Increased access to appropriate services and support for all who experience family violence regardless of age or gender.
- Increased capacity in primary health care to identify and address family violence.
- Improved collaboration across the broader service system including mental health, housing, alcohol and other drugs and social supports.

Community voices

"I want to see greater investment to prevent family violence."

"I would like greater awareness of local supports available for domestic violence."

"I would like local supports for men's health without negativity and stigma."

"I don't want to tell my story more than once – it's traumatising and makes you feel worse."

Health Status

Definitions

There are many forms of family violence, and many are not well recognised (**Table 28**). Definitions and examples are provided below.

Table 28. Definitions and examples of family violence (GWH 2021b).

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, humiliation and degradation
Spiritual	Not allowing practice of beliefs, forced to change religion, not respecting religious practices

Family violence stems from power imbalances in relationships of trust (AIHW 2024i). Gender inequality is one power imbalance that is a major driver of family violence (AIHW 2024i). In 2021-22, one in four women, and one in fourteen men had experienced intimate partner violence since the age of 15 (AIHW 2024i).

Other power imbalances contributing to family violence include racism, ableism, cisgenderism, heteronormativity, culturally specific norms about relationships, and systemic barriers and social and economic disadvantage (AIHW 2024i). These drivers can intersect, meaning that some groups experience family violence in different ways to others. These imbalances mean that some people are more likely to experience family violence than others. For example:

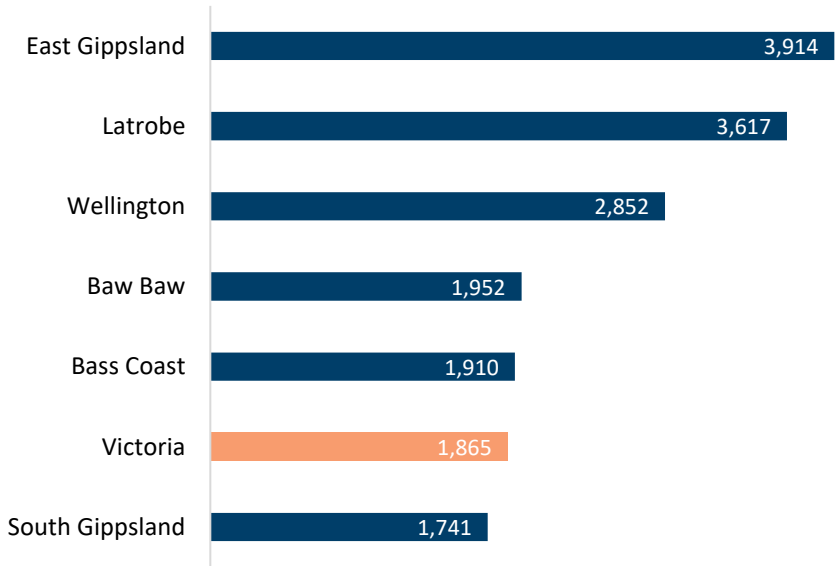
- Aboriginal and/or Torres Strait Islander women and families,
- Women from culturally and linguistically diverse backgrounds,
- People with a disability,
- People who identify as LGBTIQ+, and;
- People in regional, rural and remote areas.

In this chapter, family violence is generally discussed in terms of the experiences of and impacts on victim-survivors. However, when working to prevent and respond to family violence, we need to look at perpetrators and the power imbalances, as outlined above, that drive family violence (Centre for Innovative Justice 2015). In Australia, 95% of all people who experience violence, experience violence from men (Respect Victoria 2024).

Gippsland data

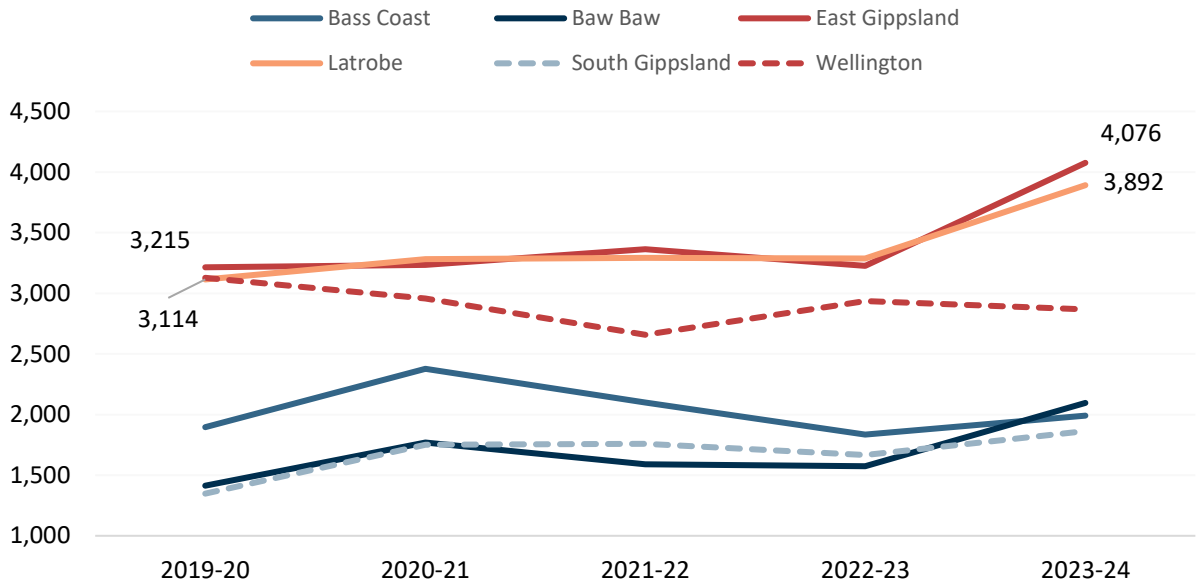
Gippsland experiences high rates of family violence incidents (**Figure 112**). In the year ending March 2024, East Gippsland had the highest rate of family incidents per 100,000 in Victoria, followed by Latrobe with the second highest rate in the state. Wellington had the eighth highest rate.

Figure 112. Family incidents per 100,000, year ending March 2024 (Crime Statistics Agency 2024).



All Gippsland LGAs have experienced higher rates of family incidents over time when compared to Victoria (**Figure 113**). It is important to note however, that a family incident is an incident attended by Victoria Police where a Risk Assessment and Risk Management Report was completed (Crime Statistics Agency 2024). Therefore, this data cannot measure family violence where police were not involved.

Figure 113. Family incidents per 100,000, 2020 to 2024 (Crime Statistics Agency 2024).



Impact on health and wellbeing

Family violence has a significant impact on health and wellbeing. In 2018, it was estimated that if no females aged 15 and over experienced partner violence in Australia, then females would have experienced (AIHW 2024i):

- 46% less homicide and violence
- 19% less suicide & self-inflicted injuries
- 17% less early pregnancy loss
- 15% less depressive disorders
- 11% less anxiety disorders
- 4% less alcohol disorders

One of the most visible ways family violence occurs is through injuries and deaths due to physical violence. This can also include long term issues such as acquired brain injuries, disabilities, and chronic conditions (Safe and Equal n.d.).

Family violence can also have short and long term impacts on mental health, including intergenerational impacts (AIHW 2024i). These impacts include experiences of anxiety and depression, feelings of fear, suicidality, or complex trauma.

Family violence can also have significant impacts on a person's economic and financial wellbeing (AIHW 2024i). This can be caused by financial abuse, as well the costs of seeking legal support, healthcare, or leaving a home to leave the abusive relationship. In Gippsland, family violence is one of the most common reasons people seek homelessness support (GHN 2020).

Family violence can also have indirect impacts on a person's health and wellbeing in the long term, such as on education and employment (AIHW 2024i).

Family violence has a significant impact on the health and wellbeing of children and young people, whether they are abused, witness abuse, or are exposed to the effects of family violence in their environment (Safe and Equal n.d.). Children who experience family violence may need additional support in these areas as they grow. In 2021-22, 13% of adults had witnessed intimate partner violence against a parent before the age of 15 (AIHW 2024i). Family violence can impact children's:

- Physical, neurological and emotional development,
- Sense of security and attachment in relationships,
- Mental health, and cognitive and behavioural functioning, and;
- Ability to cope and adapt to different situations.

Service Utilisation

- Primary care services, such as general practice, have a key role in responding to family violence. An estimated 20% of women who experience intimate partner violence asked a GP or other health professional for support (AIHW 2024i). Some programs in Australia and internationally are looking at health services' role in identifying and engaging with perpetrators of family violence, while not risking the safety of victim-survivors (Centre for Innovative Justice 2016).

- In 2020-21, 1800RESPECT answered 286,546 telephone and web chats (AIHW 2024i).

- National data shows that 38% of clients seeking assistance from homelessness services had experienced family and domestic violence, (AIHW 2024j). The most common living arrangement for these clients was one parent with a child or children.

- In 2022-23, the Crime Statistics Agency (2024) recorded 611 Women and Children's Family Violence Services cases in Inner Gippsland, and 353 in Outer Gippsland.

- In 2022-23, the Crime Statistics Agency (2024) recorded 468 Family Violence Perpetrator Interventions cases in Inner Gippsland, and 155 in Outer Gippsland. This includes men's behaviour change programs and perpetrator case management.

Professional Stakeholder Perspective

Gippsland PHN professional stakeholder input, including from Clinical Councils (GPHN 2024e):

- Family violence was consistently rated as a high priority during consultations with key stakeholders in Gippsland, including among workshop attendees and by LGAs through their local feedback.
- There is a need to work more with men as perpetrators.
- There is increased pressure on services providers during community emergencies.
- There is a significant lack of emergency accommodation and this leads to people having to leave support networks and their local communities.
- There is a need for age-appropriate services for victim/survivors for young people and children.

Community, Consumer and Carer Perspective

Insights from the Gippsland PHN consultations (2024d and 2024e) related to family violence include:

Experiences of family violence

- Many victim-survivors spoke about their experiences of family violence, and the significant impact this has had on their life.

  "I suffer from a lot of anxiety, a lot of flashbacks, a lot of, I suppose, depression, all that stuff." (community member)
- Many victim-survivors spoke about how valuable support systems and support services had been for them.

  "Now see them groups were brilliant. Just having that support. Especially when you're single. Having that support of girls that have gone through it and the support workers they bring in." (community member)
  "I had a helper, a case worker named [name of case worker], who helped me through the domestic violence thing. With the court and all that sort of stuff. It was marvellous." (community member)
- Some people spoke about having to choose between staying in a violent situation or becoming homeless.

  "A lot of women don't [leave abusive relationships] … because there's a huge waiting list for public housing." (Community member experiencing homelessness in Gippsland)
- Some participants spoke about their experiences of elder abuse.

  "My daughter got into the ice… it escalated five months ago until where she abused me for three and a half hours. It was never physical. I thought for a long time I thought it would be. I was always terrified of her." (Older community member)

Prevention of and response to family violence

- A priority is preventing gendered violence and inequality.
- Trauma-informed therapy is valuable.

Community perceptions of family violence

- Family violence is a big issue in East Gippsland; high rates of family violence flow on to physical health, mental health and to all members of the family.
- Community members sometimes felt that family violence increased with external stressors, like the cost of living, mental health, AOD, and farm pressures. See the **health status** section of this chapter for more information on the drivers of family violence.
- Some community members felt that for men that perpetrate family violence, poor mental health, and issues around alcohol and drugs fed into this issue. They spoke about how improving health in these areas was one aspect of preventing and responding to family violence.

Chapter 10: Access to Primary Healthcare for Marginalised Communities

"Marginalisation refers to the inequality certain individuals face in society due to power imbalances built into our systems" (Diversity Council of Australia 2024).

Summary

Gippsland health insights

- Centring the voices of people with lived experiences of marginalisation ensures a more comprehensive understanding of systemic barriers.
- Gippsland had the second highest proportion of people (7.8%) with a severe or profound disability of all PHN regions nationally (6.0%).
- In 2021, 67% of LGBTIQA+ respondents had concerns or serious concerns for their mental health according to a 2023 survey.
- In 2023-24, 7,736 people in Gippsland used specialist homelessness services. This is more than double the national average per 1,000 people.
- 12.4% of the Gippsland population was born overseas (30.0% in Victoria).
- Importance of interactions with the justice system as a factor associated with complex healthcare needs and systemic barriers for access.

As a result of the insights gained from this chapter, Gippsland PHN will prioritise activities which support:

- Increased access to appropriate care for population groups with poorer health outcomes and poor access to healthcare, including for people who have experience/s of:
  - Homelessness
  - Multicultural
  - Disability
  - LGBTIQA+
  - Poverty
  - Contact with Justice System
- Increased opportunities for people to develop meaningful connections in the community.
- Improved access to data relevant for health planning for marginalised communities.
- Increased health equity for individuals and population groups across Gippsland.
- Improved competency in primary care to work with people experiencing complex intersecting forms of marginalisation.

Community voices

"I want to feel welcomed, included and a sense of belonging regardless of age, race, sex, gender, physical appearance etc."

"I want my health professional to connect with me."

"I want to be screened as a PERSON."

"I want to be able to afford to look after my health."

"I want services people can just walk into without needing to pay."

"I want access to LGBTIQA+ specific services."

"I want migrants having GP sessions with an interpreter."

Health Status

There is strong evidence that the social determinants of health have an important influence on health inequities (AHHA 2024) (see **Social Determinants of Health**).

A conceptual model of the link between social determinants of health and marginalisation has been presented and provides a framework for addressing the structures that impact individuals experiencing marginalisation (Baah et al 2019). It describes how the social, political and economic contexts influence a person's social position and how systems and structures make life harder for people who experience marginalisation.

Centring the voices of people with lived and living experiences of marginalisation ensures a more comprehensive understanding of systemic barriers (Diversity Council of Australia 2024).

"[Having my voice centred means] *being heard holistically and intersectionally, instead of being sliced up into sections…* [like 'woman', 'CARM person' (Culturally and Racially Marginalised) and so on]." (Diversity Council of Australia 2024).

Intersectionality refers to different aspects of a person's identity that can expose them to overlapping forms of discrimination and marginalisation (Victorian Government 2021b). There are many aspects of an individual's identity that can result in experiences of marginalisation, including, but not limited to:

- Aboriginality
- Gender
- Sex
- Sexual orientation
- Gender identity
- Ethnicity
- Colour
- Nationality
- Refugee or asylum seeker background
- Migration or visa status
- Language
- Religion
- Ability
- Age
- Mental health
- Socioeconomic status
- Housing status
- Geographic location
- Medical record
- Criminal record

An improved understanding of the lived experience of marginalisation can be fostered through an understanding of what it means to experience intersectionality.

The attitudes, systems and structures in society and organisations that interact to create inequality and result in exclusion may include:

- Sexism
- Racism
- Homophobia
- Biphobia

- Transphobia
- Intersex discrimination
- Ableism
- Ageism
- Stigma

When multiple personal characteristics combine, examples of what may occur include:

- Individuals are more likely to experience a greater risk of family violence.
- Individuals may find it harder to get the help they need due to systemic barriers.
- Individuals may be at increased risk of social isolation.

While marginalisation leads to challenges, impacted communities often show great community strengths, cultural knowledge and leadership (Victorian Department of Health 2024). Taking a strengths-based approach means to focus on the capacity, skills, knowledge, connections and potential of people and communities. It means providing the supports and services required to enable people to thrive.

When working with marginalised individuals in a healthcare setting, it is critical health professionals adopt a person-centred approach, treating each patient respectfully and as an individual human being. A person-centred approach requires understanding of what is important to the patient, their family, carers and support people. There is sound evidence that person-centred care can improve safety, quality and cost-effectiveness of healthcare, as well as improve both patient and staff satisfaction (ACQSHC n.d.).

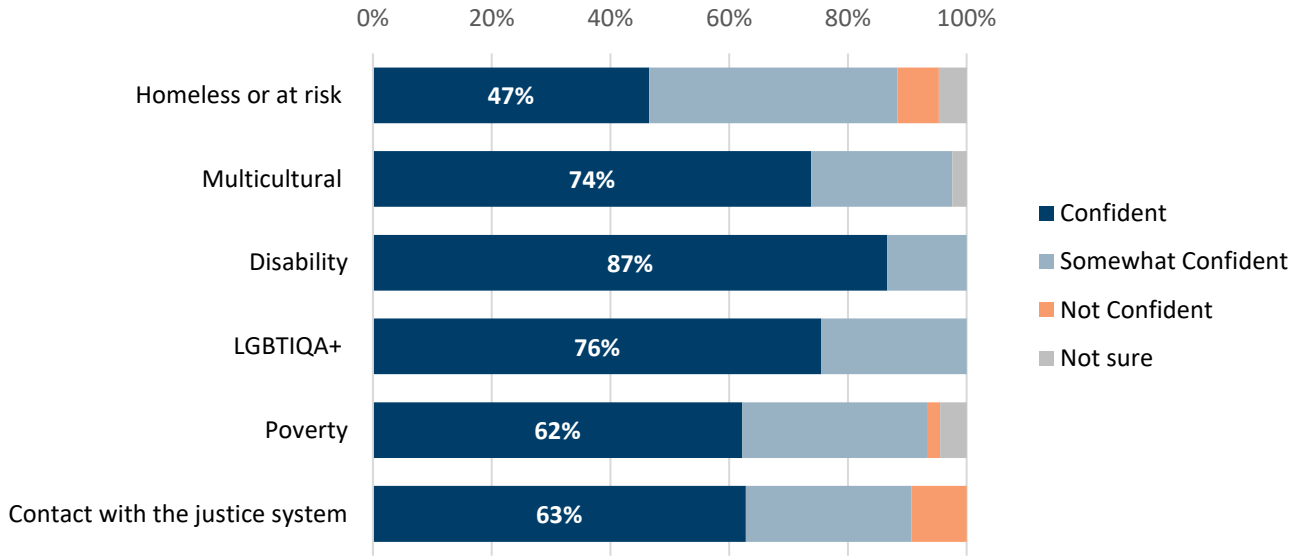
Gippsland data

Provider perspective

Engagement with **Gippsland general practices** via practice visits in 2025 (GPHN 2025g) highlighted that providers were largely confident in their ability to support marginalised individuals. In particular, providers were most likely to feel confident in supporting people living with a disability, see **Figure 114**.

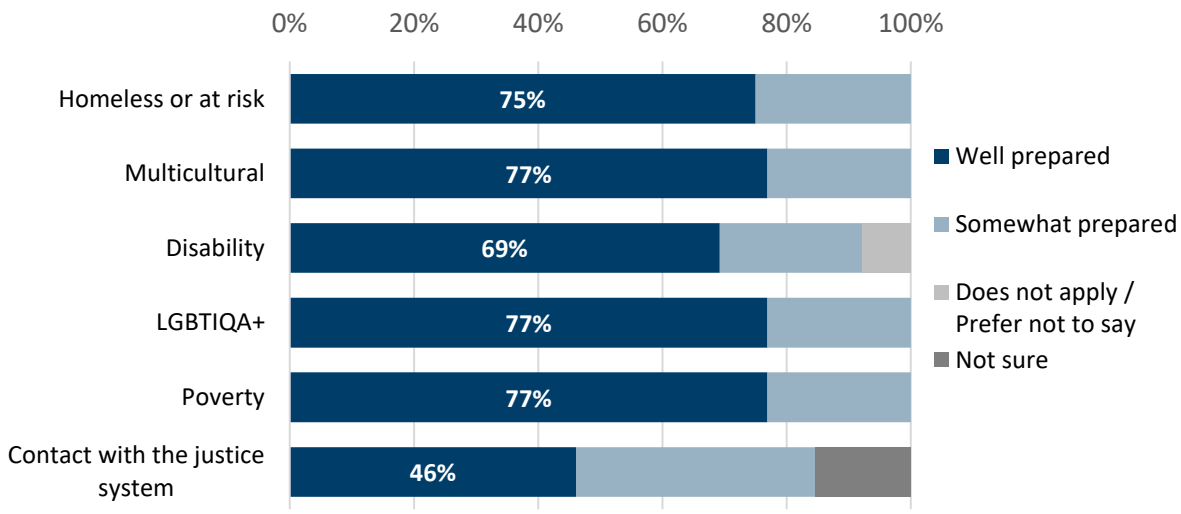
Providers were least confident in providing services to people experiencing homelessness or at risk of homelessness, followed by people experiencing poverty and those who had contact with the justice system.

Figure 114. Percent of Gippsland PHN general practice respondents who reported confidence in providing a service to marginalised groups, n=45 (GPHN 2025g).



Results from a survey for **Gippsland PHN's commissioned service providers** (including community health, non-government organisations and mental health service and aged care providers) in 2025 (GPHN 2025h) indicated that this group of providers were least prepared in providing services to people who had experienced contact with the justice system (46%), followed by people living with a disability (69%), see **Figure 115**.

Figure 115. Percent of Gippsland PHN commissioned service providers who reported being well prepared to provide a service to marginalised groups, n=14 (GPHN 2025h).



Homelessness

National Context

Homelessness Australia (2024) defines homelessness according to the ABS definition:

"When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:

- *is in a dwelling that is inadequate; or*
- *has no tenure, or if their initial tenure is short and not extendable; or*
- *does not allow them to have control of, and access to space for social relations"*

According to 2021 census data, more than 122,000 people in Australia experienced homelessness. This includes people sleeping rough on the streets, people 'couch surfing', seeking shelter in a car, relying on temporary accommodation and people living in severely overcrowded conditions (AIHW 2024q).

The Victorian Inquiry into Homelessness (Victorian Government 2021a) identified that census data likely underestimate the numbers of people experiencing homelessness and that there are multiple contributing factors to this growing issue in Australia, including insufficient income support, an increasingly competitive housing market and sudden personal changes in circumstances, such as due to loss of employment, loss of relationships, family violence, illness and eviction. Homelessness response is often crisis focused rather than preventative.

In Victoria there are increasing pressures on services to support people in need, leaving vulnerable people at risk whilst waiting for support (CHP 2024). Groups at highest risk include women and children impacted by family violence, young people, people sleeping rough, Aboriginal and/or Torres Strait Islander peoples and transgender and gender diverse people.

Both National and State-levels of government are committed to reducing homelessness. A National Housing and Homelessness Plan and a National Agreement on Social Housing and Homelessness are currently in development (Australian Government 2025). In addition, the Victorian Government housing and homelessness response includes delivery of housing and homelessness services through the Big Housing Build which will expand the social and affordable housing options (DFFH 2025).

Health impacts

People who experience homelessness die an average of 22 to 33 years younger than those who are housed (AIHW 2024q). Evidence shows that the effects of homelessness can be reversed by secure housing which leads to improved overall wellbeing, improved mental health and reduced rates of hospitalisation.

Healthcare needs vary depending on the **type of homelessness experienced** (Clifford et el, 2022);

- primary or street homelessness (or people sleeping rough);
- secondary homelessness, in temporary shelters and refuges; or
- tertiary homelessness, referring to boarding houses or other accommodations that fall below community standards of privacy or amenity.

Nationally, 27% of people seeking homelessness support did so due to health-related reasons (AIHW 2024q). Of these clients, the most identified health-related reasons for seeking assistance were (clients may have identified more than one issue):

- Mental health issues: 75%
- Medical issues: 36%
- Problematic drug or substance use: 26%
- Problematic alcohol use: 12%

The bidirectional relationship between homelessness and poor health and the barriers that individuals who experience homelessness face when trying to access healthcare are well documented (Bennet-Daly et al 2022). A high rate of both physical and mental health conditions were usually present. Poorly managed mental health was commonly reported for people experiencing homelessness in a regional area.

Bennet-Daly et al (2022) also identified key barriers to healthcare access:

- **Client-level barriers**: including living day to day, financial, health literacy, mental health conditions, behaviour, safety and stigma
- **Provider-level barriers**: including few bulk-billing doctors, fragmented services, limited resources, negative past experiences with healthcare
- **System level barriers:** including transport, funding constraints and over-stretched healthcare services.

Health conditions are often difficult to manage for people experiencing homelessness and multiple challenges have been identified (Davies and Wood 2018, AAEH 2023) including, but not limited to:

- Management of multiple complex health conditions.
- Competing priorities with a focus on finding shelter and satisfying other basic needs.
- Physical barriers including no money to access services and transport.
- Experiences of stigma, judgement and discrimination leading to disengagement from the healthcare system.
- Frequent delays in seeking support for health issues increasing the burden on the acute healthcare system.
- Increased reliance on ambulance and emergency department services, particularly by people who are sleeping rough.

- When attending an emergency department:
    - Wait times to receive care are often longer
    - Individuals are more likely to discharge themselves against medical advice or leave before being seen
    - Individuals are more likely to re-present at a later time, often more unwell. For example, a Melbourne study reported that 43% of people experiencing homelessness re-presented to the same emergency department within 28 days of their initial assessment (Ayala et al 2021).

Health services play an important role in preventing and reducing the health impacts of homelessness by identifying risk factors and adopting early intervention approaches.

The Council to Homeless Persons (CHP 2024) acknowledges that homelessness can happen to anyone but that it can impact people in different ways depending on demographics, necessitating a person-centred approach to care.

Women

Women experiencing homelessness have a life expectancy almost 40 years less than the general population, with a median age at death of 47 years (compared to 85 years) (Wood & Villiers 2024). Barriers to healthcare access for women experiencing homelessness may include:

- A high incidence of family, domestic and/or sexual violence, which can lead to women avoiding health care that involves physical touch, examination and trauma disclosure. A controlling partner may also prevent women seeking healthcare.
- Healthcare settings can be triggering due to bright lights, feeling judged and often having to repeat one's story to multiple professionals.
- Practical struggles can include cost, lack of access to a mailing address and information, lack of transportation, nowhere to store medication and no device/calendar to keep track of appointments.

Enablers to health care for women experiencing homelessness may include (Wood & Villiers 2024):

- Trauma-informed care practices embedded across the healthcare system
- Empowerment of women through person-centred care
- Asking women if they have a safe place to sleep as not all homelessness is visible
- Referring to healthcare services in locations where women feel safe
- Considering in-reach by female practitioners and less invasive clinical assessment options (like self-swabs for cervical screening), where possible
- Providing free, accessible and flexible service options including access to peer workers or other supports
- Considering medication management based on an individual's housing circumstances

Young people

Youth homelessness may be caused by a range of factors, including family relationships and disruptions at home including neglect, conflict, and abuse (physical, sexual, substance and/or emotional). These issues can severely impact a young person and may lead to them leaving home, even without another home to go to (AIHW 2024j). There are often multiple reasons for seeking support, and insights from homelessness services data reveal that experiencing homelessness as a young person can have far-reaching effects, including but not limited to:

- Disruption to education and the transition to employment which can impact future job opportunities and potential earnings.
- Disruption to social life and reduced social support networks.
- Harsh living conditions which can leave young people traumatised and at greater risk of experiencing persistent homelessness.

Furthermore, 69% of young people receiving homelessness support also received income support (AIHW 2024r), compared to 18% of young people who did not access homelessness services. The type of income support varied by age group and included unemployment benefits, parenting payments and student payments.

A Melbourne City Mission study (MCM 2024) provides a snapshot of 179 young people, aged 15-24 years, who accessed Frontyard Youth Services, located in Melbourne CBD, on 8 April 2025. Findings include the following:

- Intersectionality is common among young people experiencing homelessness. Among the sample of young people studied:
    - 33% identified as culturally and racially marginalised
    - 26% identified as coming from a regional rural, or remote area
    - 15% identified as LGBTIQA+
    - 13% identified as First Nations
- The researchers found that:
    - Family violence increases the likelihood of homelessness for young people: 82% grew up experiencing family violence and 54% of those young people were known to child protection.
    - Homelessness erodes mental health, increasing the risk of self-harm and suicide: 55% of young people reported self-harm, suicidal ideation and/or had attempted to take their own life. In addition, 45% of young people had attended an emergency department for mental health concerns; of those young people, 64% were discharged from hospital into homelessness.
    - Homelessness persists with no access to secure, supported, and affordable housing: 72% of young people had experienced homelessness for at least two years and around a third first experienced homelessness at 16 years or under.

Service system

The Victorian Inquiry into Homelessness (Victorian Government 2021a) identified a need for non-homelessness services and institutions, which often interact with people before they reach a crisis point to play a greater role in early intervention and prevention of homelessness. This may include real estate agencies, schools, and healthcare facilities. These institutions should be equipped to refer at risk individuals to appropriate services before they reach crisis point.

The Gippsland Homelessness Network (GHN 2024) provides resources for services operating within the homelessness sector in the Gippsland Region (see **Appendix 15** for list of member agencies).

Gippsland data

Census data from 2021 reported that there were 1,007 people experiencing homelessness in Gippsland (ABS 2021a). Of these 392 people were in Latrobe (39%), 214 in East Gippsland (21%), 137 in Baw Baw (14%), 126 in Wellington (13%), 66 in Bass Coast (7%) and 50 in South Gippsland (5%). In addition, Morwell was identified as the 10th area of fastest growth (85%) in homelessness between 2016 and 2021 (CHP 2023).

The Gippsland Homelessness Network (GHN 2024 and 2025) report that homelessness in Gippsland continues to increase and is becoming more visible. There are likely multiple factors contributing to this, including:

- Decrease in the supply of social and private rentals and a lack of one bedroom accommodation options
- The rising cost of living affecting singles and young people in particular
- The rising cost of private rentals, particularly in Morwell, Bairnsdale and Sale-Maffra
- High rates of family violence
- An increase in households accessing homelessness services sleeping rough in cars, tents or in the open; a 32% increase between 2023-24 and 2024-25 (572 households, making up 16% of all households accessing homelessness entry points in 2024-25)
- Long wait times for homelessness case management; 4-6 weeks and up to 6 months in 2025
- Service providers are under stress and in high demand with some rough sleepers no longer bothering to seek support as there is limited support is available
- Many people in Gippsland are on a low income and experience other forms of disadvantage (see also **Social Determinants of Health**).

Housing pressures are also affecting more people in Gippsland (GHN 2024 and 2025):

- 11% of people accessing homelessness service entry points were employed in 2025

- In March 2025, there were 7,520 Gippsland households on the Victorian Housing Register for Priority Access (up from 2,268 in 2022), with the largest numbers in Traralgon (956), Morwell (758), Moe (708), Bairnsdale (603) and Warragul (561)
- In 2024-25, 132 young people were supported by Youth Homelessness Refuges and 194 young people received outreach support in the community

Homelessness services

In 2023-24, 7,736 people in Gippsland used specialist homelessness services, which is a 6% increase from 7,278 in 2022-23 (AIHW 2025a), and more than double the national average per 1,000 people. In Wellington, the rate was more than three times the national average, with East Gippsland and Latrobe also showing high rates (**Figure 116**). Of these clients in Gippsland:

- Females: 56%
- Experiencing homelessness: 37%
- At risk of homelessness: 63%
- Age distribution is shown in **Figure 117**
    - Aged 0-17 years: 28% (2,189 children)
    - Aged 18-24 years: 13% (967 young people)
- Domestic or family violence: 44% (3,407 people); up from 41% (3,002 people) in 2022-23

Figure 116. Rate of people accessing specialist homelessness services per 1,000 population, 2023-24 (AIHW 2025a).

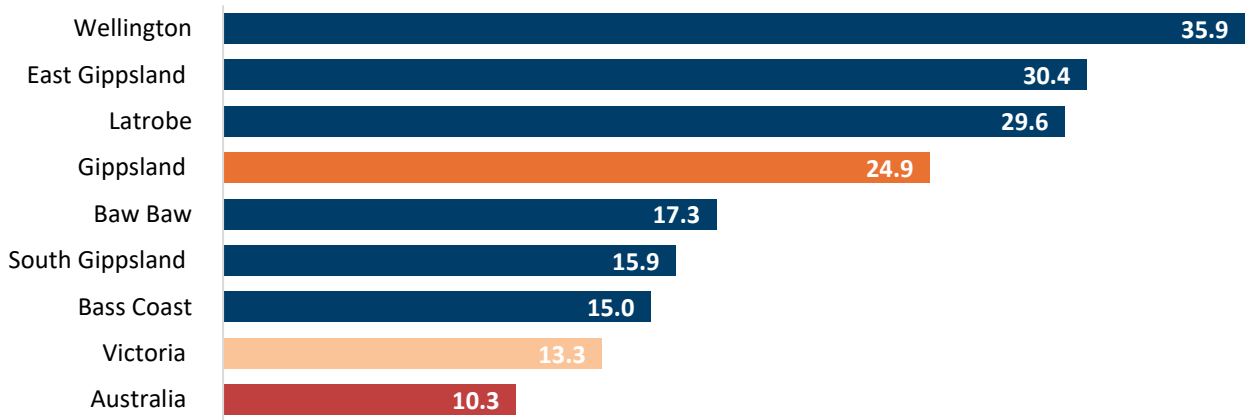
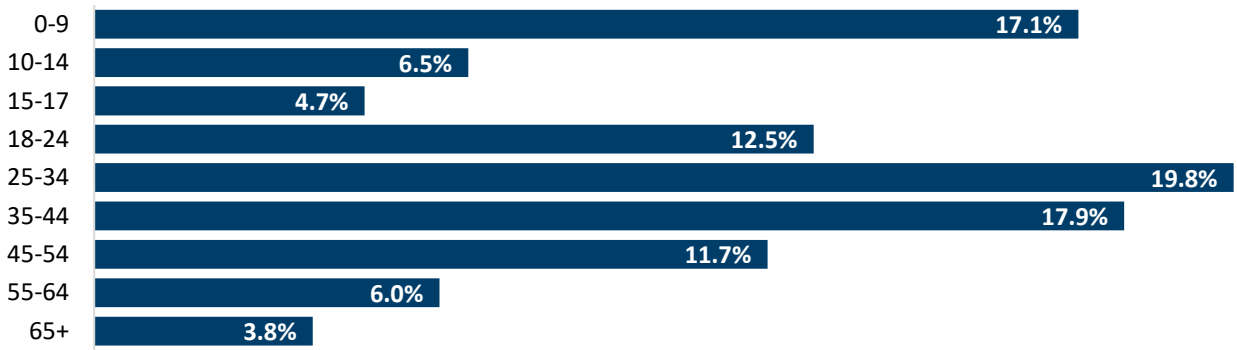


Figure 117. Percent of people accessing specialist homelessness services in Gippsland by age group, 2023-24 (AIHW 2025a).

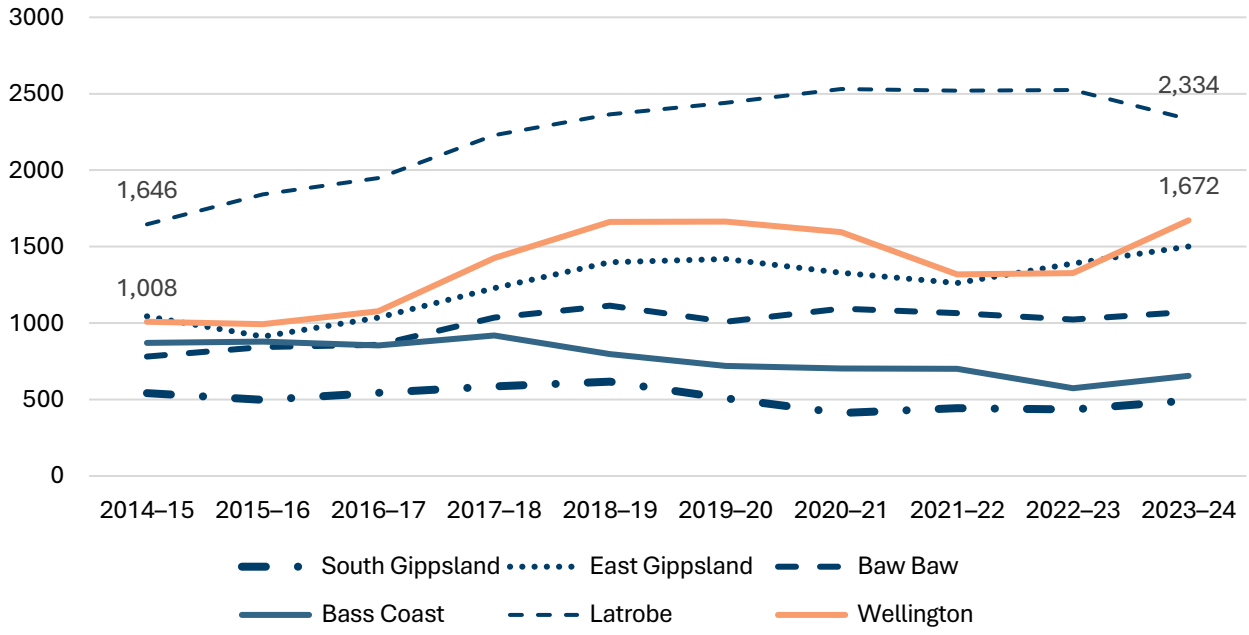


Overall, Latrobe has had the largest number of people accessing homelessness service in Gippsland over the past 10 years (**Figure 118**). It can also be noted that:

- All LGAs except Bass Coast and South Gippsland recorded an increase in numbers
- A recent increase in Wellington (and an average increase of 6% per year)
- An increase in East Gippsland (and an average increase of 4% per year)

It should be noted that service providers are unable to meet demand for services so these numbers do not include unmet community demand for services (GHN 2025).

Figure 118. Number of people accessing specialist homelessness services in Gippsland by LGA, 2014-15 until 2023-24 (AIHW 2025a).

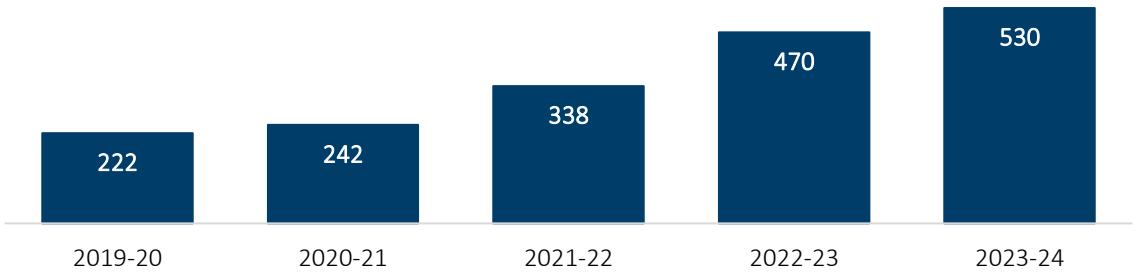


Emergency department (ED) presentations

Analysis of Gippsland residents experiencing homelessness who presented to ED between 2019-20 and 2023-24 shows that:

- Of all ED presentations, 0.3% of all ED presentations (1,802 presentations) were for people experiencing homelessness
- There was a 35% average annual increase in presentations, rising from 222 presentations in 2019-20 to 530 in 2023-24 (**Figure 119**)
- The top diagnoses were:
    - 8.4% suicidal ideation
    - 4.8% unknown and unspecific causes of morbidity
    - 4.7% schizophrenia
    - 3.8% psychotic disorder (acute and transient)
    - 3.1% general psychiatric examination ('requested by authority')
    - 3.1% mental disorder due to alcohol intoxication

Figure 119. Number of Gippsland residents experiencing homelessness presenting to emergency department, 2019-20 until 2023-24 (DH 2024b).



Gippsland PHN Commissioned Services

Gippsland PHN currently collect some data on homelessness status in mental health and alcohol and other drugs commissioned programs:

- 3.5% of mental health services consumers (based on episodes) were recorded as homeless in 2024-25; similar to the proportions recorded in 2022-23 (3.5%) and 2023-24 (3.3%), (GPHN 2024f).
- <1% of alcohol and other drug service consumers were recorded as homelessness from 2022-23 to 2024-25 (GPHN 2025e).

Improving the health and wellbeing of people experiencing homelessness

The 'Housing First' approach is the basis for the work of the **Australian Alliance to End Homelessness** (AAEH), which emphasises that the primary priority in assisting persons experiencing homelessness is stable, ongoing housing. Once a person has permanent accommodation, support services may then be engaged to help address the root causes of homelessness, and in turn health and wellbeing.

Primary healthcare models that support people experiencing homelessness have been identified (Davies & Wood 2018, Clifford et al 2022 and AAEH 2023), and they include:

- **Referrals to housing services as a health solution** removes homelessness as a major barrier to accessing health services and supports.

- **Integrated multidisciplinary services** which can address social determinants concurrently by offering a broad range of wrap-around services, including care coordination, trauma informed care, nursing, allied health, peer support workers and mental health practitioners. A model described by Grove et al (2025) provided a combination of primary care, behavioural health care, and services to address health-related social needs to individuals experiencing homelessness, multiple chronic medical conditions, serious mental illness, and substance use disorders. Outcomes included reduced emergency department presentations and improvements in self-reported psychosocial functioning and substance use symptoms.

- **Continuity of care** through coordinated case management and discharge planning assist with effective follow up and reduce hospital presentations.

- **Hospital in reach models** where general practitioners connect with patients in hospital to support them in accessing community-based services to reduce the likelihood of future emergency department presentations.

- **Specialised homelessness general practices** can increase client engagement. Davies and Wood (2018) provide examples from the UK, US and Australia and note that: "*practitioners need to have strong links to the homelessness sector, particularly services able to connect homeless people to housing*." They also note that: "*practitioners need to be experienced in managing complex multimorbidities and need to understand the interactions between physical illness, mental illness and drug dependency issues.*"

- **Medical respite centres** where people can recover or rehabilitate after surgery to avoid becoming unwell and being readmitted.

- **Assertive outreach models** that proactively engage individuals in their environments are recognised as an evidence-based intervention to improve healthcare access and outcomes among

people experiencing homelessness. Such models, particularly those that are trauma-informed, culturally safe, and incorporate peer workers, have been shown to improve engagement, support continuity of care, and connect people with broader health, housing, and social supports. An example of a nurse-led model was found to improve access to primary healthcare, be cost-effective, and assist other service providers to deliver appropriate care (Goeman et al 2019).

- **Drop-in care models** can reduce barriers and improve access by removing barriers such as planning and keeping appointments**.**

Professional Insights

Gippsland PHN surveyed health and social service providers about access to primary healthcare for people experiencing homelessness or at risk of homelessness (GPHN 2024l). Twenty-eight responses were received: 64% worked for an organisation providing homelessness services and supports; 32% had insights about what people experiencing homelessness need to access healthcare; and 4% had experienced homelessness or were at risk of homelessness themselves. Key themes from this survey are shown in **Table 29.**

Table 29. Themes identified in a Gippsland PHN survey seeking insights about access to primary care for people experiencing homelessness, n=28.

Theme	Description	Quotes
Significant barriers to access primary care	• People are often transient, and this makes it harder to access healthcare • Workforce limits capacity and impacts access • Wait times for housing support • Wait times for healthcare referrals • No safe place to keep belongings if admitted to hospital • Cost of healthcare and related things like transport combined with low income • Stigma leads to people not feeling welcome or valued • Complex presentations and lack of continuity of care	*"… all of their worldly possessions are in one tent and if they were to receive treatment in hospital their belongings would be stolen and they would start again so they choose to not get healthcare and remain on the street."*
Mental health	• People with mental health challenges are often less likely to access services • Dual diagnosis (of mental health and alcohol and other drug misuse) is very common and not well managed	*"… the clients we work with are usually in very vulnerable situations. They often feel like they are not being supported and we lose engagement …."*

	• No service providers for hoarding and squalor	
Disability	• Access to NDIS is near impossible as it's so complex to get through the process • Improved income support options	*"Gaining access to assessments, diagnoses … and NDIS supports are far too restrictive and almost impossible for … people in these cohorts."*
Family violence	• Family violence described as the biggest causal factor for homelessness • A significant factor in older females seeking accommodation support • Access to specialist services is needed	*"Male perpetrators of family violence need improved access to crises, short and long-term accommodation to both prevent homelessness and to provide better levels of safety to family violence victims by way of intervening so perpetrators do not need to return home."*
Models that work	• 24 hours bulk billing clinic • Outreach models • Providing transport to access services • Improving access to longer term case management support • Connected care with improved communication between healthcare and support services • More crisis accommodation • Community supports like food banks, free showers and laundry services	*"A holistic approach to homelessness or at risk needs to be considered down to simple food requirements, hygiene and wellbeing service and provision"* *"…access to healthcare is an essential first step to improve health and wellbeing to people experiencing homelessness"* *"I think a 'street team' or 'assertive outreach' team is very much needed in Gippsland that includes specialist homelessness assertive outreach practitioners in partnership with health providers including nursing, dual diagnosis clinicians"*
Alcohol and Other Drugs	• Need for additional residential rehabilitation and detoxification services • Culturally specific Aboriginal and/or Torres Strait Islander AOD service that provides both residential detoxification and rehabilitation services • Free service available when needed • More AOD support workers	*" Access to emergency rehab that is free and live in as drugs and alcohol cause a lot of, or stem from, mental health [issues] and when asking for help through hospitals they are dismissed…"*

In addition to the above survey, Gippsland PHN gathered broader insights from professional stakeholders, including from Clinical Councils, related to homelessness (GPHN 20224d, GPHN 2024e and 2025b):

Responding to homelessness

- Gippsland needs funded assertive outreach programs across its LGAs.

- There is an opportunity to support people facing hardship in the healthcare system. Providers and reception staff need to be aware of available services and supports.

  "If more people knew how easy it can be to end up homeless, they would treat people with respect and dignity and that can make all the difference." (Professional)

  "…we now have regular and visible rough sleeping. A stark contrast to just a few years ago, before COVID-19." (Professional)

- If the response to rough sleeping is to forcibly move people on, then they are moved away from their local area and any social supports they may have. People are criminalised for trying to survive and this adds to the multiple pressures experienced.

Housing affordability and availability

- Migration from metropolitan areas during the pandemic caused rent increases and locals now can't afford their rent.

Young people and homelessness

- Young people can be especially at risk due to lack of public transport, limited employment opportunities and often there is a need to move away from their local community to seek support
- There are major service gaps for young people with very few refuge places and transitional housing options.

Increasing demand for homelessness services

- Regional homelessness service providers report a sharp increase in rough sleepers who need different supports.
- Homelessness in regional areas increased by 52% between 2016 and 2021 (17% in metro areas), based on changes in census data (CHP 2023).
- Funding for homelessness does not meet demand.
- An increasing number of people are being turned away when seeking support due to a lack of available emergency beds.

Older people and homelessness

- A growing problem often linked to poor mental health.
- Housing services may lack knowledge and funding to support older people.
- Health services for older people end up supporting those experiencing homelessness due to lack of alternatives.
- Digital systems for support are not accessible (includes aged care, financial and social supports).

A **Training Needs Analysis** was undertaken to understand the interplay between healthcare and homelessness in the Gippsland PHN catchment (Larter Consulting, 2024). Data were collected via literature

review, surveys, interviews and document reviews with a focus on the Latrobe City LGA. The summary highlights that "*healthcare for people experiencing or at risk of homelessness must address the multiple and interconnected barriers they face, with a focus on integrated, accessible, and empathetic medical, mental, and social care. Healthcare solutions must consider the entire spectrum of an individual's needs*." Additional key findings from the Training Needs Analysis include:

- Specialist homelessness services and community organisations are strong advocates for improved outcomes for their clients who often need to prioritise daily needs such as food, water and shelter over health.
- Health impacts vary across different forms of homelessness, whether rough sleeping, living in temporary shelters or staying in insecure housing.
    - General practitioners and practice teams spoke of their commitment to providing accessible healthcare to people within these communities, but there are challenges in doing this while ensuring practice viability.
    - Challenges navigating and providing healthcare for people experiencing or at risk of homelessness are compounded by:
        - Financial constraints including costs of services and medication with the ability to prioritise basic needs like food and shelter
        - The lack of a fixed address limits access to healthcare cards and identity documents and creates challenges storing medication, maintaining hygiene and keeping appointments
        - Limited and expensive transportation which can lead to use of emergency services
        - Mental health challenges alongside substance misuse, which often becomes a way to cope
        - Stigma and lack of trust in healthcare settings which can lead to people avoiding seeking help out of fear of being treated poorly, especially for those who have experienced trauma
        - Navigating the healthcare system is extremely difficult for individuals without stable living conditions
        - Short consultations can fail to address the complex needs of individuals facing multiple health issues
    - Recommendations for improved healthcare for people experiencing or at risk of homelessness included the following:
        - Healthcare provider training to improve understanding of homelessness, its causes, and the impact on health and wellbeing as well as trauma-informed care training
        - Improving communication skills to build rapport with vulnerable patients
        - Conducting rapid assessments and utilising bulk-billing strategies to address urgent health concerns
        - Working to identify at risk groups by screening for domestic violence, suicide risk, and substance use, and implementing harm reduction strategies

    - Establishment of trusted community access points, such as housing services and community centres to help individuals feel safe and respected
    - Comprehensive, integrated care and dedicated case management with a focus on collaboration between GPs, allied health providers, social workers, and homelessness services
    - Affordable care options
    - Strategies to reduce stigma within general practices
    - Establishment of outreach service models
    - Simplified medication regimes
- Quotes from the Training Needs Analysis highlight some of the main themes:

> *"It's just something else to add to their mental load - not that they're lazy, but having to build up confidence to make appointment then get the money or the resources to make appointment then follow through on that… "*
>
> *"Their focus is on getting a house first then look after their health."*
>
> *"But a lot don't want to make any commitment because they don't want to set themselves up to fail. It's a sad spot to be." (Community organisation)*
>
> *"We understand that sometimes people need more than just medical care. That's why we go the extra mile, offering practical assistance." (General practice)*

Finally, workshops on Crisis Accommodation in Outer Gippsland (Simpson and Felmingham 2025) recently brought together local government, health services, non-government organisations and university partners. Opportunities for collaboration were encouraged. Insights included:

- Housing First as a preferred model (AAEH 2023)
- A need to link family violence, mental health and alcohol and other drug service providers with crisis accommodation providers to share specialist knowledge
- Use of motels and other purchased accommodation options are not safe and should be used as a last resort
- Joint planning across all levels of government for crisis accommodation and longer-term housing options is needed
- Safe spaces for women, children and young people are needed
- An outreach model for rough sleepers is needed

Community Insights

A Gippsland PHN interview study (GPHN 2024c) gathered insights from 26 people with current and/or past experiences of homelessness. Key themes from the broader engagement are found in the Community,

Consumer and Carer section of this chapter. The main insights from people experiencing homelessness include:

Constant stress

- The constant stress of housing insecurity affects people's mental health.

Barriers impact progress

- There are so many practical barriers to doing simple things like trying to access pension payments and Medicare when you don't have an address. It also impacts getting to appointments (no phone, no reminder, no transport, no money, couldn't have a shower so felt too ashamed).

Judgement and stigma

- It is very common to be met by judgement and stigma when a person experiencing homelessness is seeking healthcare and this leads to people avoiding healthcare until it is acute. This is combined with multiple and often complex conditions, often involving trauma making it difficult to have the mental capacity to find a clinic with available appointments and go through the process of making contact.

  "It's very stressful. Upsetting when you've got nowhere to go… And you know that any moment, you know, they could say, look, we can't pay anymore and then you're out."

  "Because when you're homeless, you don't have an address. And I had no-one, apart from friends, I suppose, that I could give an address to for mail or – you know, all the, the things that we need a mailbox for… It could be a licence, you know? Voting."

  And then, then house prices start to rise. And then you …see the same car... Or, you know, a caravan parked at a spot that's been there for three weeks. You instantly know they're not camping. (Person experiencing homelessness in Gippsland)

  The first 12 months [after leaving family violence] were a state of total upheaval. A lot of women don't [leave abusive relationships], you know, because there's a huge waiting list for public housing. (Person experiencing homelessness in Gippsland)

  Because you'll find a lot of people that don't want to reach out for whatever reason. Either they're just scared to reach out. They're ashamed to reach out. Or, whatever their story might be… (Person experiencing homelessness in Gippsland)

Importance of support

- The importance of neighbourhood houses and other community supports where basic needs can be met can be lifesaving. They often provide shelter, food, a place to wash and a friendly conversation.

"I guess these places because they've got showers and stuff. Showers and they've got washing machines. They're probably like one of my biggest favourite things about these places… Especially when you're homeless, when you're broke. And like they give out free food and stuff here." (Community member)

"So if there's more access to homeless shelters, I think there wouldn't be as many people sleeping in parks and stuff. I think that would definitely be good for my wellbeing anyway." (Community member)

More recent engagement, including with the Gippsland PHN Community Advisory Committee (GPHN 2025b) has highlighted ongoing and growing concerns about people experiencing homelessness across Gippsland.

- A growing awareness in the community of the number of people experiencing homelessness, including people in 'hidden homelessness' such as those living in cars.
- Community supports such as food, laundry services and phone chargers, including via libraries and community organisations can make a big difference for individuals.
- Education and training on reasons for homelessness and how to interact with people who are experiencing homelessness to community organisations can be needed to ensure non-judgemental support for this vulnerable group.
- There is a role for someone to act as an advocate for homeless people, someone to assist them to seek health and social care services.

"Growing homelessness and complexity of access (including transport)…" (Community member)

Multicultural

National Context

According to the PHN Multicultural Health Framework (PHN Cooperative 2024), 'people of multicultural backgrounds' refers to those whose cultural identity varies from the Anglo-Celtic majority or Aboriginal and/or Torres Strait Islander populations. It is recognised that there is great diversity among people from multicultural backgrounds across cultures, faiths, languages, migration journeys and experiences. The term Culturally and Linguistically Diverse (CALD) is often used by service providers and in data collections.

The Australian Human Rights Commission (2023) states that:

Racism is the process by which systems and policies, actions and attitudes create inequitable opportunities and outcomes for people based on race. Racism is more than just prejudice in thought or action. It occurs when this prejudice – whether individual or institutional – is accompanied by the power to discriminate against, oppress or limit the rights of others.

The PHN Multicultural Health Framework (PHN Cooperative 2024) was developed to improve health and wellbeing outcomes and experiences for multicultural communities. Action areas include:

- Identify and understand the needs of multicultural communities
- Collaborate and co-design to develop appropriate local programs and resources
- Improved primary care models, information and navigation to improve access
- Professional development for primary care staff, including reception staff
- Promote and support interpreters in primary care to build capacity
- Improved data collection using five recommended fields:
    - Country of birth
    - Ethnicity
    - Language spoken
    - Interpreter required
    - Year of arrival in Australia
- Involve multicultural people in governance systems, healthcare reform and service co-design activities to ensure inclusivity

Supports for multicultural communities in Victoria are underpinned by the Victorian Department of Health Multicultural Health Action Plan 2023–27 (DH 2024d). This document sets out to embed cultural competency into all of the department's services, programs and policies.

The Embrace Multicultural Mental Health Framework (Embrace 2024) has been developed to support mental health services, practitioners and the healthcare sector more broadly to work towards improved equity for multicultural communities. Mental health and suicide prevention needs of multicultural

communities can vary between groups (Embrace 2024). This can include differences in how mental health is understood and described, beliefs about what constitutes mental illness, how distress is or isn't displayed, and help seeking behaviour.

Health Impacts

A survey conducted in regional Victoria estimated that 60% of people had experienced racism in the past 12 months but only 17% had reported it (Chiang 2024). The Racism in Victoria report (Victorian Government Department of Health 2023) noted that people experiencing racism are 5 times more likely to have poor mental health and 2.5 more likely to have poor physical health.

Racism can affect health directly and indirectly via a number of pathways (DH 2023). Direct pathways can include chronic stress, mental impacts such as anxiety and depression and also potential for physical injury from racially motivated violence. Indirect pathways can include reduced access to employment, housing and education and the downstream impacts of these factors (see also **Social Determinants of Health**). Racism can also result in behaviours such as sleep, exercise, smoking, consumption of alcohol and overeating, as a means of coping. Furthermore, maternal exposure to racism can have harmful effects on a foetus, with potential impacts that may persist into adulthood (DH 2023).

People with a multicultural background may face challenges when accessing health and social care services, leading to poorer health outcomes (AIHW 2024n). First generation immigrants can arrive in Australia with relatively better health than Australian-born people due to screening and eligibility criteria (for example some visas require medical screening), and skilled migration can favour healthier individuals. This is the so called 'healthy migrant effect'. However, the prevalence of chronic conditions increases with time since arrival and is higher among people with lower English proficiency and varies by country of birth. Some health issues are more prevalent in different groups. For example, dementia, heart disease, stroke, diabetes and kidney disease are more common for people born in Polynesia, South Asia and the Middle East.

Refugees and other forcibly displaced populations may have further distinct health needs, due to experiences of trauma, and challenges associated with migratory status and fear of deportation (WHO 2022). Refugees often experience multimorbidity and have a high prevalence of mental health issues in the initial years of settlement (Khatri & Assefa 2022). An AIHW (2023d) report into the health of humanitarian entrants in Australia identified the following key insights:

- Humanitarian entrants had high rates of GP attendances. 90% of humanitarian entrants had a GP attendance in 2021, with 99% of these bulk billed.
- Humanitarian entrants had a higher rate of self-reported diabetes compared with the rest of the Australian population. This was 7.6%, compared to 4.3% among the general population.

- Humanitarian entrants had higher rates of certain causes of death. The leading cause of death for female humanitarian migrants was cerebrovascular disease, and coronary heart disease for males. Rates of accidental deaths from drowning were also higher for humanitarian entrants, when compared to other permanent migrants and the general population.
- Self-reported mental health conditions were 50% less common among humanitarian entrants compared with the rest of the Australian population. Female humanitarian entrants were more likely than males to report mental health conditions, as is also the case for the rest of the Australian population.

Refugees and humanitarian entrants are more likely to experience health conditions related to trauma, challenges related to the migration experience and access to care compared to the general population (AIHW 2023d). 7.6% reported having diabetes, compared to 4.3% for the general population. Refugees and humanitarian entrants were 2.4 times more likely to drown. Antidepressant prescribing is 50% more common among female refugees compared to the general population. GP attendances are 40% more likely among refugees compared to the general population (with rates highest for people from Iraq, Iran, Syria and Afghanistan), yet refugees were less likely to have a GP mental health plan.

Service system

See **Appendix 16** for a list of providers offering healthcare support for multicultural people in Gippsland, as well as national and state services.

Healthcare providers have access to interpreting services (TIS National), provided by the Department of Home Affairs. This is often an essential resource for people from multicultural backgrounds to access general practice and other health services.

Many non-health organisations providing support to multicultural communities have a role in connecting people with appropriate healthcare services (GPHN 2025d). This includes training providers, providers of English language classes, and neighbourhood and community houses. Staff from these organisations shared in a 2025 consultation (GPHN 2025d) that they felt building trust with multicultural community members often resulted in people feeling more comfortable asking for help, including help interpreting medical forms or knowing where to go to access healthcare services.

Gippsland data

Demographics

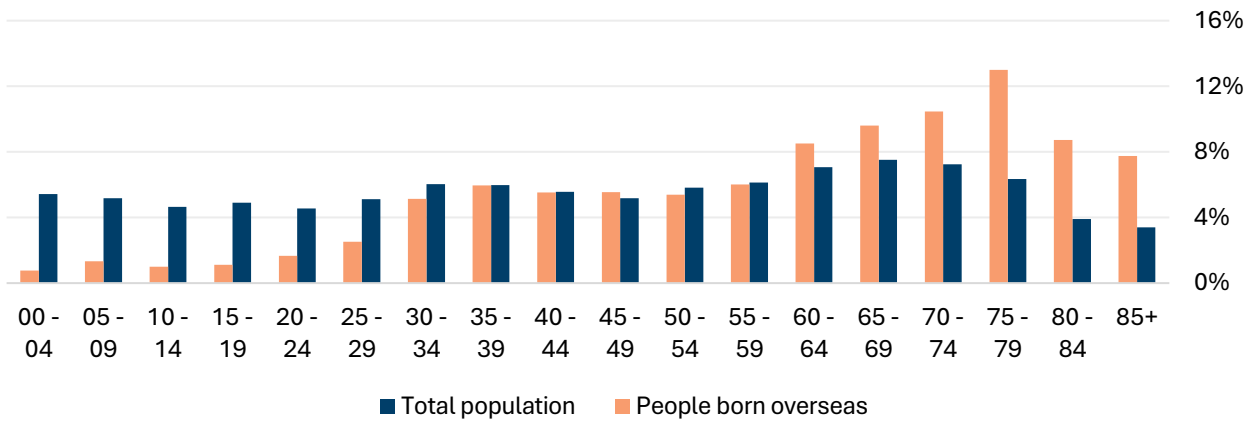
According to 2021 census data (ABS 2021a):

- 12.4% of the Gippsland population was born overseas (30.0% in Victoria)
- 6.3% were born in a non-English speaking country (24.1% in Victoria)
- 6.7% of households use a language other than English (30.2% in Victoria)

- 0.5% of people have low English proficiency (3.8% in Victoria)
- 1,492 people in Gippsland did not speak English well, and 414 did not speak English at all

The age distribution of general practice patients born overseas differed significantly from the general patient population, with a lower proportion of younger people born overseas and a higher number of older people born overseas, see **Figure 120**.

Figure 120. Proportion of general practice patients by age, total population compared to people born overseas (GPHN 2025a).



According to an estimate from the 2023 Victorian Population Health Survey (VAHI 2025), 56% of adults in Gippsland agreed that multiculturalism makes life in their area better. This was an increase since 2020 when an estimated 52% of Gippsland adults agreed (DH 2024c). In 2023, Baw Baw and Latrobe had the lowest estimates at 53% and all Gippsland LGAs had lower estimates compared to 67% of adults across Victoria (VAHI 2025).

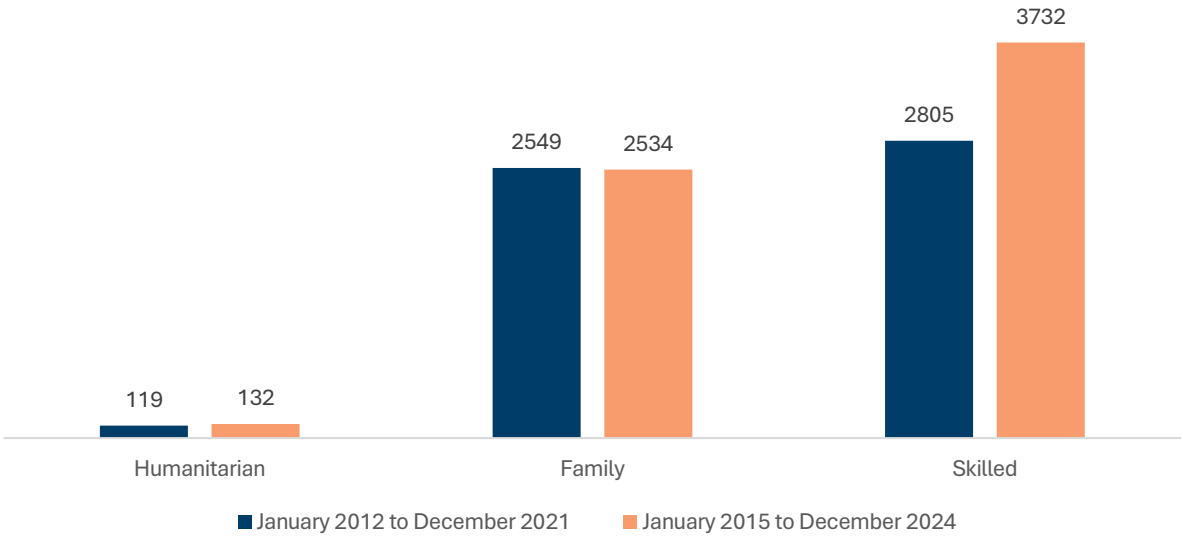
Permanent Settlers

Data on permanent settlers looks at the numbers of migrants on a pathway to permanent residency. It includes the skilled migration stream, the family migration stream and special eligibility visas. Permanent residence can also be obtained on humanitarian grounds (Department of Home Affairs 2025b).

Between the periods of January 2012 to December 2021 and January 2015 to December 2024, the number of permanent settlers in Gippsland has remained largely the same for humanitarian and family stream migrants, see **Figure 121**. The number of permanent settlers from the skilled stream has increased by 33% over this period of time.

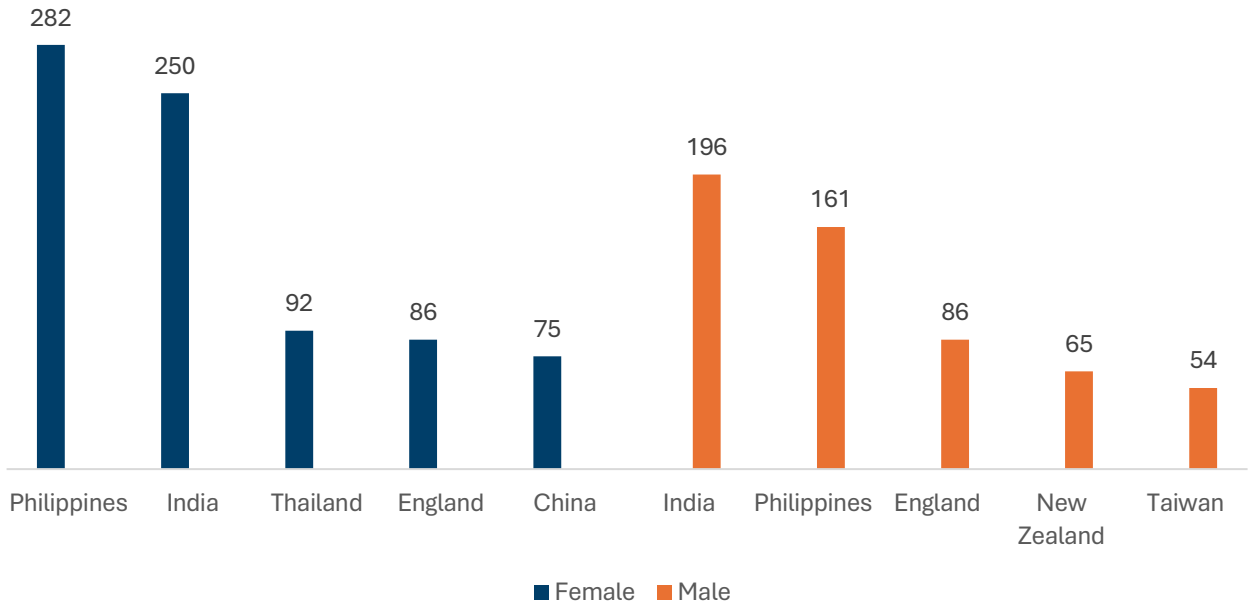
Between 2015 and 2024, there were a total of 6,398 permanent settlers in Gippsland (an average of 640 per year). Skilled migrants made up 58% of this total, family migrants 40% and humanitarian migrants 2%.

Figure 121. Permanent Settlers in Gippsland by Migration Stream, 2012 to 2021 – 2015 to 2024 (Department of Home Affairs 2025a).



For people arriving in Gippsland between 2017 and 2021, the top countries of birth were India (446), the Philippines (443), England (172), New Zealand (134) and Taiwan (122) (ABS 2021b). The top countries of birth differed between men and women (see **Figure 122)**. The top countries of birth for women were the Philippines (282), India (250), Thailand (118), England (172) and China (115). For men, they were India (196), the Philippines (161), England (86), New Zealand (65), and Taiwan (54). During this time, 274 more women than men arrived in Gippsland (ABS 2021b). The largest gender gap was for people born in the Philippines, with 121 more women than men.

Figure 122. Top five countries of birth for people arriving in Gippsland between 2017 and 2021, females and males (ABS 2021b).



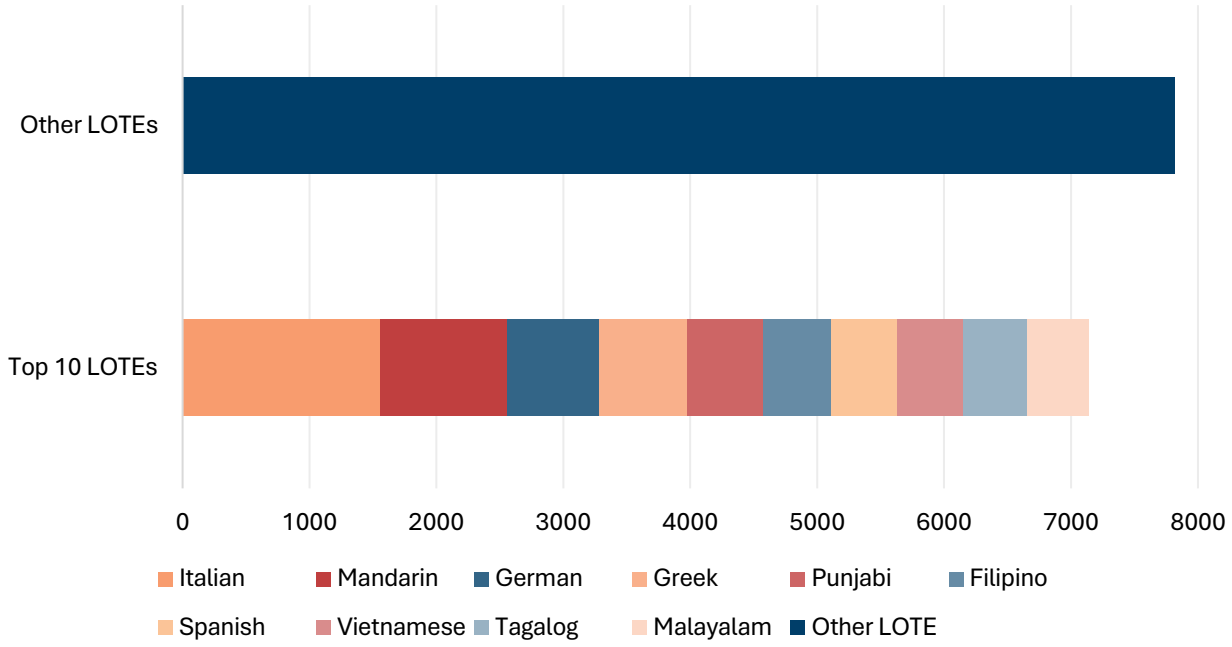
These findings were broadly supported by organisations working with community members (GPHN 2025d). When asked who the main cultural groups they interacted with were, people from the Philippines were mentioned most frequently. Asian communities, and in particular southeast Asian communities, were also mentioned often. Interviewed organisations agreed that Gippsland has a broad range of smaller multicultural communities.

Languages other than English

Based on the 2021 census data, 14,992, or 5.0% of the Gippsland population stated they spoke a language other than English (LOTE[14]) at home (ABS 2021b), with a total of 138 languages identified. The most common languages in Gippsland were Italian (1,559), Mandarin (1,000), German (725), Greek (695) and Punjabi (596) (ABS 2021b), see **Figure 123**.

[14] Language other than English (LOTE): The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.

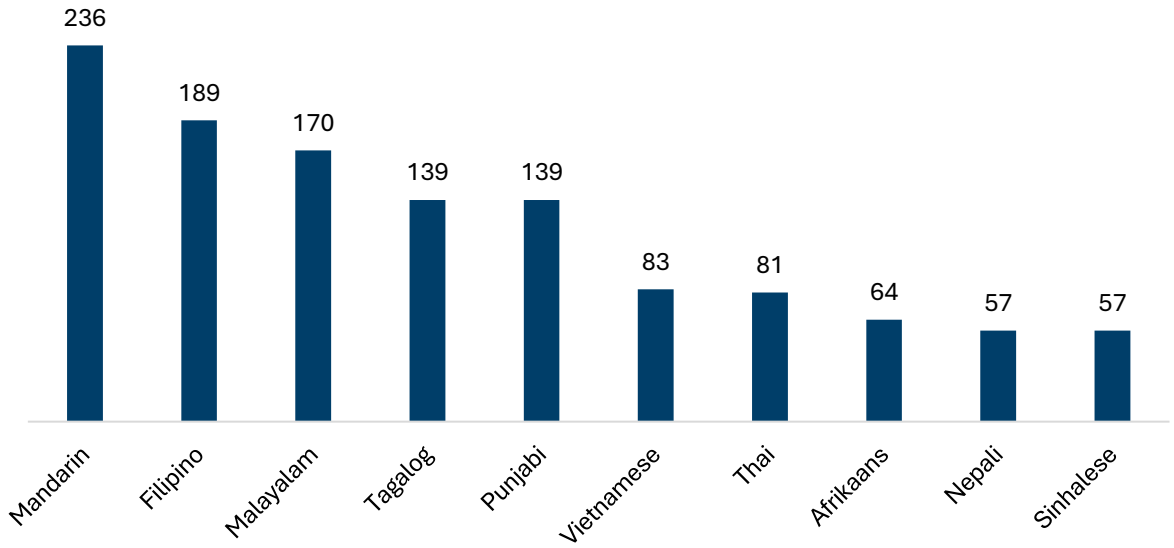
Figure 123. Languages other than English Spoken at Home in Gippsland, 2021 (ABS 2021b).



Gippsland has many smaller groups of people speaking languages other than English at home. While 7,141 people speak the top 10 most common languages at home (48%), there are 7,820 people who speak the other 128 languages at home (52%). One staff member from a multicultural health service stated that she finds the question of top five languages difficult to answer, because it does not give an accurate picture of Gippsland's diverse multicultural community (GPHN 2025d).

The most common languages spoken in Gippsland are different again when considering people who have arrived more recently (ABS 2021b). For the 2,940 people arriving between 2017 and 2021, English was the most common language spoken at home (831), followed by Mandarin (236), Filipino (189), Malayalam (170), Tagalog (139) and Punjabi (139). See **Figure 124.**

Figure 124. Top 10 most common Languages Other Than English spoken at home in Gippsland by arrivals between 2017 and 2021 (ABS 2021b).



Census data reveals that of people in Gippsland who identified they speak a language other than English at home, 12.2% spoke English not well or not at all (ABS 2021b). This was fairly consistent across Gippsland, with the lowest proportion in Gippsland–South West at 10.6%, and the highest in Latrobe Valley at 13.9%.

Interpreter services

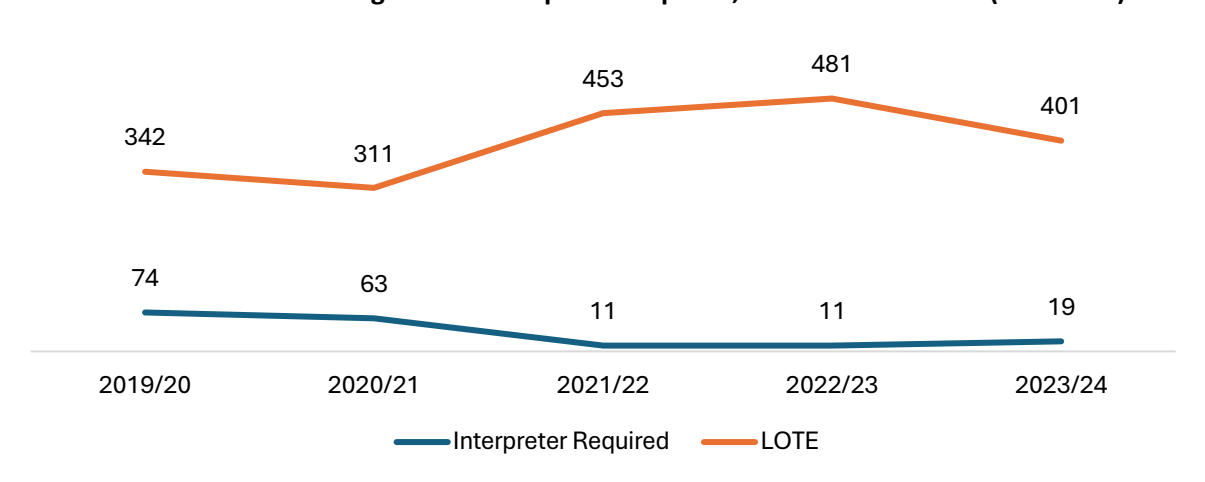
There was a total of 395 free interpreter sessions with healthcare providers, including allied health professionals, general practitioners, medical clinics, nurse practitioners, pharmacies and specialists in Gippsland in 2023-24 (Department of Home Affairs 2024a). This was a 19% increase since 2022-23 and 72% of free interpreter sessions were with a GP. The top five languages used in free interpreter sessions in 2023-24 were:

- Vietnamese (71 sessions)
- Myanmar language (alt Burmese) (55)
- Thai (55)
- Mandarin (49)
- Khmer (14)

Emergency Department (ED) presentations

The yearly number of ED presentations where the patient nominated a preferred LOTE for communication increased by 59 between 2019-20 and 2023-24 (DH 2024b). However, presentations where an interpreter was required reduced by 55, or an average annual reduction of 19%, see **Figure 125**.

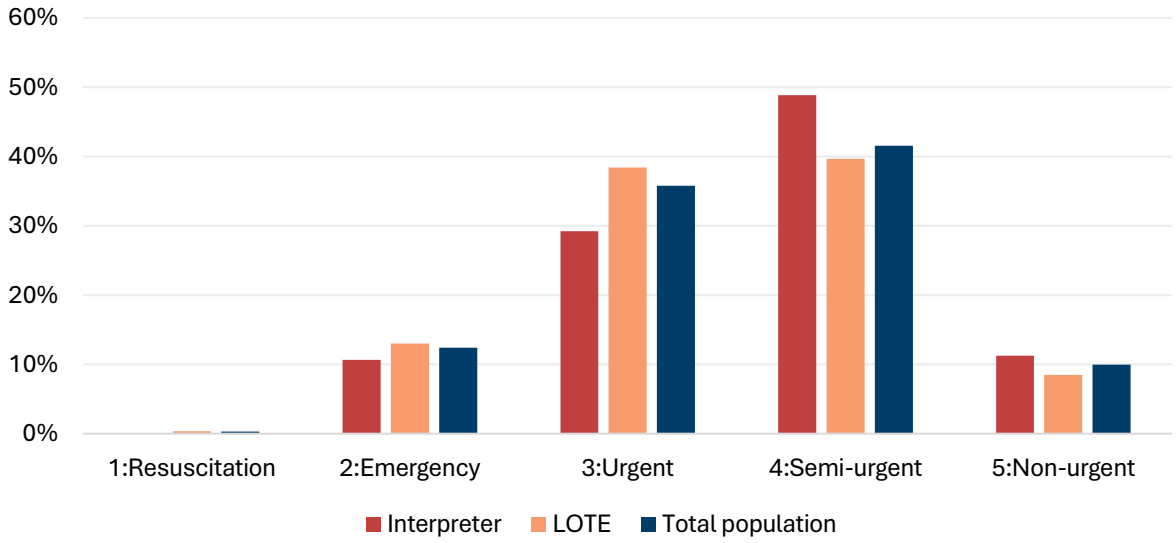
Figure 125. Emergency Department presentations for Gippsland residents with a preferred Language Other than English and interpreter required, 2019-20 to 2023-24 (DH 2024b).



More ED presentations were identified as having a patient with a preferred LOTE for communication than as using an interpreter. What this means for patients is unclear. Patients may identify a preferred LOTE while being fluent in English, but a reduced use of interpreters over time may suggest barriers to communication for some patients.

Interpreters were required 20% more often for semi-urgent ED presentations compared to those with a preferred LOTE for communication or general population (**Figure 126)**. For urgent presentations, interpreters were required for approximately 25% fewer presentations compared to those with a preferred LOTE or general population (DH 2024b).

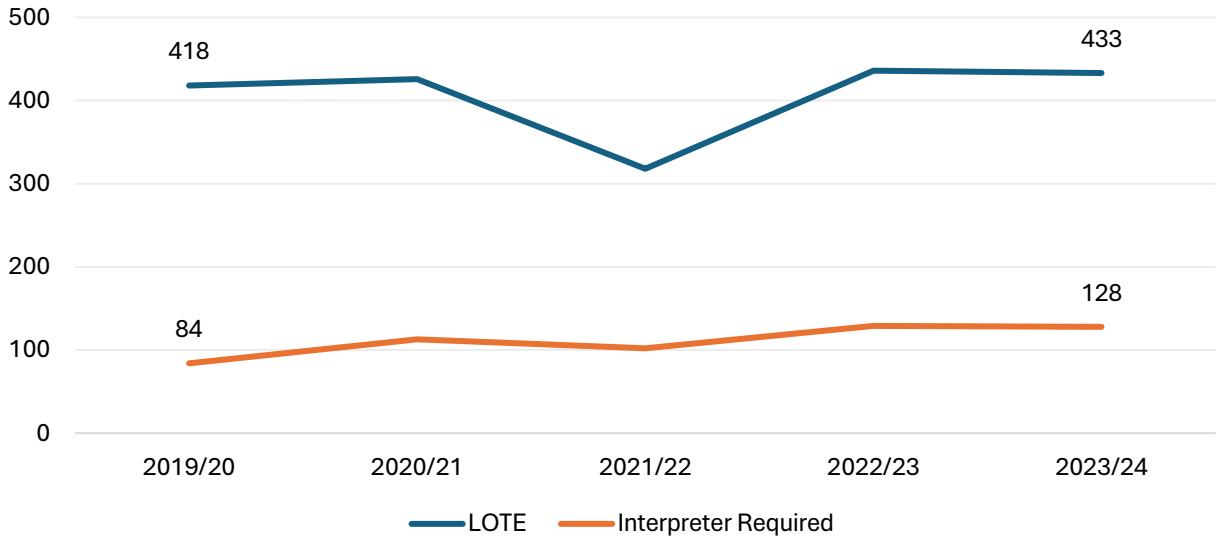
Figure 126. Proportion of Emergency Department presentations for Gippsland residents with a LOTE and interpreter compared to total presentations, by triage category, 2019-20 to 2022-23 (DH 2024b).



Hospital admissions

Hospital admissions data shows more admitted episodes for patients having a language other than English than those who required an interpreter between 2019-20 to 2023-24 (DH 2025c), see **Figure 127**. The number of hospital admissions where an interpreter was required increased by an average of 13% per year between 2019-20 to 2023-24. This contrasts with emergency presentations where there was a decrease. This may indicate that when patients were admitted to hospital there was a higher likelihood of accessing an interpreter, compared to when presenting to the ED.

Figure 127. Hospital admissions for Gippsland residents with a LOTE and interpreter required, 2019-20 to 2023-24 (DH 2024a).



Gippsland PHN Commissioned Services

Data collection varies by program, however the most commonly recorded multicultural data item is country of birth. Based on data collected by Gippsland PHN commissioned services:

- 12% of older people participating in the Early Intervention program (aged care) were born outside Australia (2023-24 to 2024-25); this was the highest proportion across programs (GPHN 2025e).
- 6% of mental health service consumers were born outside Australia (this was similar from 2022-23 until 2024-25 (GPHN 2024f).
- 6% of alcohol and other drug service consumers were born outside Australia for services between 2022-23 and 2024-25 (GPHN 2025e).

Professional Insights

Gippsland PHN gathered insights from professional stakeholders working with multicultural communities in Gippsland in 2024 and again in 2025 (see also **Stakeholder Consultation**):

- In 2024, insights about access to primary care for multicultural people in Gippsland (GPHN 2024m) were gathered via a survey, interviews and other consultations.
- In 2025 (GPHN 2025d) a survey and interviews gathered insights from providers who support multicultural communities with healthcare or broader support services. In addition, insights were gathered from general practices via practice visits.

Key themes from consultations were identified:

- **Language and communication barriers**
    - For many migrants, language barriers made it more difficult to navigate health systems, understand entitlements and rights, or connect with local communities. One neighbourhood house staff member discussed how valuable it was to be able to support a community member to fill in a medical form (GPHN 2025d).
- **Value of welcoming and inclusive health services**
    - Once community members had connected with services, a welcoming service was highly valued (GPHN 2025d). Some multicultural community members mentioned negative experiences with services where reception staff were unfriendly, abrupt or dismissive, and led them to being reluctant to return to the service. Both community members and staff from organisations noted the value of staff who were friendly and took the time to explain processes clearly.
    - Specific cultural protocols that were mentioned included (GPHN 2025d):
        - Differing concepts around mental health, including shame in discussing this with others.
        - Wanting to see providers of the same gender, particularly in relation to reproductive health.
        - Involving family members in care decisions.
        - Traditional health beliefs that may differ from western medical models.
        - Hesitation around disclosing or discussing family violence.
        - Concerns around discussing issues that could bring shame to their families (such as mental health, alcohol and other drug misuse, and family violence), especially in small communities, whether that be small towns or small ethnic groups where anonymity can be challenging.
    - The SBS Cultural Atlas (2019) was noted as a valuable free resource that can help clinicians and others be aware of potential cultural protocols for different nationalities and ethnic groups (GPHN 2025d).

- Some multicultural young people identified that they avoid seeing doctors from the same background as them. This was due to experiences of receiving care that was more aligned with traditional values, and different from what their white Australian peers would receive (GPHN 2024d).

  ''I think we need to be open to adapting our practices to cater well for all ethnic groups" (General Practitioner)

- There are few local providers of culturally competent care, especially for communities with few migrants and for recent arrivals.
- There is limited knowledge among professionals about the challenges multicultural people face and services and supports that are available. This includes:
  - Sometimes it is assumed that people will be able to understand and navigate health systems, including GPs, specialists, hospital-based specialist and emergency services.

    "No one explains … how the system works, and people are left to find out for themselves."

  - Lack of knowledge about interpreter services.
  - Lack of availability of interpreters, which is the most common reason for cancellations of interpreter services.
  - Reliance on family, friends and Google translate due to difficulty accessing interpreter services.
- Experiences of stigma, discrimination, racism and exclusion both in the general community and by providers.

  "I think that more education needs to be provided to our communities on how to accept people with a multicultural background. Especially in the regional and rural areas. There is still a lot of cultural inclusivity and safety issues in these areas."

- **Service navigation challenges, especially as a recent arrival**
  - A significant issue for new migrants in Gippsland is the "hard beginning" (Porter et al. 2024), a stage where some migrants can have an extremely difficult time adjusting to the way things work in Australia, including service navigation and use. As one interviewee observed, Australia's health system can be challenging to navigate for those who were born here and speak English as a first language, let alone those who have only just arrived and/or may be less than proficient in English (GPHN 2025d).
  - Competing priorities for recent settlers (GPHN 2024m).

"As a migrant who is trying to get set up in a new country there are so many things you need to spend money on. All this needs to happen on a smaller than average wage because when you have just moved you're often on a low income even though you work harder than most, you don't know the system and there is so much to sort out."

- Social isolation is common, especially when newly arrived

  "…it can be very lonely in a new country, and you have little time and energy left after doing all the necessary things."

- Many of the organisations interviewed identified the importance of organisations outside of the health system for supporting migrants and linking them with services (GPHN 2025d). Staff at English classes and neighbourhood houses had supported new migrants to find appropriate services. Organisations identified that it was through building trusting relationships that people felt comfortable to ask for help when they needed it.
- Anxiety, distrust and fear of government services, most common among humanitarian arrivals (GPHN 2024m).
- A different cultural understanding of health can mean late presentations or avoidance of seeking help for sensitive issues such as reproductive health (GPHN 2024m).

- **Visas as a service access challenge**
  - The visa system, and entitlements that come with these, can cause confusion for visa holders and health professionals. For many visa holders, private health insurance is required or strongly recommended when Medicare is unavailable due to visa type (DHA 2024b). However, people can still find themselves without access. Temporary and bridging visas restrict access to Medicare (DHA 2025b) and other services (GPHN 2025d).
  - Access to other services outside of healthcare can also vary depending on visa type, including access to housing support and legal protection such as family violence services (Australian Red Cross 2022). One interviewee from an organisation that provides food relief, stated they operate their service without the need to show a healthcare card in order to avoid migrants being excluded (GPHN 2025d).
  - Interviewees also discussed instances where those on visas did not understand their entitlements (GPHN 2025d). This knowledge gap is often heightened by language barriers, low health systems literacy and limited access to translated materials (Peprah, Lloyd & Harris 2023). As a result, individuals may avoid engaging with services due to financial costs or misinformation.
- **Limited use and knowledge of interpreter services**

- It was common for practices to identify they had never needed to use interpreter services. Those who had overwhelmingly said they had used TIS National, and that the service was easy to use (GPHN 2025d).
- More often, services were delivered in language by general practitioners (GPHN 2025d). Many clinics advertised their doctors' languages on their website, and found patients booked in with them specifically for this reason. One clinic had a total of 12 languages available through multilingual staff.
- Many clinics identified that multicultural patients often had friends or family members interpreting for them (GPHN 2025d). While this may be the preference for some people, there are significant risks posed when patients are not able to speak for themselves or understand medical information themselves.
- Language and communication issues impact ability to communicate needs and understanding responses, sometimes leading to misunderstandings and poor use of appointment times (GPHN 2024m).

- **Other significant themes included**:

  Consultations identified additional themes compared to the earlier literature review, and as such additional references have been used in some sections below to expand on what participants shared.

  - Family violence
    - When discussing who the most vulnerable multicultural populations might be, many interviewees described women who had come to Australia on a family visa to be with their husband, lived out of town, may not be able to drive or have access to a car, may not know anyone in Australia, and/or may not speak English well or at all (GPHN 2025d).
    - Visa abuse had been observed, where someone's temporary visa status is used to control their behaviour (AIHW 2024i). Interviewees shared situations they had witnessed where a male perpetrator had threatened to cancel his partner's visa to control her behaviour (GPHN 2025d), despite this not being something he has the legal power to do (Women's Legal Service Victoria n.d.).
    - People from multicultural communities may be exposed to additional risk factors for family violence, or different barriers for accessing support (AIHW 2024i). These include:
      - language barriers

- temporary or dependant visa status
- lack of support networks
- lack of culturally appropriate information or services
- distrust for authorities because of pre-settlement experiences
- backgrounds where it is the norm for family violence to not be acknowledged, or where family violence is dealt with in the family

- Employment
  - In many cases, employers make significant efforts to support their migrant workers to be connected in the community (GPHN 2025d). This included connecting staff with health services, as well as accommodation and community groups. For some working arrangements, such as the Pacific Australia Labour Mobility (PALM) scheme, this is a requirement, and employers are required to appoint a welfare and wellbeing officer to support employees (PALM 2024).[15] Interviews also highlighted cases where workers were not supported and PALM workers can find themselves with no health cover if they need to leave their employer. Research also shows that migrant workers are 40% more likely to experience workplace exploitation than Australian workers (IARC 2024).
  - Financial stress and vulnerability due to unstable work have flow on effects both in terms of time constraints, transport issues and inability to pay gap fees.
- Refugees and people seeking asylum often have added barriers impacting health (GPHN 2024m), including:
  - High burden of disease and illness combined with poor and interrupted healthcare, extreme living conditions and marginalisation
  - Restricted eligibility for Medicare, Health Care Card and other supports
  - Social determinants such as low income, job insecurity, housing and risk of exploitation
  - Mental health impacts of war, trauma, torture, loss/separation from family and prolonged uncertainly about visa processing
- Homelessness among the multicultural community is a hidden problem linked to low income, isolation and disconnection from community.

The Victorian Multicultural Commission Regional Advisory Council identified priority issues for Gippsland, which include the following:

[15] The Pacific Australia Labour Mobility (PALM) scheme allows eligible Australian businesses to hire workers from 9 Pacific islands and Timor-Leste when there are not enough local workers available. There is an un-known number of workers on the PALM scheme in Gippsland.

- Barriers accessing mental health and suicide prevention services and supports
- Racism
- Lack of culturally appropriate family violence services
- Lack of community spaces to meet and organise events
- High reliance on CALD volunteers in community organisations
- Education and training to allow migrant to use their skills

Gippsland health professionals have reported instances of migrants without access to Medicare, and the barriers this creates for health care provision, including for issues such as Hepatitis B (GPHN 2025e).

Community Insights

A Gippsland PHN interview study (GPHN 2024c) gathered insights from 29 people with a multicultural background, either recent or historic, and participants included both older people and young people. Key themes from the broader engagement can be found in the **Community, consumer and carer** section of this chapter. Main insights from people with a multicultural background include:

Access to services

- New arrivals have significant barriers in accessing services and understanding the system.

  …it is really hard for them to make an appointment. [Referring to recent arrivals]

  "…we need to have the welcoming pack…how to set up Medicare, how to enrol your child into kindergarten or school." (Multicultural community member)

  "When I arrived I didn't know the Ambulance service needed a subscription – someone has to tell people this. You don't know how school, health or anything works when you arrive." (Multicultural community member)

  "Oh, we bulk bill the – the children but not adults…I didn't know that." (Multicultural community member)

- Appropriate services and supports for multicultural people are often not available in Gippsland.
    - A lack of culturally safe services can lead to people staying home even if they need care (often getting isolated, challenges with safety, food, language)
    - People with visa issues experiencing family violence don't access services and are very isolated
    - Consider carers coming to Australia from overseas; some may have family violence issues and are not accessing services easily
    - Some people react differently to people in uniform, and can find Ambulance or Victoria Police uniform terrifying

- Also examples of models that work: *"…they've [the school] … got a nurse … onsite. They go by what the community wants…which is really good." (Community member)*

- Cost is a major barrier for multicultural people

  "It's really hard to get into the GP lately… some GP clinics don't bulk bill Medicare." (Community member)

- Interpreting services may not be offered and when they are they may not be appropriate.

  "… there was a change where they said that we can't use family members as interpreters anymore ... but then, it's a struggle again because these interpreters speak a different dialect … so it's hard to understand them." (Community member)

Multicultural experiences

- Young multicultural people have some unique challenges trying to navigate two cultures.

  "But you need to, like, prioritise yourself and your health too. They [parents] didn't grow up with that, and so they expect us to do the same." (Multicultural young person)

- People have experienced that regional areas can have more problems with racism than metro areas.

  "Migrants have to work 10 times harder, they don't take advantage of the Australian system (as some people think)." (Community member)

Disability

National Context

Disability includes those who have long-term physical, mental, intellectual or sensory impairments that, in interaction with various attitudinal and environmental barriers, may hinder their full and effective participation in society on an equal basis with others (State Government of Victoria, Disability Access and Inclusion Plan 2021–2025). Disability can be permanent or temporary, visible or invisible. Some conditions and impairments are present from birth while other people acquire or develop disability during their lifetime from an accident, condition, illness or injury. For some people, support requirements can increase over time while others can experience fluctuating or episodic disability. Some people may experience multiple disabilities, giving rise to different support requirements.

Neurodiversity is the umbrella term used to describe the neurological ways that people process information. This includes all those who are neurodivergent as well as neurotypical people. Being **neurodivergent** is when the neurological ways information is processed in our brains is different from the majority population. This includes people whose thought patterns, behaviours, or learning styles fall outside of what is considered neurotypical, including Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) (ADN 2024).

National data

National figures from the 2022 Disability, Ageing and Carers Survey show (ABS 2024g):

- **Disability Prevalence**: 21.4% of Australians estimated to be living with disability in 2022, up from 17.7% in 2018.
    - Several factors are likely to have contributed to the increase: growing awareness, increased prevalence of long-term health conditions, an ageing population and an online survey offered for the first time in 2022.
    - Increasing with age: 6% of children (0-4 years) to 83% of people aged 90+.
- **Types of Disability**: For 75% of people living with a disability, the main form was physical (down from 77% in 2018), while 25% reported a mental or behavioural disability as their main condition (up from 23% in 2018).
    - The most common physical conditions were arthritis (12%) and back problems (12%)
    - The most common mental and behavioural conditions were:
        - psychological development, behavioural, cognitive and emotional conditions (9.4%), such as Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder (ADHD), an increase from 6.9% in 2018.
        - anxiety disorders (7.4%), such as generalised anxiety, phobias, panic attacks, obsessive compulsive disorders, and post-traumatic stress disorder, an increase from 6.1% in 2018.

    - Those with a profound or severe limitation were more than twice as likely to report a mental or behavioural disorder (31.7% compared to 16.2% for those with a moderate or mild limitation).
- **Disability Discrimination**: 10% of people living with disability aged 15+ had experienced discrimination, with some groups more likely:
    - 18% of young people (15-34 years)
    - 19% of people living with a profound or severe limitation
    - 28% of LGB+ people living with disability
- **Avoiding Situations**: 35% of people living with disability avoided situations because of their disability in the past year.

Other national data show (AIHW 2024):

- **Health Ratings**: Only 31% of people living with a disability rate their health as excellent or very good, compared to 68% of those without a disability.
- **Psychological Distress**: 33% of adults living with a disability experience high or very high psychological distress, compared to 12% of adults without a disability.
- **Social isolation**: 19% of people living with disability aged 15-64 experienced social isolation, compared to 10% of people without a disability.
- **Education and skills**: 10% of school students (5-18 years) live with a disability.
    - Generally lower educational attainment
    - 31% of students living with disability do not receive support or too little support at school
- **Employment**: 48% of people aged 15-64 living with a disability were employed, compared to 80% of people with no disability.
- **Chronic conditions**: Some chronic conditions may be associated with a high likelihood of disability. For people who have experienced a stroke, 64% live with a disability, with the following conditions also associated with a high proportion of disability: arthritis (54%), back problems (52%), coronary heart disease (44%).

Substantially **higher mortality** for people living with a disability compared to without (Yang et al, 2025):

- the largest number of excess deaths were due to cancer and cardiovascular disease
- the greatest difference in mortality rates was for neurological conditions, chronic lung disease and diabetes (ranging from 5-12 times higher)
- deaths from unintentional injuries and suicide were 2-4 times higher among people living with a disability
- results suggest prevention, diagnosis and treatment are less accessible for people living with a disability

96.8% of people living with a disability reside in private dwellings (ABS 2024g), with 3 in 5 of this group needing help with at least one daily activity.

47% of adults living with disability had experienced violence after the age of 15 years (AIHW 2024m).

Australia's Disability Strategy 2021–2031 (Commonwealth of Australia 2024) sets out a plan for improving the lives of people living with disability. Seven outcome areas are identified and within Health and Wellbeing, priority areas and outcome measures include:

- All health service providers have the capabilities to meet the needs of people with disability, including safe access
- Prevention and early intervention, including regular health assessments to address:
    - Avoidable emergency presentations
    - High rates of smoking, sugary drink consumption and alcohol consumption
- Mental health supports and services; "*People with disability continue to experience poorer mental health, including higher rates of anxiety and depression, than people without disability*."
- Disaster preparedness, risk management plans and public emergency responses are inclusive of people with disability, and support their physical and mental health, and wellbeing

The **National Autism Strategy 2025-2031** (Australian Government 2025) takes a neurodiversity-affirming approach, valuing and respecting all neurotypes. It seeks to promote safety, understanding, acceptance and appreciation of neurodiversity and highlights that the need for change sits with society as a whole. Four key outcome areas:

- Social inclusion
- Economic inclusion
- Diagnosis, services and supports
- Health and mental health, including suicide prevention - via the National Roadmap to Improve the Health and Mental Health of Autistic People 2025-35 which identifies some key outcomes including:
    - Autistic people are welcomed and supported in all health and mental health settings
    - Health and mental health services are better able to support people transitioning between services
    - Health and mental health professionals capably address and understand the health needs of autistic people and intersecting needs with priority populations

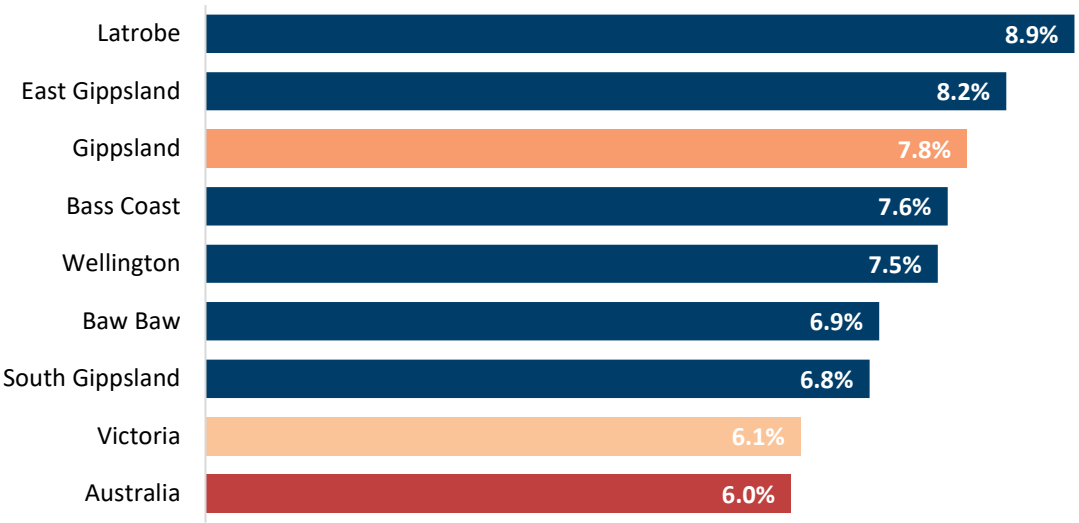
There are **data challenges** with existing data sources including (AIHW 2024m):

- inconsistent definitions of disability across data sources
- poor adoption of a disability flag to identify people with disability across mainstream data sources
- fragmented, dispersed and incomplete data about services used by people with disability limited integration of data across settings to examine pathways and outcomes

Gippsland data

In Gippsland, over 65,000 people live with a disability (based on a national prevalence of 21.4%). However, we know that Gippsland has the second highest proportion of people (7.8%) with a severe or profound disability of all PHN regions nationally. See **Figure 128** for comparison of Gippsland LGAs to Victoria and Australia. Within Gippsland, 35,859 people, or 14.4% of people 15 years or older, provided unpaid assistance to a person living with a disability – this is the highest proportion of Australia's PHN regions (ABS 2021a). See Carer Health and Wellbeing for more information on the health of carers.

Figure 128. People with severe and profound disability (all ages), 2021 (ABS 2021a)



Services and supports:

- 8.0% of people aged 16-64 years receive a Disability Support Pension (PHIDU 2024b); higher than 4.4% in Victoria
- 3.1 NDIS participants per 100 population in 2023 (age-standardised) (PHIDU 2024b); Gippsland had the 5th highest rate of PHN nationally and higher than 2.5 participants per 100 population in Victoria
    - 8,825 NDIS participants across Gippsland
    - Highest in Latrobe (3.8) and lowest in Bass Coast and South Gippsland (2.5)
- 4% of general practice patients in Gippsland had an active disability diagnosis (GPHN 2025a), with the most common disability diagnoses being:
    - Autism Spectrum Disorder (ASD) – 1.5% of all patients
    - Intellectual functioning disability – 0.5% of all patients
    - Parkinson's disease – 0.3% of all patients
- Gippsland PHN commissioned mental health services recorded (GPHN 2024f):

- 9.9% of episodes where the consumer received the disability support pension in 2024-25, up from 8.3% in 2022-23 and 8.9% in 2023-24
- 2.4% of episodes where the consumer was a NDIS participant in 2024-25, down from 2.9% in 2022-23 and 2.5% in 2023-24

Needs identified in Gippsland based on stakeholder consultations include (GPHN 2024e and 2025b):

- Disability workforce shortages
- A need for increased skills for healthcare staff working with people living with disability
- Getting support is hard and requires navigating a complex system
- People living with disability are some of the most frequent users of health services, but 70% experience significant barriers accessing required services
- Social isolation is especially problematic for people living with a disability who also experience housing and employment concerns
- Mental health is the most common co-occurring health issue and often not well serviced
- People living with disability were most likely to report a health problem that had not been well managed (44% compared to 22% of all respondents)
- People living with disability were least likely to think they can get the help they need if they had a health issue (26% compared to 10% of all respondents)
- People fall through the gaps if they don't fit into the categories or eligibilities of the system
- More support is needed to look after carers
- Concerns related to changes to the NDIS were raised in 2025, including:
  - Ongoing support for children with autism
  - Cuts in funding for allied health leading to inability to offer home visits

"It is not the inability to walk that keeps a person from entering a building by themselves but the stairs that are inaccessible that keeps a wheelchair-user from entering that building" (Community member)

"Treat us as humans as we are entitled to be heard, shown respect and offered dignity" (Person living with disability)

"… carers are often overlooked by practices … they don't usually ask or make appointments for the same day." (Community member)

"It is as if it [NDIS] has been set up to be hard to access." (Community member)

LGBTIQA+

National context

The term LGBTIQA+ refers to Lesbian, Gay, Bisexual, Transgender, Intersex, Queer / Questioning, Asexual and other individuals who identify outside of traditional gender and sexuality norms and is used throughout this document for consistency. An estimated 4.5% of the population aged 16 years and over are LGBTIQA+ based on Australian Bureau of Statistics data from four surveys (ABS 2024i). The proportion of people who are LGBTIQA+ is highest among young Australians and lowest in older Australians, with 10% of 20–24-year-olds estimated to be LGBTIQA+. It is noted that the estimates are subject to limitations and error and should be used with caution.

There is enormous diversity within LGBTIQA+ communities, with different communities facing different challenges, such as trans and gender diverse people. Other experiences are shaped by intersectionality, such as Aboriginal and/or Torres Strait Islander peoples. LGBTIQA+ people are more likely to face stigma and discrimination, are at a higher risk of poor mental health and suicidal behaviours, and need improved and safe access to appropriate services with a well-trained workforce (AIHW 2025c).

In 2024, Australia's first 10 Year National Action Plan for the Health and Wellbeing of LGBTIQA+ People was released (DHDA 2024). To achieve its vision of equitable health and wellbeing outcomes with access to safe, respectful, high-quality and inclusive health and wellbeing services for LGBTIQA+ people, the plan identifies the following areas for focus:

- Build system wide leadership and cultural change
- Strengthen preventive health, protective factors and build health literacy
- Enhance accessibility, availability and safety of healthcare services
- Ensure workforce capability and capacity across both mainstream and LGBTIQA+ led services
- Improve research, data and evaluation

The Writing Themselves In survey (Hill et al. 2021) surveyed 6,418 young LGBTIQA+ people in Victoria in 2019. Participants were aged between 14 and 21. The survey found that:

- Less than half talked about their sexual identity or gender identity
- 42% experienced verbal harassment
- 23% experienced sexual harassment
- 10% experienced physical harassment
- 81% experienced high or very high psychological distress in the past four weeks
- 24% had attempted suicide. This was 48% in the transgender community according to a national survey

Research shows that LGBTIQA+ people in rural areas face additional challenges and poorer health outcomes than both their rural non-LGBTIQA+ counterparts, and their metro LGBTIQA+ counterparts (Pride Foundation Australia 2025). This includes being more likely to experience the following:

- greater feelings of isolation
- being unsafe
- feel less valued
- have less trust
- feel greater isolation from friends and neighbours
- higher levels of verbal or physical discrimination or harassment and assault
- higher levels of family and intimate partner violence
- lower levels of support in educational institutions for LGBTQA+ young people
- lower household incomes and higher unemployment
- a greater likelihood of experiencing homelessness
- twice the likelihood of experiencing food insecurity.

Health Impacts

The stigma and discrimination outlined above have a significant impact on health and wellbeing, as well on people's access to healthcare. As one Gippsland health professional observed (GPHN 2025b):

> *"We had instances where patients would tell us they couldn't talk to their GP about serious health issues, because their GP didn't know they were gay, and they couldn't come out to their GP because they were scared of being discriminated against." - Gippsland Health Professional*

It is important to note that LGBTIQA+ people are not one homogenous group, and that different groups and people have different experiences and needs (DHDA 2024).

Due to Gippsland demographics, the following groups may be more common:

LGBTIQA+ people experiencing family violence

- Gippsland has some of Victoria's highest rates of family violence (see **Family Violence**). LGBTIQA+ people experience family violence at similar rates to cisgender, heterosexual women in the general population (Qlife 2022a).
- Of people completing the Private Lives 3 Survey 2020, more than 2 in 5 had experienced intimate partner violence, and almost 2 in 5 had experienced family violence perpetrated by an immediate family member (Qlife 2022a). 70% of this was from parents, 30% from older siblings.

- Family violence can include LGBTIQA+-related abuse, such as threats to out someone based on their identity or HIV status, verbal abuse around identity, or withholding hormones or medication (Qlife 2022a).
- LGBTIQA+ people are often not represented in discussions and information relating to family violence, and as such sometimes may not realise what is happening to them is family violence. Health providers naming their experience as family violence can help support people to understand their experiences and make decisions around their safety (Qlife 2022a).

Older LGBTIQA+ people

- Older LGBTIQA+ people have experienced historical and modern forms of discrimination, including times where significant legal discrimination, and physical and verbal abuse was widespread (Qlife 2022b). This can impact mental health, and fears of discrimination that may be experienced when accessing health services.
- Older LGBTIQA+ people may fear disclosing their gender, sexual orientation or intersex status variation when entering aged care (Qlife 2022b). This can lead to an increase in suicidal ideation or preference for voluntary assisted dying.
- Loneliness and isolation may occur in older LGBTIQA+ people (Qlife 2022b). Older transmen, transwomen, and non-binary people are more likely to experience estrangement from family after transitioning. Older gay, bisexual/pansexual and queer men are also noted as being more likely to experience loneliness and disconnection from community.

LGBTIQA+ people with disability

- Research shows LGBTIQA+ people with a disability experience increased discrimination and reduced access to services when compared with heterosexual people with a disability, and LGBTIQA+ people without a disability (Qlife 2022c). It is important for LGBTIQA+ services to be accessible and inclusive for those with disabilities, and for disability services to be accessible and inclusive for LGBTIQA+ people.
- Stereotyping can result in the perception that that people with a disability have no sexual desires at all, resulting in assumptions around sexuality and gender from service providers.

LGBTIQA+ people living in rural areas

- Social isolation is a particular risk for LGBTIQA+ people in rural and regional areas (Qlife 2016). This can be due to lack of community awareness about LGBTIQA+ people's lives, or active discrimination and exclusion.
- Fear of discrimination and privacy concerns can prevent LGBTIQA+ people in rural and regional areas from accessing health services (Qlife 2016). This can include concerns around accessing services where relatives, colleagues, or friends work.

- There can be a lack of LGBTIQA+ specific or inclusive services in rural areas (Qlife 2016). Increasingly, many rural communities are developing services that are specific to LGBTIQA+ communities, or are inclusive of LGBTIQA+ people. Many health services, youth groups, and other inclusive spaces act as gateway services that can support people in accessing expert providers.

For many LGBTIQA+ communities, it is important to keep in mind that collection of identifying information has historically been used to cause harm (Qlife 2022a). In small communities, this information can identify or out people. As such it is important for health professionals and other services to be mindful of what information is being collected and shared, why it is being asked for, and to do so with consent. This includes information around gender, sexuality, pronouns, and what name they use.

For LGBTIQA+ Victorians, the Pride in our future: Victoria's LGBTIQA+ strategy 2022-32 (DFFH 2022) highlights some key statistics:

- 43% had experienced abuse within an intimate relationship
- 38% were abused by a family member
- 34% felt discriminated against or were treated unfairly by others in the last year
- 36% faced social exclusion in the past year
- 21% experienced homelessness

Health issues are more common among LGBTIQA+ people when compared to the general population (DFFH 2022):

- 2.1 times as likely to have a disability or long-term health condition (38% v 18%)
- 1.7 times more likely to be diagnosed with anxiety or depression by a doctor (45% v 27%)
- 2.2 times more likely to have sought professional help for a mental health problem in the previous year (37% v 17%)
- 4.2 times more likely to have had high or very high levels of psychological distress in the past four weeks (54% v 13%)
- 18% struggled to manage their alcohol use
- Higher risk of suicide and self-harm, especially among young people
- More people in rural and regional areas rated their health as fair or poor
- People who also had a disability and/or a multicultural background were more at risk

Pride Foundation Australia (2025) identifies that rural LGBTIQA+ people are more likely to experience the following health issues:

- two or more chronic illnesses
- poorer life satisfaction
- lower acceptance rates in the community and at health care services, particularly when visiting a GP
- mental health conditions (including anxiety or depression)
- higher psychological stress (including youth and during the COVID pandemic)
- greater difficulty accessing inclusive mental health services
- higher suicide risk, with both LGBTQA+ adults and youth experiencing substantially higher suicide ideation and suicide attempts
- higher tobacco smoking, alcohol and illicit drug consumption rates, and alcohol and other drug (AOD) harm
- reduction campaigns are less likely to be LGBTQA+ inclusive
- poorer dental health.

Gippsland data

The Gippsland Rainbow Brick Road Report (Porter, Reeves & Prokopiv 2023) was carried out in Gippsland in 2022. 184 surveys were received, and 119 people registered to attend professional development workshops across each Gippsland LGA. The report found that:

- 67% had concerns or serious concerns for their mental health
- 30% had concerns or serious concerns about their physical health
- 25% felt that they did not have access to general health and medical services in their immediate location
- 53% were accessing general and medical services outside their immediate area
- 45% were not able to access mental health support in their immediate location
- 25% had experienced discrimination, harassment or mistreatment when seeking medical attention or support

Stakeholder feedback suggests that there are a range of improvements that could be made to improve the health and wellbeing of the LGBTIQA+ community in Gippsland (GPHN 2024e):

- Access to regionally based gender affirming care
- Education and training for health professionals to increase access to evidence-based clinical practice
- Mental health services are tailored to meet the needs of the LGBTIQA+ community
- Suicide and self-harm prevention initiatives are developed and implemented for the LGBTIQA+ community
- Services including abortion and cancer screening are accessible, welcoming, safe and inclusive

- Embed LGBTIQA+ voices in all health and wellbeing planning and co-design
- Build a peer workforce

Additional feedback from stakeholders in Gippsland include (GPHN 2025b):

- Difficulty finding a supportive local GP
- Lack of continuity of care impacted by GPs moving and difficulties transferring medical records

  "… people become disconnected [from GP] and have to start again." (LGBTIQA+ community member)

Pride Foundation Australia (2025) identifies the significant issue that because data sources used in health planning by rural health services often do not include data on LGBTIQA+ health and wellbeing, services often do not plan for LGBTIQA+ health and wellbeing. However, the organisation's report, The Health & Wellbeing of LGBTIQA+ People in Rural Australia, also identifies that LGBTIQA+ health data at this level is not necessary for local health care planning due to the well documented data available on LGBTIQA+ health and wellbeing more broadly. This report includes recommendations for rural health service providers, including Shire Council health and aged care services.

Poverty

Poverty has a significant impact on people's health. The social gradient is a widely understood concept in public health, where the lower someone's socio-economic position, the poorer the health is expected to be (WHO 2013).

Poor health can also increase the risk of experiencing poverty (Callander, Fox & Lindsay 2019). This can be due to reduced ability to work, or with costs associated with treatment. This is also the case for mental health, where mental health issues increase risk of poverty and poverty increases risk of mental health issues (Australian Parliament 2024).

National Context

There are several definitions of poverty. One definition that the Australian Council of Social Service (ACOSS) uses is 50% or below of median income (Davidson, Bradbury & Wong 2023). In 2022, this poverty line was $489 a week for a single adult, or $1027 a week for a couple with two children. An estimated 13.4% of people experience poverty in Australia, with a higher rate of 16.6% among children.

Over time, the poverty gap—the difference between the average income of all people in poverty and the poverty line—has widened (Davidson, Bradbury & Wong 2023). In 1999, this gap was $168 a week, increasing to $291 in December 2019, and reaching $310 by June 2020.

Just over half (50.8%) of households experiencing poverty in Australia have government pensions and allowances as their main source of income (Davidson, Bradbury & Wong 2020). This includes Newstart Allowance, where in 2020 56.9% of recipient households experienced poverty, the parenting payment where 54.3% experienced poverty, the disability support pension where 41.1% experienced poverty, and the age pension where 14.7% experienced poverty. However, 37.8% of households experiencing poverty have wages as their main source of income. This is known as waged poverty (South Australian Council of Social Services 2024).

Health impacts

Poverty impacts health and wellbeing in a variety of ways (Australian Parliament 2024):

- Food insecurity with missed meals and inadequate nutritional intake
- Barriers to managing diet and physical health
- Negative impact on children's physical health and development
- Chronic health implications, including insufficient resources to manage chronic illness
- Not being able to afford medical appointments
- Not being able to afford medication
- Barriers to accessing to culturally safe health services for Aboriginal and Torres Strait Islander people

- Increased risk of poor mental health due to the stresses of continually living in 'survival mode'
- Increased risk of poor mental health due to stigma against people who experience poverty or receive income support

Gippsland data

In Gippsland, 23.3% of people have a weekly household income of less than $650, which is higher than the Victorian average of 16.4% (ABS 2021a). Additionally, 52.2% of households in Gippsland fall into the bottom 40% of the income distribution, compared to the Victorian average of 40.9% (ABS 2024a).

In 2023, 8.0% of 0-64 year olds in Gippsland were healthcare card holders, compared to 6.0% across Victoria. Gippsland had the third highest rate of Australia's PHNs (PHIDU 2025a).

Gippsland PHN GP Data

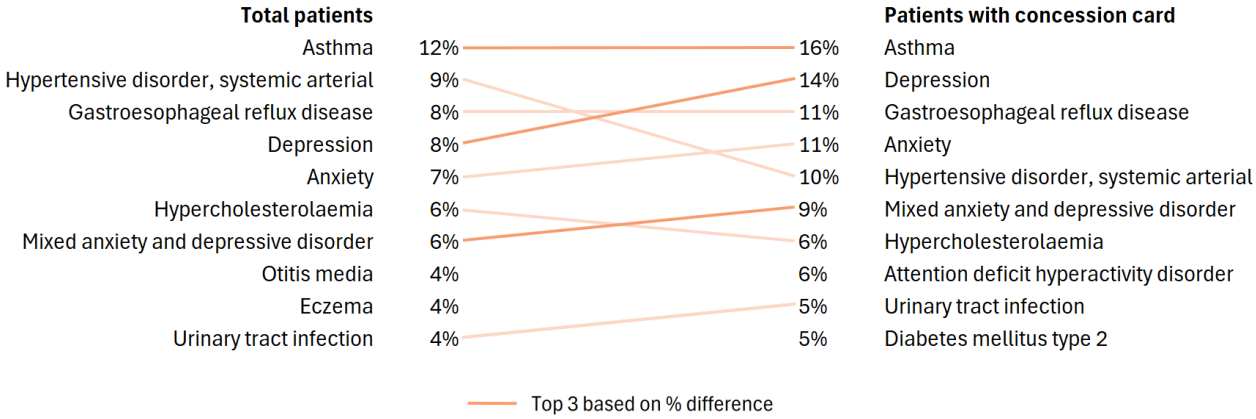
For this analysis, concession card status has been used as an indicator of lower income. This is not a perfect proxy, but can help in understanding the needs of patients, as pension and concession card holders have some of the lowest incomes (PHIDU 2025a).

In Gippsland, 44% of general practice patients had a concession card (GPHN 2025a). This was 29% of patients under 65, and 76% for those over 65. Women were slightly more likely to have a concession card, with 46% of females having one and 42% of males.

The top diagnoses among Gippsland general practice patients aged under 65 years with a concession card were compared to total patients (see **Figure 129**). The largest differences in prevalence of diagnoses were:

- **Depression**: 14% of those with a concession card, compared to 8% for the total population.
- **Mixed anxiety and depressive disorder**: 9% of those with a concession card, compared to 6% for the total population.
- **Asthma**: 16% of those with a concession card, compared to 12% for the total population.

Figure 129. Comparison of top 10 diagnoses among Gippsland general practice patients with a concession card to total patients, patients with activity in 2024-25 aged 0-64 years (GPHN 2025a).



Gippsland PHN Commissioned Services

Data collections vary by program with the below data items available for mental health service consumers (GPHN 2024f):

- 15% of mental health service consumers were unemployed (this was similar between 2022-23 and 2024-25)
- 28% of mental health service consumers had a Health Care Card in 2024-25; down from 36% in 2023-24 and 40% in 2022-23

Stakeholder feedback has identified improvements that could be made to the health and wellbeing of people experiencing poverty (GPHN 2025b):

- Stronger connections are needed between welfare and mental health services and programs
- A need for ongoing funding for psychosocial support initiatives
- A growing number of people accessing food support

Contact with Justice System

National context

People who are or have been in prison are some of the most marginalised members of society, often coming from disadvantaged backgrounds and experiencing high healthcare needs (AIHW 2023c). Of people entering prison:

- 73% used illicit drugs in the past year
- 51% had a history of a mental health condition
- 31% had an education level of year 9 or below

In addition, 48% of people being released from prison expected to be homeless (AIHW 2023c).

Many people are in prison for short periods, and many enter and exit the system multiple times. Therefore, their health is an important part of public health. (AIHW 2023c).

There was a total of 5,918 **prisoners in Victoria** in 2024 (ABS 2024h), and Victoria had the lowest rate of prisoners per population in Australia (108 per 100,000 population compared to 208 in Australia):

- 95% were male
- Median age of 37 years
- 12% were Aboriginal and/or Torres Strait Islander
- 66% were sentenced; 34% un-sentenced (can also be referred to as on remand or in custody)
- 52% had a prior imprisonment

The **youth justice system** varies by jurisdiction (AIHW 2025b). It deals with young people who commit or allegedly commit a crime when they are old enough to meet the minimum age of criminal responsibility (in Victoria the age will be raised from 10 to 12 years 30 September 2025).

Health services for people in prison are the responsibility of state and territory governments (AIHW 2023c). In Victoria, a discharge summary is developed for the prisoner before leaving (Corrections Victoria 2025).

Health impacts

People in prison often have complex, long-term health needs (AIHW 2023c) and the health of people in prison is so much poorer than that of the general population that people in prison are often considered to be elderly at ages 45–55.

Young people

Adolescence (10–19 years) is a period of increased sensitivity to both positive and negative experiences (AIFS 2025), meaning children and young people are particularly vulnerable. It has been shown that:

- The earlier a child comes into contact with the youth justice system the more prolonged their contact with this system is likely to be.
- Those in the youth justice system have an increased risk of premature death from largely preventable causes, such as suicide and transport accidents.
- Children who are diverted away from the youth justice system, and are provided with appropriate health and social supports, are less likely to reoffend.

Many vulnerable young people under youth justice supervision are involved with other services (AIHW 2025b):

- 65% had received a child protection service
- 33% received alcohol and other drug treatment services (ages 10-17 years), compared to 1% in the general population

A linked data study in Queensland has found that youth with contact with the justice system are at increased risk of premature death and poor health (Kinner 2025). There was a dose-response relationship with greater involvement associated with a higher mortality rate. The author concludes that "*These young people need our help and support, both during and, critically, after contact with the criminal justice system*".

Health issues

People who experience incarceration often have poorer health than the general population with elevated rates of multiple conditions. Health challenges are often compounded by multiple, intersecting experiences of social disadvantage—such as poverty, unstable housing, trauma, racism, and unemployment—and structural and systemic inequalities (Pellicano 2025). Elevated rates among incarcerated people have been identified for (Stewart et al 2020, Trofimovs J et al 2023, Meurk et al 2020, Wang et al 2019):

- **Mental illness** and/or **high psychological distress**, often in combination with additional health issues including substance dependence
    - **Suicide** had been attempted by 23% of 14-17 year old survey respondents (Meurk et al 2020), or 6 times higher than the general population
    - **Two or more mental disorders** experienced by 33% of 14-17 year old survey respondents (Meurk et al 2020)
- **Cognitive disabilities**, including intellectual disability
- **Substance use disorders**
- **Chronic conditions**
- Bloodborne and other infectious disease, including Hepatitis C
- Non-sexual **abuse** had been experienced by 75% of 14-17 year old survey respondents (Meurk et al 2020)

- **Head injury** that resulted in loss of consciousness had been experienced by 44% of 14-17 year old survey respondents (Meurk et al 2020)

A high risk of hospitalisation and death immediately following release from prison has been documented (Wang et al 2019).

Barriers to accessing healthcare for people with contact with the justice system

Multiple and significant barriers can result in a fragmented system where people with the most complex needs receive the least coordinated care. Structural and systemic barriers can hinder equitable access to basic needs and can lead to a cycle of poor health and disadvantage (Pellicano et al 2025).

- **People transitioning from incarceration back into the community** face extensive barriers to accessing timely, appropriate, and culturally safe healthcare. While prisons provide some access to health services, these are often limited in scope and disconnected from community-based primary care systems (Pellicano et al 2025). Upon release, gaps in continuity of care are common (Jennings et al 2021). This can result in people cycling in and out of prison and this has traditionally not been addressed in the primary care setting (Wang et al 2019).
- **Lack of integration** between justice, health, and community support sectors for people with co-occurring mental health and substance use issues, particularly youth, who frequently fall through the cracks between siloed service systems (Steele et al 2021; Meurk et al 2020, Jennings et al 2021).
- **Stigma** and institutional distrust remain significant barriers. People with a history of incarceration frequently report discriminatory treatment in mainstream healthcare settings, leading to avoidance of services even when health concerns are urgent (Seaward et al 2023).
- **A lack of trauma-informed care** leads to poor experiences of care for patients who may then disengage despite a high need for support (Chaudri et al 2019).
- **A lack of culturally safe care** for Aboriginal and/or Torres Strait Islander people within and outside the justice system perpetuates harm (Yoorrook 2025).
- **Bureaucratic obstacles** such as lack of identification and Medicare cards can leave individuals without access to primary healthcare and medication (Wang et al 2019, Jennings et al 2021). For example, police may remove medications during detention which can lead to rapidly deteriorating health.
- **Lack of access to alcohol and other drug services** in the community, including Medication Assisted Treatment for Opioid Dependence (MATOD) (GPHN 2025b).

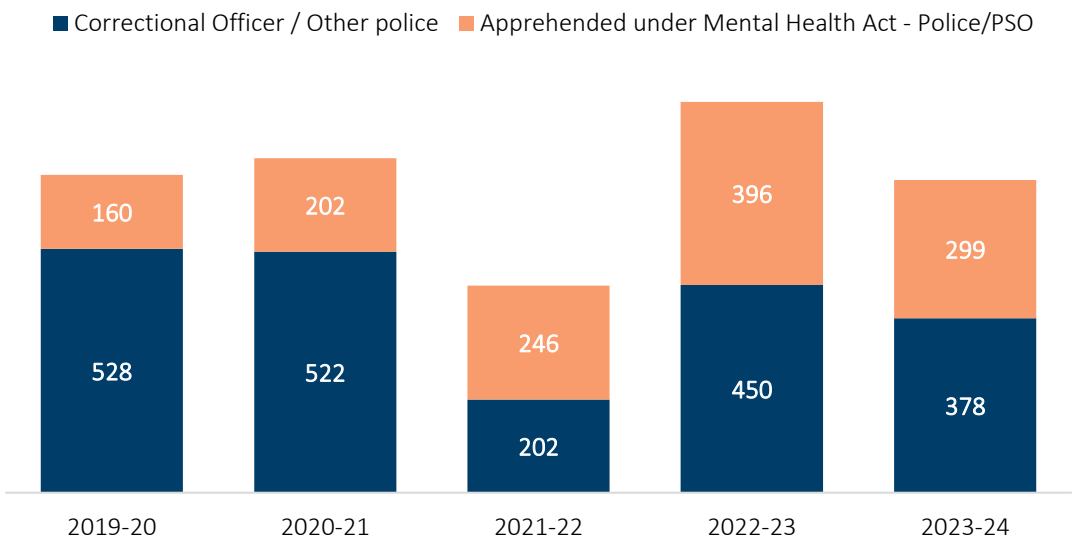
Gippsland Insights

Emergency department (ED) presentations

ED presentations for Gippsland residents between 2019-20 and 2023-24 were analysed and findings related to interactions with the justice system include:

- There was an annual average of 677 referrals to ED involving correctional officer, police or Protective Services Officer (PSO), representing 0.6% of all ED presentations (**Figure 130**).
    - 39% of these were individuals apprehended under the Mental Health Act (by police or PSO)
    - The proportion of people referred to ED being apprehended under the Mental Health Act increased over time, with an average annual increase of 17% between 2019-20 and 2023-24
- There was an annual average of 170 ED presentations per year where departure was to a correctional or custodial facility
    - 64% of these individuals resided in the Wellington LGA where the Fulham correctional facility is located
- The top diagnoses among referrals involving correctional officer, police or Protective Services Officer (PSO) were:
    - 21% suicidal ideation
    - 6% psychotic disorder (acute and transient)
    - 4% schizophrenia
    - 4% special screening examination for other viral diseases
    - 3% general psychiatric examination (requested by authority)

Figure 130. Number of Gippsland residents where referral to emergency department involved police, 2019-20 to 2023-24 (DH 2024b).



Gippsland PHN Commissioned Services

Gippsland PHN commissioned alcohol and other drug services recorded 13.6% of consumers where the referral source included police/youth justice in 2024-25, up from 3.1% in 2022-23 and 3.6% in 2023-24 (GPHN 2024e).

Other commissioned services do not currently collect data about contact with the justice system.

Stakeholder insights

Stakeholder feedback has identified a range of issues where improvements could be made for people who have had interactions with the justice system in Gippsland (GPHN 2025b):

- Appropriate referrals from the justice system to the healthcare system, especially for people coming out of incarceration
- Risk of homelessness when transitioning from prison is a significant risk factor
- Improved competency in primary healthcare to work with people experiencing complex intersecting forms of marginalisation including disability, homelessness, family violence, LGBTIQA+ and mental health conditions
- Alternatives to a traditional police response when working with people experiencing trauma and mental health conditions to avoid a heavy-handed approach that can escalate distress

  "GPs need to know how to work with these people [complex presentations]" (Community member)

  "People released from justice system are not routinely referred to health care" (Community member)

Improving access to primary care

Addressing system challenges between the justice and health systems offers opportunities for improvements to accessing healthcare. There is recognition of the need for coordinated person-centred models of care. Research suggests that enhanced primary care for individuals just released from prison can lead to fewer days in a correctional facility in the following year (Wang et al 2019).

Models and strategies that improve access to primary healthcare include:

- **Health Justice Partnerships** brings together health, legal and other services to address complex problems (Health Justice Australia 2025). People experiencing social disadvantage are more likely to be dealing with multiple legal problems, including those related to family breakdown, housing and financial issues. They are also less likely to seek legal help. By embedding legal support in

trusted health and wellbeing services, access is improved. There is evidence health justice partnerships are effective in improving health and wellbeing both for individuals and vulnerable communities with complex need by integrating service responses around client needs and capability. Vulnerable communities that have benefited include:

  - Mental health services for culturally and racially marginalised people: where health justice partnerships were described as "…*an antidote to some effects of intersecting marginalizations*." (Plage 2025)
  - Young people were supported to improve their health and wellbeing by addressing their unmet legal needs (Camilleri 2025). Youth and allied health workers in regional areas were integral in the early identification of young people dealing with legal matters and identify suitable referral pathways and services to support them with their unresolved legal issues.

- **Enhanced discharge programs** to link people with primary care and support networks following release from prison. This can include clearly defined responsibilities and connecting individuals to primary care prior to release to encourage relationships. Continuity in medication is an important consideration to manage cost and access (Wang et al 2019, Jennings et al 2021).
- **Interagency collaboration** to address incompatible digital systems, differing organisational priorities, and uncertainty about information-sharing protocols (Pellicano et al 2025, Steele et al 2021).
- Equip and enable **improved health literacy** among individuals leaving custody to improve confidence and ability to navigate complex healthcare system, particularly for older adults exiting prison who may experience cognitive decline, isolation, or lack of digital access (Hwang et al 2025).
- **Trauma-informed care** enables GPs, nurses, and allied health professionals to better recognise and respond to people with an experience of trauma (Chaudhri et al 2019). This includes realising the widespread impact, recognising signs and symptoms, responding appropriately and resisting re-traumatisation.
- **Culturally safe care** to address existing and complex un-met health needs including mental health challenges, disability, alcohol and other drug dependence (Yoorrook Justice Commission 2025).
- **Improving data sharing** across justice, health, and social care sectors and between sectors of the healthcare systems. Interoperable systems that protect client confidentiality while allowing for proactive service coordination could prevent care disruptions and support early intervention (Pellicano et al 2025, Jennigs et al 2021).
- **Co-design and place-based research** with people with lived experience of the justice system is needed to inform local strategies to suit rural justice health interfaces. Address the intersecting experiences of people most at risk, including Aboriginal and Torres Strait Islander communities, young people, older adults, and individuals with disability.

Professional stakeholder perspective

Insights based on Gippsland PHN consultations with clinicians and other professional stakeholders relevant across groups of people experiencing marginalisation in healthcare in 2024 and 2025 were summarised. In 2024 methods included the Gippsland PHN Clinical Councils and other regular meetings (GPHN 2024e) and insights identified in internal documents such as reporting (GPHN 2024g). In 2025, methods included the Gippsland PHN Clinical Council and other regular meetings (GPHN 2025b), general practice visits (GPHN 2025g) and a survey for commissioned service providers (GPHN 2025h). See also **Stakeholder Consultation** section. Summary themes included:

- We need improved recruitment, **education and training** for GPs and other professionals to ensure high quality care and trust among people experiencing marginalisation.

  "Voice of lived experience as a way to design services and to be involved in planning is critical." (Professional)

- **Intersectionality** is the rule not the exception, for example:
  - LGBTIQA+ health and wellbeing intersect with multiple other factors, including mental health, loneliness and lack of services

    "… a 5 hour bus to gender affirming care". (Professional)

- We need systems that can **support transitory people and families**. It is common for people experiencing homelessness and/or family violence to move between areas of Gippsland and outside Gippsland to seek support and safety. We see women and children who *"slip between the cracks"*.

  "[Need] Good education for our health professionals on how to deal with trauma in patients and challenge their own bias. (Professional)

- **Building rapport and trust** with people seeking support for complex personal and family situations can be a turning point, including:
  - delivering high quality and individually tailored supports
  - include the client, family and carers and all relevant providers

- Challenges related to the **business model** as a possible added layer of marginalisation for people with high healthcare needs:
  - Some practices choose not to offer services to marginalised communities, including due to concerns other patients may be hesitant to attend if they feel the clinic caters mainly to people with higher or more complex needs (for example, people experiencing homelessness or interactions with the justice system)
  - A lack of funding for complex cases, including for allied health

- Marginalised groups have high non-attendance rates and business models may need to be modified, for example to include telehealth

- **Additional marginalised groups** were identified:
  - Families involved in **out of home care** and those supported by **child protection** are marginalised communities. See also **Chapter 7: Growing Up Healthy (0-25 years)**
  - Remote / isolated communities
  - Other population groups which are already Gippsland PHN priority areas were also identified, especially if they intersect with the above marginalised groups; Family Violence, Aboriginal and/or Torres Strait Islander, People with poor mental health, Alcohol and Other Drug dependent and People 65+ (especially if living with dementia or requiring palliative care)

Suggestions for improvements:

- Improve awareness of the role allied health practitioners can play in supporting growth and development, including for those accessing NDIS funding or others who experience physical challenges
- Continued education and training provision, including cultural training
- Provide resources and/or information that can be shared to support holistic care, for example access to food/fuel voucher options
- Support funding models that incentivise clinicians spending the additional time needed to engage with marginalised communities experiencing complex health needs

  "Prevention and early intervention for at risk/priority groups across all sectors of healthcare. (Professional)

Community, consumer and carer perspective

Insights from Gippsland PHN consultations (GPHN 2024d, GPHN 2024e and GPHN 2025b) include:

Social determinants of health

- There are many people in the Gippsland community experiencing disadvantage; often associated with low health literacy and difficulty advocating for healthcare needs.
- We need to recognise that marginalisation is often the root cause of many issues, including alcohol and other drug misuse, chronic disease, poor dental health and family violence.

- Remote communities have their own unique challenges and can have their needs ignored due to a smaller population.
- Crime and anti-social behaviour are impacting on the health of the community.

  "The social determinants of health affect every dimension and outcomes of health and wellbeing; equity across all priorities is vital." (Community member)

  "Voices you don't hear need priority." (Community member)

  "We compartmentalise too much. All these individual areas prevent us from seeing, and treating, the whole person (and addressing social determinants of health)." (Community member)

Service access and utilisation

- Administration of NDIS access is a big burden on consumers, carers and for general practice.
- Appropriate services for LGBTQIA+ communities are very hard to access locally, and many people seek services outside Gippsland to meet their needs.
- People who are seeking assessment and management of ADHD can find themselves stuck in the system as they need an assessment but cannot afford to pay the specialist they need to see.
- There has been an increase in demand for food bank services reported in several locations.

A Gippsland PHN project called ***Tell Gippsland PHN why you don't access healthcare even if you need it*** was conducted in 2023-24 (GPHN 2024c); for methods see Stakeholder ConsultationStakeholder Consultation

Stakeholder . The study provided deep insight into the many complex and interrelated factors affecting access to healthcare among people in the Gippsland region. It highlights the need for a more holistic approach to healthcare that recognises socioeconomic, cultural, environmental, and individual factors. There were six key themes identified from the data analysis (**Table 30**).

Table 30. Themes for why people don't access health even if required (GPHN 2024c).

Themes	Details
Person-centred Care	• Empathy and mutual trust are necessary for consumers to feel heard, respected, and valued in their healthcare interactions. • Active listening and personalised care plans are important tools. • People value continuity of care with trusted clinicians who communicate to deliver coordination of care. • An absence of person-centred care can lead to feeling judged and a reluctance to seek care again, resulting in care being seen as a waste of time and poor value for money.
Mental Health and Wellbeing	• Participants highlighted challenges managing medications, describing difficulty accessing doctors, important benefits but also difficult side effects.

	• Coping strategies included hobbies, volunteering and the critical role of social supports. • Childhood experiences and trauma has a big impact and intervening early is important. • A need for a holistic approach that incorporates mental health into overall wellbeing.
Barriers to accessing services	• Cost of accessing services was a major barrier for accessing GPs, specialist care and allied health, leading to delays in seeking care, or inability to access care. • Geographic and transport challenges in regional and remote areas due to very limited public transport, cost and time required, as well as difficulty travelling when in poor health. • Language barriers and the importance of cultural competence. • Noticing changes post COVID including more stressed professionals. • Pressures on carers can lead to neglecting own health needs. • Reluctance to seek help due to fear and/or shame. • Lack of awareness about what care options are recommended or available.
Service system challenges	• Limited workforce and facilities impacting availability and access. • Bureaucratic barriers leading to delays in accessing care. • Long wait times have flow on effects to avoidable hospitalisations. • Concerns about fairness with differences in what people can access. • Unmet healthcare needs impacts consumer wellbeing.
Social determinants of health	• Participants emphasised that health is often shaped by social and economic factors. • Financial struggles can lead to basic needs not being met. • Loneliness and social isolation. • Housing and homelessness issues. • Living with problematic substance use and lack of support services. • Experiences of family, domestic, psychological abuse and sexual violence. • Community services can provide vital support and connections to promote wellbeing.
Information gaps and technology	• Lack of clear information about available supports and services. • Address language barriers, including through simple English and multilingual resources. • Technology and telehealth opinions varied, with some valuing convenience and others facing challenges due to low digital literacy.

Other Identified Needs

Gippsland PHN has identified additional health needs of the Gippsland community through the triangulation and analysis process which remain a focus for all Gippsland health services.

Reproductive and Sexual Health

Women's health

Several health needs were identified related to sexual and reproductive health of women. For instance, they include access to abortion and contraception, endometriosis, menopause and perimenopause.

Abortion

Abortion can either be a medical (by taking tablets, up to nine weeks) or surgical termination of pregnancy (GPHN 2022). In Victoria, it is legal to have an abortion up to 24 weeks of pregnancy and in certain situations, beyond this. In Australia it is estimated that half of all pregnancies are unplanned and half of those will be terminated Between one quarter and one third of Australian women will experience abortion in their lifetime. A survey found that 26% of women who have ever been pregnant have had an abortion; 10.5% had a medical termination and 17.6% had a surgical termination.

While there are access issues to abortion in Gippsland (GPHN 2022) some local government areas have higher rates of medication abortion than the state average. East Gippsland had the second highest rate in the state, at 8.4 medication abortions provided per 1,000 population (GPHN 2024a).

Contraception

Contraception refers to methods used to prevent pregnancies. Contraceptive methods include hormonal options (oral pills, patches, implants), barrier methods (diaphragms, condoms), and intrauterine devices (IUDs) (WHO 2024b). In addition, hormonal contraceptives assist in managing several health conditions, such as polycystic ovarian syndrome (PCOS), menstrual disorders, and endometriosis.

Endometriosis

Endometriosis is a condition when the tissue endometrium (like the lining of the uterus) grows outside the uterus and sometimes other parts of the body. Symptoms include abdominal pain (before and after periods and during sex), irregular and heavy bleeding, bloated and inflammation, scar tissue formation, fatigue, depression, anxiety, and infertility (Healthdirect Australia 2019). As a result, endometriosis can cause stress, depression, anxiety and social isolation. Additionally, can impact relationships and sexual health. Furthermore, decreases work productivity and financial issues.

14% of females in Australia have endometriosis and on average it takes 6.5 years to diagnose the condition (Endometriosis Australia 2024).

Perimenopause and Menopause

Perimenopause is a transitional phase leading to menopause, in which hormone levels fluctuate and irregular menstrual cycles. Perimenopause can initiate several years prior to menopause, often starting in the 40s and can last from 1 to 10 years. Symptoms include hot flashes, night sweats, headaches, fatigue, disturbed sleep, sore joints, muscles and breast, and vaginal dryness. Some women also experience brain fog, mood swings, anxiety and depression (Healthdirect Australia 2023).

Menopause is when a female has permanent cessation of menstruation, usually occuring between the ages of 45 to 55 (Better Health Channel 2019). Menopause is determined when one has not had a period or spotting for 1 year. Additionally, changing hormone levels can cause different symptoms and some women may have no symptoms. Common symptoms include night sweats, hot flushes, sleep issues, muscle and joint pain, dry vagina, and tender breasts. Also, some may experience mood changes, fatigue, brain fog, anxiety, depression and forgetfulness.

Sexually transmissible disease (STI)

Sexually transmitted infection (STI) refers to infections primarily spread via sexual contact, such as anal, vaginal and oral sex. STIs are caused by bacteria, viruses and parasites. Some STIs may be transmitted from mother to child during pregnancy, breastfeeding and childbirth (WHO 2023b).

STIs can cause acute symptoms such as itchiness, pain, discharge and sores, thus can be distressing and uncomfortable. However, if left untreated STIs can lead to serious health issues, such as infertility, ectopic pregnancy, pelvic inflammatory disease (PID), and chronic pelvic pain (WHO 2023b). Additionally, certain viral STIs such as HPV are linked with increased risks of cancers (throat, anal, and cervical). STIs can cause complications in pregnancy, to both the child and mother. A diagnosis of an STI can lead to psychological distress, such as anxiety, stigma fear, and embarrassment. Stress from the impact it might have on the relationship and future health (Elendu et al. 2024).

In Gippsland, there are over 950 cases of sexually transmitted infections (STIs) each year, including chlamydia and syphilis (Latrobe Regional Health 2023).

Chlamydia remains the most commonly reported STI in Gippsland (Latrobe regional Health 2023). Much like gonorrhoea, chlamydia often shows no symptoms, leaving many unaware they are infected. Estimates suggest that up to 70% of chlamydia cases may be asymptomatic and thus undetected without regular screening. Chlamydia is often referred to as the ‘silent infection’ because if left untreated, it can lead to serious long-term health issues such as ectopic pregnancy and infertility in women.

Gippsland experienced its highest number of gonorrhoea cases in 2023, with an increase of almost 20% compared to previous years (Latrobe regional Health 2023). In 2023, 61% of gonorrhoea cases in Gippsland were reported in men, particularly those aged between 20 and 34.

Community Insights

Insights from Gippsland PHN consultations (2024c, 2024d and 2024e) include:

- Many women and girls spoke about experiences of having reproductive health issues dismissed by health professionals. These often related to period pain.
  Like, extremely painful periods to the point, like, you're thinking, "Wait, this can't be normal." Painful, irregular, all those things you can think of… So he was like, "Oh, you're young, so your options are either birth control or just wait it out." (community member)
- Some general practice staff spoke about noticing more STI prevalence in their communities.

Carer Health and Wellbeing

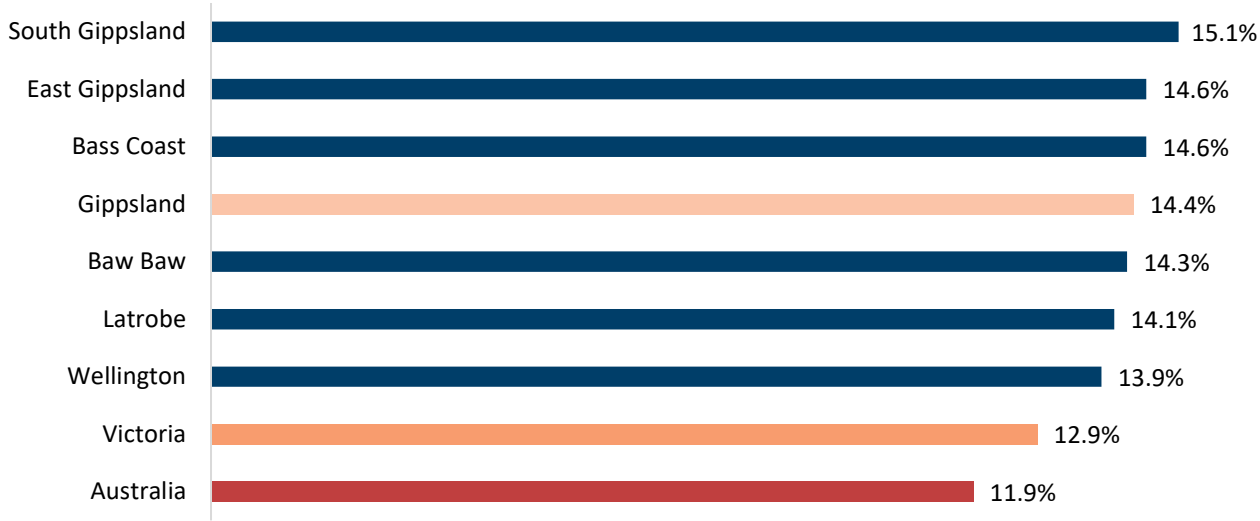
Carers are people who provide unpaid care and support to someone with a disability, mental health issue, chronic condition, or other needs (Carers Australia 2024). Carers are an essential part of Australia's health system.

Although providing care can be a rewarding experience (Carers Australia 2021) it can be a demanding role, which can impact carer health and wellbeing.

Health status

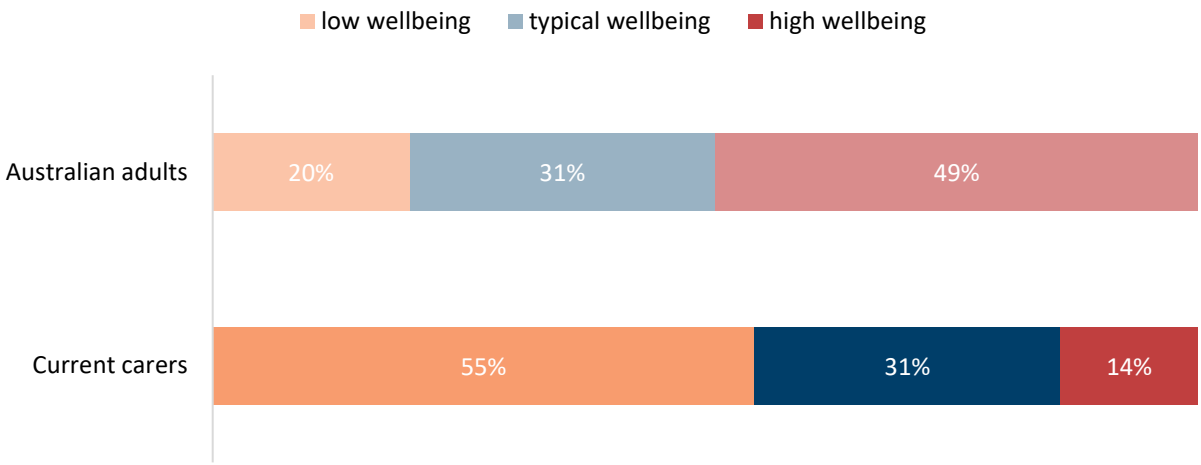
Gippsland has a higher proportion of carers at 14.4%, compared to 11.9% nationally (**Figure 131**).

Figure 131. Proportion of people who provided unpaid assistance to persons with a disability (of all people 15 years and over).



According to the Carers Australia survey of carers, (Carers Australia 2021), carers are much more likely to experience low wellbeing than the general population (**Figure 132**).

Figure 132. Wellbeing of current carers, 2021, and Australian adults, 2021 (Carers Australia 2021).



Key health issues for carers include (Carers Australia 2021):

- Higher rates of psychological distress, with an average psychological distress score of 25/50 compared to 19.3/50 for Australian adults in 2020.
- Higher rates of loneliness, with 35% often or always feeling lonely compared to 11% of Australians.

- Poorer financial wellbeing, with 52.8% of carers reporting their household was very poor, poor, or just getting along financially, compared to 33.8% of the population generally
- Lower levels of employment, with 51.6% of carers employed. This rate goes down as the needs of the person being cared for go up. Labour force participation also goes down the longer the carer provides care.
- 46% of carers have one or more disabilities of their own.

The carer wellbeing survey also identified several groups of carers who are at a particularly high risk of poor health outcomes (Carers Australia 2021):

- Carers aged 35 to 54
- Female carers
- Those with high weekly caring hours
- Those who have been a carer for many years
- Those who care for multiple people
- Those who care for a child or grandchild
- Those who care for a person with autism spectrum disorder, development disorder, or intellectual disability
- Those who care for someone with a mental illness/psychosocial disability
- Those who care for someone with a drug/alcohol dependency.

Community Insights

Insights from Gippsland PHN consultations (2024c, 2024d and 2024e) include:

- Significant health needs are reported for people with experience of dealing with health issues in their families. Caring for others often means ignoring their own health issues due to the significant pressures and needs that are ongoing and often without an opportunity to get a break.
- Carers of people experiencing mental health and alcohol and other drug issues are frequently impacted due to significant difficulties accessing services and supports and this can often be combined with isolation and shame due to stigma in the community.
- Carers of older people unable to access help at home are also frequently impacted.
- It is important to remember to include young carers under the age of 18 when considering carer health and wellbeing.

Dental & Oral Health

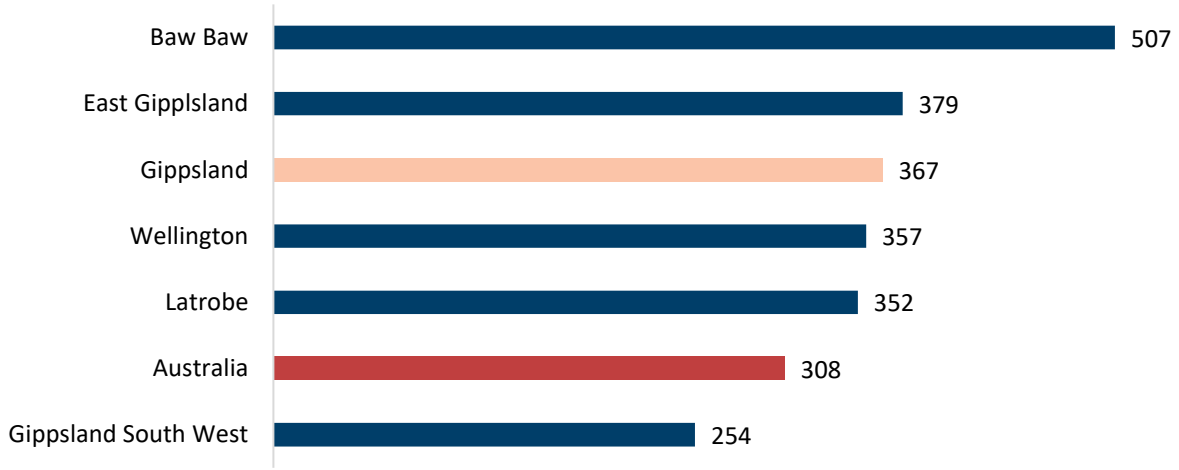
Dental and oral health refers to the health condition of an individual's teeth, gums and related structures of their mouth, such as muscles and bones (AIHW 2023). Good oral health includes prevention, accurate diagnostics and treatment of dental conditions. However, poor oral health includes cavities, periodontal

disease (gum disease), oral infections, and poor hygiene practices. Also contributing to dental issues are irregular checkups, behaviours such as smoking and alcohol consumption, and diets high in sugar. Unfortunately, oral health deteriorates throughout a person's lifespan (AIHW 2023). Having good oral health is crucial for an individual's overall health. Poor dental health can detrimentally impact an individual's physical, emotional and social health, due to pain, discomfort and low self-esteem. Oral diseases can damage mouth tissues, tooth loss can decrease mouth functionality (difficulty chewing and swallowing) and thus can impact nutrition consumption. Moreover, poor oral health can be associated with chronic conditions such as cardiovascular disease, lung conditions, adverse pregnancy outcomes, diabetes, stroke and oral cancers (AIHW 2023).

Health status

Poor oral health contributes to 4.5% of all the non-fatal burden of disease in 2022 in Australia (AIHW 2023). Gippsland's potentially preventable hospitalisations per 100,000 population from dental conditions are 19% higher than the national rate (**Figure 133**).

Figure 133. Potentially preventable hospitalisations from dental conditions (per 100,000) (AIHW 2022d).



Service system

Ultimately, the accessibility and availability of dental clinics significantly impact an individual's ability to maintain good oral health. Unfortunately, there is a lack of affordable private dental services and long waiting periods for public dental services (AIHW 2023). Consequently, individuals with low socioeconomic status are hindered in their ability to access dental services, and dental pain can impact employment. For several reasons including low reimbursement rates, delayed payments, time-consuming administrative work, and limited services covered, some local dentists hesitate to accept vouchers provided for dental emergencies.

Additionally, people living in regional and remote areas have poorer dental health compared to those living in metropolitan areas (AIHW 2023). In Gippsland, there are a total of 70 dental and oral healthcare services (Studio Health Map 2024) (**Table 31**).

Table 31. Dental services in Gippsland (Healthdirect Australia Healthmap 2024)

Dental Specialty	Number of services in Gippsland
Dental Hygiene	1
Endodontic	1
General Dental Practice	48
Oral Medicine Service	0
Oral Surgery	1
Orthodontics	6
Paediatric Dentistry	1
Prosthodontic	12

Dental and oral health intersect significantly with primary care. For instance, primary care providers can identify signs of conditions such as diabetes, cardiovascular disease, and autoimmune conditions via oral health. Concerns such as dry mouth, lesions and gum disease may indicate poor oral health and promote early dental intervention.

General practitioners (GPs) can provide chronic disease management, as oral health practices influence infection and inflammation risks. Additionally, some medications prescribed by GPs can impact oral health resulting in dry mouth that increases the risk of cavities. General and dental practitioners can collaborate to monitor and maintain oral concerns, which can increase due to chronic conditions (Biezen et al. 2024). GPs can educate patients on preventive care and highlight the importance of oral hygiene, nutritional diets, and avoiding risk-taking behaviours (smoking and alcohol consumption). They may screen for oral health conditions due to the low number of dental services available in Gippsland.

GPs have the opportunity to identify dental issues, which can negatively impact on an individual's mental and social health, and coordinate with dental practitioners to improve patients' quality of life. Also, primary care providers are often the first point of contact and can provide initial assessment, pain and infection management and referrals for dental emergencies. GPs can provide referrals for X-rays (orthopantomogram, CBCT, and Lateral Cephalogram) to assist the dentist in diagnostics.

Community Insights

Insights from Gippsland PHN consultations (2024c, 2024d and 2024e) include:

- Poor dental health can have a significant impact on a person's overall wellbeing.

"So yeah, just working on the teeth…. We had some family photos done just me and the kids and I had to keep my mouth shut." (Community member)

- Poor dental health impacts employment.

  "So I'm bouncing back and it's just the teeth at the moment. Like I want to go back to work and like it doesn't look the best." (Community member)
- Poor dental health can cause significant pain.
- Lack of access to affordable dental care, especially for people on a low income; there are major waiting lists.
- Some local dentists don't want to take vouchers which may be provided for dental emergencies
- We need improved dental hygiene awareness (example provided of people who have no toothpaste and may share a toothbrush for whole family)

Cancer Screening

Health status

There are three population-based cancer screening programs in Australia incorporating BreastScreen Australia and the two national programs for bowel and cervical screening recorded and reported in the National Cancer Screening Register (NCSR). The Commonwealth Government is adding lung cancer screening for asymptomatic high-risk individuals to the national programs, commencing July 2025.

Rate of screening in Gippsland vary across the three existing programs, with higher than national levels for bowel and breast, but lower rates of cervical screening (AIHW 2023d). In summary:

- **Bowel cancer** screening participation rates across Gippsland in 2020-21 were 47.3%, higher than the Victorian rate of 43.9% and the Australian rate of 40.9% for the same period.

- **Breast cancer** screening participation rates in Gippsland in 2019-20 were 51.8%, higher than the Victorian rate of 46.1% and the Australian rate of 49.9% for the same period. National and Victorian rates increased further to 50.1% and 50.9% respectively in 2021-22, however Gippsland-specific data is not available for this period. Rates of the incidence of breast cancer among screened women are far higher in Gippsland than the Australian age standardised rate of 61.2%, especially in Wellington at 98.1% and also high in Latrobe 70.9%.

- **Cervical cancer** screening participation rates in Gippsland in 2018-21, among all age groups (25-74 years), was 56.4%, similar to the Victorian average of 57.0% but lower than the Australian average of 62.4% for the same period.

Community Insights

Insights from Gippsland PHN consultations (2024c, 2024d and 2024e) include:

- Many community members spoke about their own experiences of cancer, or losing loved ones to cancer.
  "A lot of my friends have died over the last two years, too. So, a lot of my friends are older. Cancer's taken just about all of them." (community member)
  "My mum passed away from cancer. Um, she had, um – it was – it is kind of, um – what's – what's the word? It was – it kind of runs in the family." (community member)

- Many community members spoke about being carers for loved ones with cancer.
  "I've been a carer, um, for my first – my youngest brother. He had bowel cancer and, um, come out through it three years later. And then my mum was sick and all the rest of it. So then I cared for her for five years, and then she just passed last May for cancer." (community member)

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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
ACOSS	Australian Council of Social Service
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
CARM	Culturally and Racially Marginalised
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
DFFH	Department of Families, Fairness and Housing (Victoria)
DH	Victorian Department of Health
DHDA	Department of Health, Disability and Ageing (Commonwealth)
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
IARC	Immigration Advice and Rights Centre
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
LGA	Local Government Area
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual
LHA	Latrobe Health Advocate
LHN	Local Health Network
LRH	Latrobe Regional Health
LOTE	Language Other Than English
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
PALM	Pacific Australia Labour Mobility
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
SBS	Special Broadcasting Service
SEIFA	Socio-Economic Index for Areas
SES	Socio-Economic Status
SHS	Shared Health Summary
STI	Sexually Transmitted Infection
TIS	Translating and Interpreting Service
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

Appendices

Appendix 1. Health Needs Assessment Data Limitations

- There are limitations in the sources of Aboriginal and/or Torres Strait Islander health information (Australian Indigenous HealthInfoNet 2024a). This includes population estimates such as the census and health related data sets including deaths and 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, LGBTIQA+, 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.

Appendix 2. Additional Health Service Mapping

Figure 134. Distribution of Allied Health providers across Gippsland LGAs (Healthmap 2024).

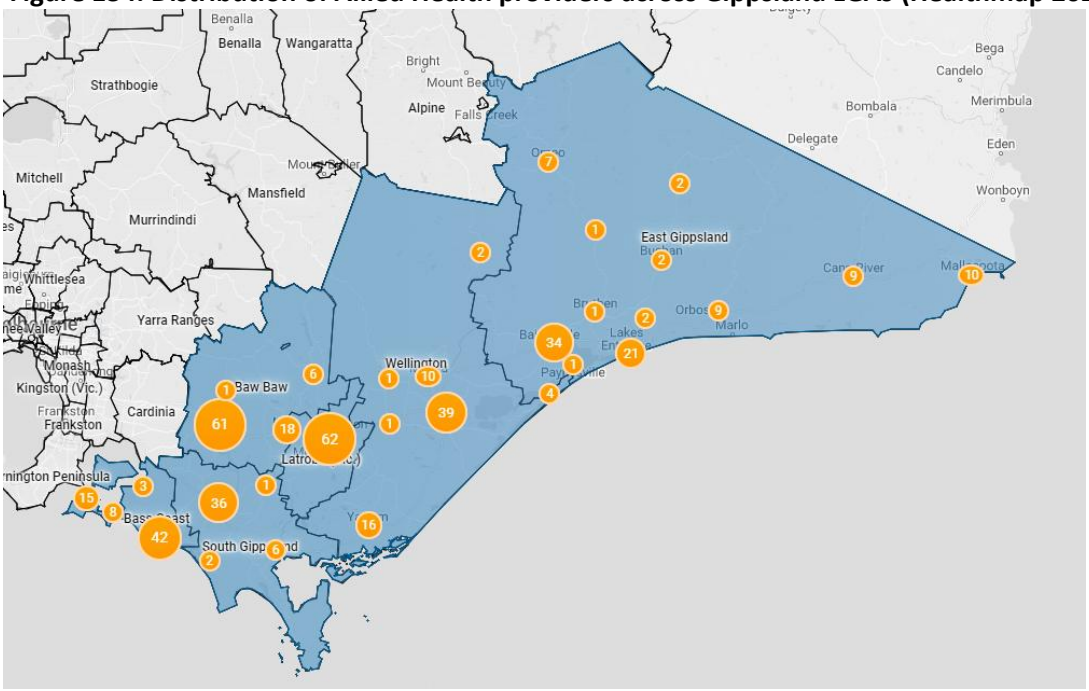


Figure 135. Distribution of hospitals (public & private) across Gippsland LGAs (Healthmap 2024).

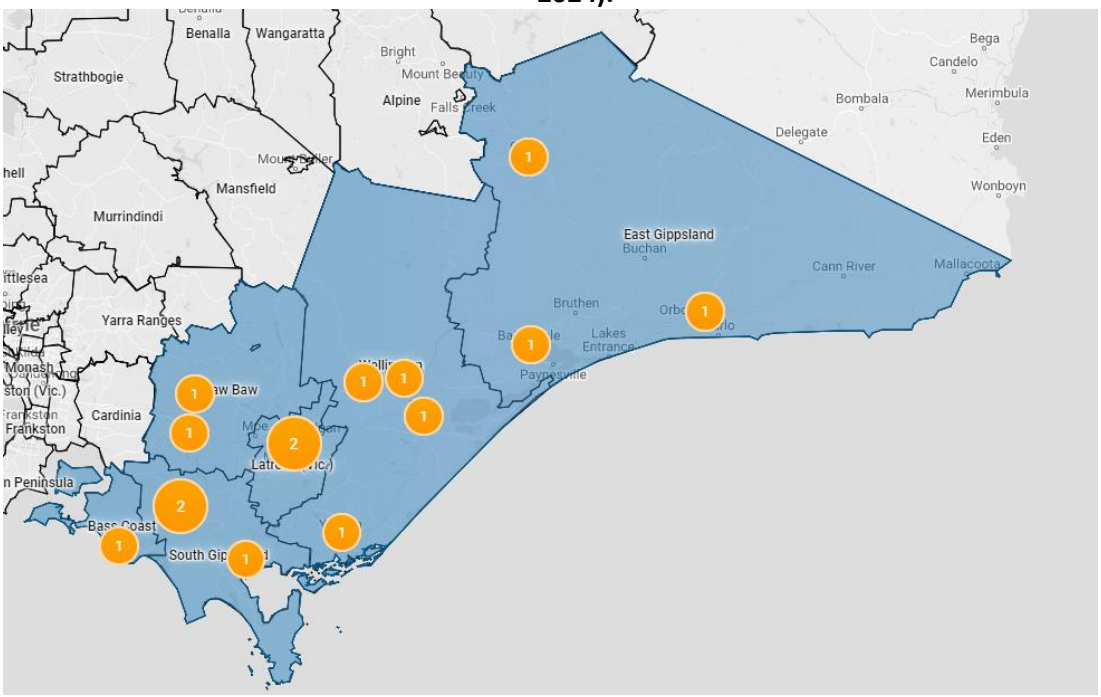
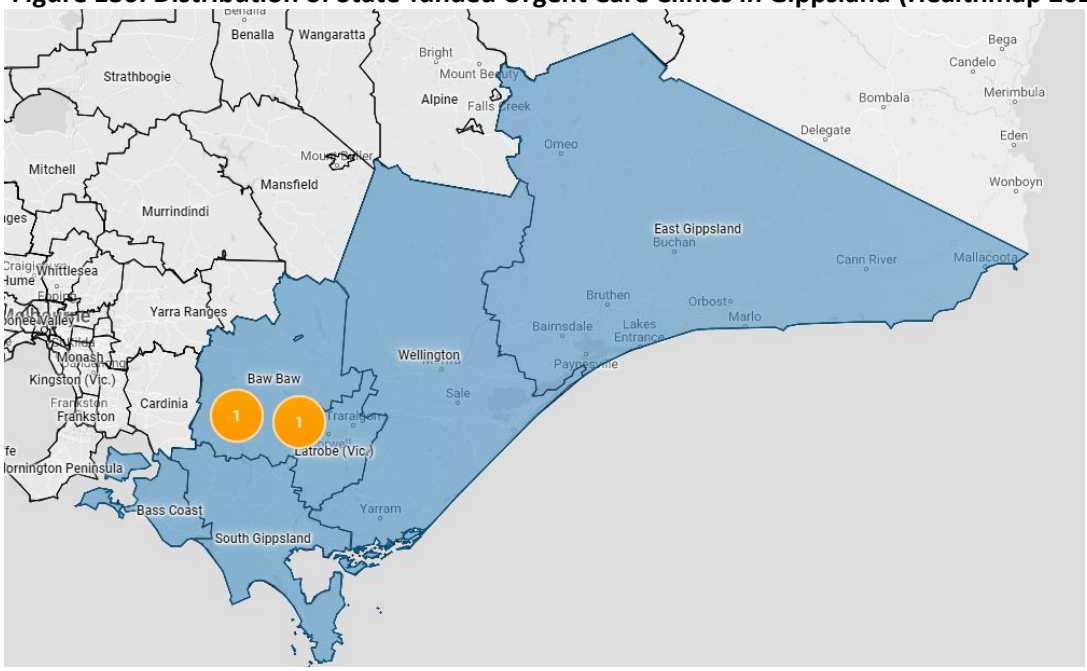


Figure 136. Distribution of State-funded Urgent Care Clinics in Gippsland (Healthmap 2024).



Appendix 3. Top Major Diagnostic Codes (MDC) for multi-day and overnight admissions for Gippsland residents, percent and number of admissions, 2023-24 (DH 2024a).

Major Diagnostic Codes	Number	Percent
Diseases & Disorders of the Musculoskeletal System & Connective Tissue	6296	11.8%
Diseases & Disorders of the Circulatory System	6043	11.3%
Diseases & Disorders of the Digestive System	5768	10.8%
Diseases & Disorders of the Respiratory System	5396	10.1%
Diseases & Disorders of the Nervous System	3899	7.3%
Pregnancy, Childbirth & the Puerperium	3628	6.8%
Newborns & Other Neonates	3215	6.0%
Diseases & Disorders of the Kidney & Urinary Tract	2577	4.8%
Diseases & Disorders of the Skin, Subcutaneous Tissue & Breast	2206	4.1%
Diseases & Disorders of the Hepatobiliary System & Pancreas	1916	3.6%
Injuries, Poisonings & Toxic Effects of Drugs	1814	3.4%
Diseases & Disorders of the Ear, Nose, Mouth & Throat	1737	3.3%
Infectious & Parasitic Diseases, Systemic or Unspecified Sites	1527	2.9%
Factors Influencing Health Status & Other Contacts with Health Services	1396	2.6%

Endocrine, Nutritional & Metabolic Diseases & Disorders	1242	2.3%
Mental Diseases & Disorders	1236	2.3%
Diseases & Disorders of the Female Reproductive System	803	1.5%
Diseases & Disorders of Blood, Blood Forming Organs, Immunological Disorders	638	1.2%
Neoplastic Disorders (Haematological & Solid Neoplasms)	506	0.9%
Diseases & Disorders of the Male Reproductive System	500	0.9%
Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders	431	0.8%
Diseases & Disorders of the Eye	343	0.6%
Burns	62	0.1%

Appendix 4. The top Potentially Preventable Hospitalisations (PPHs) and number of admissions for Gippsland residents by sex in 2022-23 (DH 2024a)

Gender	Top PPHs
Male	1. Diabetes complications (965) 2. COPD (572) 3. Congestive cardiac failure (522) 4. Cellulitis (504) 5. Iron deficiency anaemia (369) 6. Urinary tract infections, including pyelonephritis (362) 7. Angina (289) 8. Convulsions and epilepsy (267) 9. Ear, nose and throat infections (214) 10. Dental conditions (210)
Female	1. Iron deficiency anaemia (868) 2. Urinary tract infections, including pyelonephritis (650) 3. COPD (571) 4. Diabetes complications (509) 5. Congestive cardiac failure (444) 6. Cellulitis (394) 7. Ear, nose and throat infections (242) 8. Convulsions and epilepsy (233) 9. Asthma (209) 10. Dental conditions (192)

Appendix 5. Top diagnoses* among ED presentations for Gippsland residents (ICD-10 codes), percent of all presentations (n=127,702) and number of presentations in Gippsland, 2023-24 (DH 2024b).

Diagnosis (ICD-10 description)	Percentage	Number
Chest pain unspecified	4.0%	5,419
Other and unspecified abdominal pain	3.8%	5,153
Issue of repeat prescription	3.6%	4,824
Viral infection unspecified	1.7%	2,370
Unknown & unspecified causes of morbidity	1.6%	2,180
Open wound of wrist & hand part unspecified	1.5%	2,028
Urinary tract infection site not spec	1.4%	1,914
Suicidal ideation	1.2%	1,664
Syncope and collapse	1.2%	1,566
Fracture other & unspecified parts wrist & hand	1.1%	1,534
Dyspnoea	1.0%	1,421
Myalgia site unspecified	1.0%	1,315

* Including all affecting 1.0% or more of presentations

Appendix 6. Top diagnoses* among ED presentations for Aboriginal and/or Torres Strait Islander peoples (ICD-10 codes), percentage of all presentations and number of presentations in Gippsland, 2023-2024 (DH 2024b).

Diagnosis (ICD-10 description)	Percentage	Number
Other and unspecified abdominal pain	4.8%	301
Chest pain unspecified	4.3%	269
Suicidal ideation	3.5%	221
Issue of repeat prescription	3.3%	207
Unknown & unspecified causes of morbidity	2.6%	161
Viral infection unspecified	2.5%	159
Open wound of wrist & hand part unspecified	1.4%	85
Nausea and vomiting	1.1%	72
Acute URTI unspecified	1.1%	71
Superficial injury head unspecified part unspecified	1.1%	71
Fracture other & unspecified parts wrist & hand	1.0%	65
Urinary tract infection site not spec	1.0%	65

* Including all affecting 1.0% or more of presentations

Appendix 7. Top diagnoses (ICD-10 descriptions) among lower urgency presentations for people aged 65 years or older, 2023-24 (DH 2024b).

Description	Percent	Number
Issue of repeat prescription	8%	574
Open wound of wrist & hand part unspecified	3%	225
Urinary tract infection site not specified	3%	196
Attention to surgical dressings & sutures	2%	177
Unknown & unspecified causes of morbidity	2%	164
Fracture other & unspecified parts wrist & hand	2%	139
Cellulitis of lower limb	2%	130
Other and unspecified abdominal pain	2%	129
Mech comp urinary (indwelling) catheter	2%	119
F/U exam after unspecified Rx for other condition	2%	117
Myalgia site unspecified	2%	116
Pain in limb site unspecified	2%	115
Constipation	1%	110
COVID-19 virus identified	1%	100

Appendix 8.1 Total Alcohol-related Death Rate per 100,000 Population by LGA (Turning Point 2024)

Region	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Compound Annual Growth Rate
Bass Coast	240.2	181.9	197.4	233.3	230.1	264.8	227.3	216.4	205.4	218.8	-1.0%
Baw Baw	161.8	133.7	162.9	179.8	170.4	159.2	181.1	207.2	184.7	182.2	1.3%
East Gippsland	244.6	196.3	223.6	249.6	269.7	255.3	224.0	252.8	269.5	226.9	-0.8%
Latrobe	173.0	168.6	232.0	169.7	195.7	229.1	195.8	216.8	191.6	242.5	3.8%
South Gippsland	197.0	155.6	213.9	212.0	185.4	149.9	209.4	254.0	231.2	217.2	1.1%
Wellington	193.2	187.3	204.9	196.9	204.5	239.3	203.5	176.8	208.4	217.7	1.3%
Victoria	**131.2**	**127.9**	**138.2**	**141.4**	**135.0**	**131.0**	**127.0**	**143.6**	**132.2**	**141.9**	**0.9%**

Appendix 8.2. Female Alcohol-related Death Rate per 100,000 Population by LGA (Turning Point 2024)

Region	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Compound Annual Growth Rate
Bass Coast	308.2	233.2	197.3	271.2	251.5	309.8	244.2	214.5	226.1	225.9	-3.4%
Baw Baw	218.1	151.6	143.7	172.7	190.9	192.7	202.0	195.9	186.2	163.0	-3.2%
East Gippsland	234.7	190.9	220.0	278.8	239.1	248.7	232.5	229.3	268.4	199.5	-1.8%
Latrobe	163.1	200.1	250.4	156.6	200.8	212.6	179.9	227.9	197.7	232.1	4.0%
South Gippsland	199.9	182.9	229.7	254.8	197.0	175.5	247.6	311.8	230.0	235.8	1.9%
Wellington	249.5	190.9	218.4	222.0	215.5	297.2	188.7	150.3	207.2	231.6	-0.8%
Victoria	**147.1**	**144.0**	**150.3**	**153.9**	**146.0**	**142.9**	**136.0**	**146.4**	**137.2**	**147.0**	**0.0%**

Appendix 8.3. Male Alcohol-related Death Rate per 100,000 Population by LGA (Turning Point 2024)

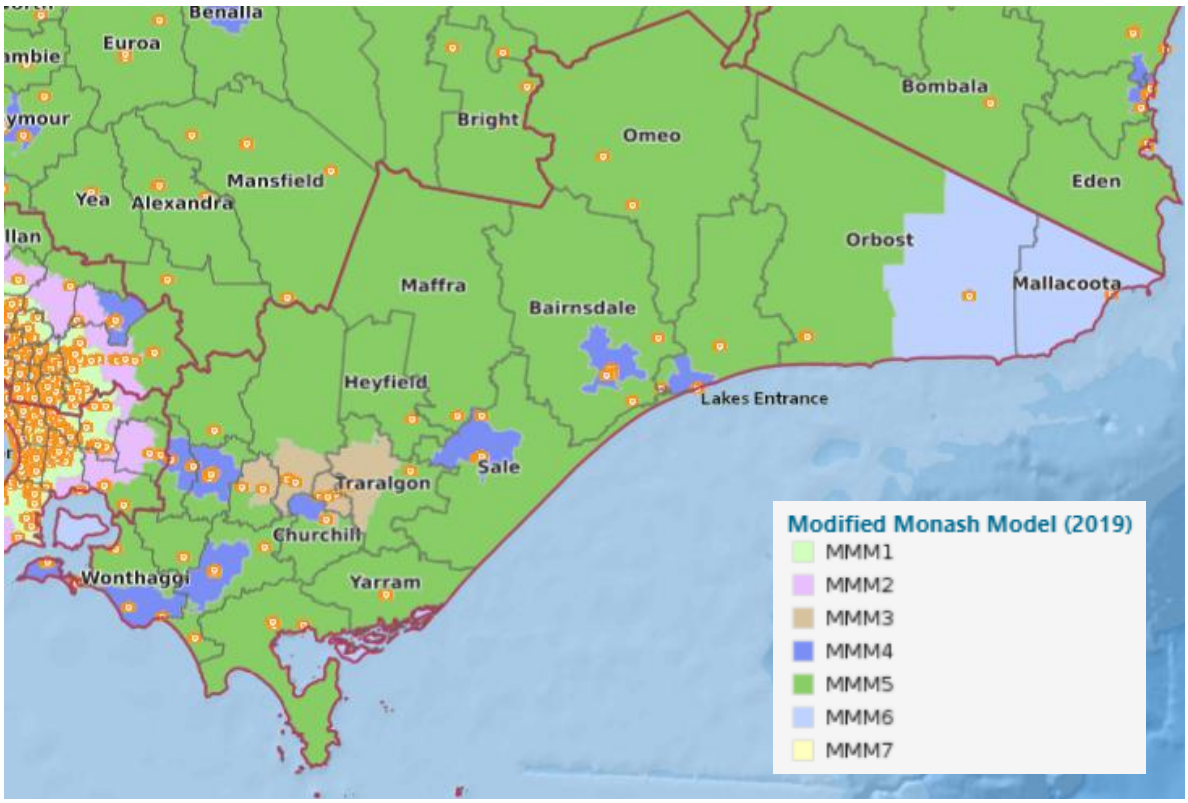
Region	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Compound Annual Growth Rate
Bass Coast	170.7	129.3	197.5	194.0	207.8	217.8	209.6	218.3	183.8	211.3	2.4%
Baw Baw	104.4	115.3	182.7	187.1	149.1	124.4	159.4	219.0	183.2	202.3	7.6%
East Gippsland	254.7	201.8	227.2	220.0	301.0	262.0	215.3	276.9	270.5	255.1	0.0%
Latrobe	183.1	136.4	213.2	183.1	190.3	246.1	212.2	205.3	185.4	253.3	3.7%
South Gippsland	194.0	128.1	197.8	168.3	173.6	123.7	170.5	195.3	232.5	198.4	0.2%
Wellington	138.9	183.8	191.9	172.7	193.9	183.5	217.8	202.5	209.6	204.2	4.4%
Victoria	**115.0**	**111.5**	**125.8**	**128.6**	**123.7**	**118.9**	**117.8**	**140.7**	**127.2**	**136.6**	**1.9%**

Appendix 9. Proportion of lifetime mental health and 12-month mental disorder by gender, age and severity; Gippsland compared to Victoria (ABS 2024e).

Appendix 10. Medicare subsidised mental health care, percentage of people who used a service, by practitioner type, 2022-23 (AIHW 2024f).

Practitioner attendance	Baw Baw	Latrobe	East Gippsland	Wellington	Gippsland South West	Gippsland	Australia
Allied health	4.6%	4.2%	3.9%	3.5%	5.0%	4.3%	5.0%
Clinical psychologist	2.0%	1.0%	1.0%	1.0%	2.0%	1.4%	2.0%
GP	9.7%	9.2%	7.0%	8.5%	9.3%	8.9%	8.3%
Other psychologist	2.3%	2.6%	2.3%	1.9%	2.3%	2.3%	2.7%
Specialist	2.0%	1.9%	1.0%	1.3%	1.5%	1.6%	1.9%

Appendix 11. Modified Monash Model (MMM) of geographical remoteness by GP catchment area in Gippsland with general practice locations shown (DHDA 2024b).



Appendix 12. Registered allied health practitioners as FTE per 100,000 population by LGA in Gippsland and comparison to Victorian average, 2023 (DHDA 2025a).

APHRA registered practitioners	Bass Coast	Baw Baw	East Gippsland	Latrobe	South Gippsland	Wellington	Gippsland	Victoria
Aboriginal and/or Torres Strait Islander	0	0	6	0	0	2	1	0
Chiropractic	11	16	12	19	25	32	19	16
Dental	42	76	37	62	40	47	54	72
Occupational therapy	34	36	34	37	27	28	33	50
Optometry	20	16	19	19	6	14	16	16
Osteopathy	11	21	17	8	38	11	16	21
Paramedicine	203	99	179	192	209	133	166	89
Pharmacy	53	46	52	68	69	61	58	62
Physiotherapy	49	51	32	36	46	20	39	67
Podiatry	19	15	5	11	4	5	10	16
Psychology	29	27	30	23	23	28	27	64

Appendix 13. Rate of children in Gippsland fully vaccinated at ages one, two, and five, 2023-24 (GPHN 2024a).

Region	1 year old children fully immunised Wellington 6th lowest SA3 in Victoria	2-year-old children fully immunised Baw Baw 2nd lowest and Wellington 5th lowest SA3 in Victoria	5-year-old children fully immunised Baw Baw 6th lowest SA3 in Victoria
Baw Baw	91.8%	88.1%	92.3%
Latrobe	93.1%	89.9%	94.7%
East Gippsland	93.0%	90.3%	96.4%
Wellington	91.5%	88.8%	94.4%
Gippsland Southwest	92.5%	90.5%	96.4%
Gippsland	92.3%	89.6%	94.7%
Victoria	93.4%	91.7%	94.8%
Australia	92.8%	91.1%	93.9%

Appendix 14. New diagnoses of chronic conditions in Gippsland general practices (GPHN 2024f).

Chronic disease category	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	Compound Annual Growth Rate
Mental Health	8646	8985	9360	11748	13747	12702	8.0%
Cardiovascular	8480	9056	9071	10802	14323	12419	7.9%
Musculoskeletal	7378	7482	7882	8807	11239	9937	6.1%
Respiratory	4944	5261	4518	7187	8756	7702	9.3%
Diabetes	3104	3347	3594	3925	4547	4150	6.0%
Cancer	2171	2099	2052	2295	3093	2449	2.4%
Disability	1086	1188	1158	1578	2092	1968	12.6%
AoD	769	728	714	953	1125	1063	6.7%
CKD	408	376	377	503	523	604	8.2%
Dementia/ Alzheimer's	352	365	398	459	714	478	6.3%
Oral	38	45	52	48	67	65	11.3%

Appendix 15. Gippsland Homeless Network member agencies (GHN 2024).

The Gippsland Homelessness Network is a resource to the homelessness sector operating in the Gippsland Region. Member agencies and their entry points are listed below:

- Community Housing Limited (Morwell and Bairnsdale)
- Gippsland East Gippsland Aboriginal Co-operative (GEGAC)
- Gippsland Lakes Complete Health (Lakes Entrance)
- Mallacoota District Health and Support Services
- Orbost Regional Health
- Quantum Support Services (Warragul)
- The Salvation Army (Leongatha, Baw Baw)
- Uniting (Sale)
- Victorian Aboriginal Childcare Agency (VACCA) (Kurnai Youth Homelessness Program)
- Yarram and District Health Service

Additional statewide services provide services and supports for people in Gippsland (GFVA 2024), including:

- The Salvation Army Crisis Service
- Family Access Network (LGBTQI+ transitional housing supports for youth 15-25)

Appendix 16. Multicultural service providers.

Providers in this space include:

- Latrobe Community Health Services Multicultural Services Team 1800 242 696 offers:
    - Refugee Health Nurse
    - Settlement Engagement & Transition Support
    - Strategic Engagement and Partnership Coordinators
    - Multicultural Health Connector Program, funded by Gippsland PHN
- Centre for Multicultural Youth, Gippsland (CMY)
- Gippsland Multicultural Services assists migrants and refugees
    - Access and Support Program helps older people find and access services
    - NDIS services
    - Respite care
    - Social support groups
- Translating and Interpreting Service (TIS National) free for people with limited English proficiency and for agencies and businesses that need to communicate with their non-English speaking clients
- Health Translations free library of translated health and wellbeing resources
- Victoria Department of Health: Refugee and asylum seeker health and wellbeing information
- Multicultural Health Connect 1800 186 815 for free health advice from a nurse
- Victorian Refugee Health Network resources, referrals and
- Centre for Culture, Ethnicity & Health provides training and resources
- Local Governments have information for new arrivals and links to community groups.