medicare local
MACEDON RANGES AND
NORTH WESTERN MELBOURNE

Connecting health to meet local needs

Macedon Ranges and North Western Melbourne Medicare Local

COMPREHENSIVE NEEDS ASSESSMENT SUMMARY

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- the CNA Strategic Leadership Group
- MRNWM-ML staff
- PwC

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- Lead West
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- Western and Central Melbourne Integrated Cancer Service
- Western Health
- Western Region Health Centre
- Women's Health West

We respectfully acknowledge the traditional owners of the land on which we reside, the Kulin nation and its Elders, their descendants and kin past and present.

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Executive Summary

The Australian Government embarked on major health reform in 2011 to address the challenges impacting the health system's effectiveness, efficiency, and sustainability. These challenges are an ageing population, rising chronic disease, and increasing treatment costs. A key part of the reform agenda was the establishment of 61 Medicare Locals tasked with reorienting the system towards stronger primary health care.

Medicare Locals are responsible for driving reform, acting as lead change agents, and working with stakeholders to improve systems and services to promote better health and wellbeing across the community.

The MRNWM-ML was established in March 2012 and serves a population of more than 500,000 people spread over 3,275 square kilometres. Its geography and demography are diverse, with a mixture of inner metro, outer metro, and rural areas. It contains significant refugee and migrant communities, pockets of socioeconomic disadvantage, and high concentrations of older Australians.

To effectively and efficiently assess and address its community's health needs, MRNWM-ML undertook a CNA between January and May 2014. A three-stage process – planning, assessing needs, and establishing priorities – and comprehensive community consultation was used to develop the CNA. Oversight was provided by a Strategic Leadership Group (SLG) made up of local health system providers and experts.

The following six priorities were identified by the community during the CNA process for action by the MRNWM-ML and its partners:

1. A GP education campaign on providing care to victims of family violence.
2. Targeted communication and education strategies to improve the health literacy of consumers in relation to drug and alcohol abuse, screening for cancer and chronic diseases.
3. Integrating care for patients as they access different health services from multiple providers.
4. Improving the information available to general practitioners on services available to patients to support them in referring their patients to the correct health services.

5. Improving access to maternal and child health services for consumers.
6. Improving access to mental health services by consumers through the establishment of mental health nurses in general practitioner clinics and other health services.

MRNWM-ML will work with local stakeholders to develop, implement, and coordinate projects and services that will specifically address these issues.

Introduction

The Australian Government commissioned a major health system review in 2009 led by the National Health and Hospitals Reform Commission. It identified opportunities for system reform to ensure the long-term effectiveness, efficiency, and sustainability of the health system. The review was triggered by the system's evident inability to adequately deal with emerging health challenges. These include an ageing population, rising chronic disease burden, and growing health inequalities which are placing a major burden on the system's resources and capacity.

The Commission recommended that the system move away from an episodic, treatment-based model of care towards one of prevention, health promotion, and effective chronic disease management. It also advocated for a stronger, better connected primary health care system to deliver on the reform objectives.

The Commission noted a lack of infrastructure and organisational mandate in the sector. It recommended that a network of local primary health care organisations be established to lead primary health care reform and the system's reorientation. The Australian Government subsequently established a network of 61 Medicare Locals across the country in three stages between July 2011 and July 2012.

The MRNWM-ML was established in March 2012 as the local primary health organisation responsible for the health of its population. It has been mandated with four tasks to help it improve its community's health:

- improving the patient journey through the health system by better connecting and coordinating services
- providing support to clinicians and service providers to improve and maintain high quality patient care
- identifying and addressing the health needs of the Macedon Ranges and North Western Melbourne catchment
- coordinating and implementing primary health care programs of national significance.

In fulfilling this mandate, MRNWM-ML undertook a CNA between January and May 2014. The CNA aimed to identify and analyse local health needs, current service gaps and capacity, opportunities for intervention, and priorities for action. This summary provides a brief outline of the CNA, including how the CNA was developed; information on the MRNWM catchment; the CNA's findings; priority areas; and an overview of potential actions. It will be used by MRNWM-ML and its partners to develop and implement health and social care projects.

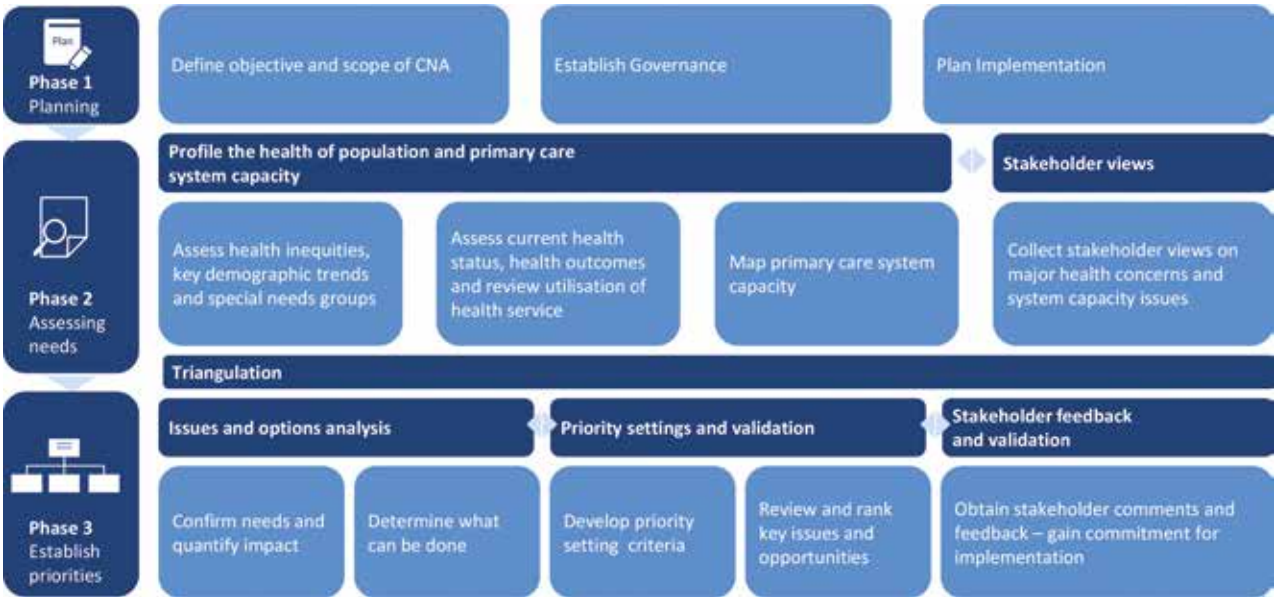
MRNWM-ML acknowledges the complex and intractable nature of the problems raised in the CNA, and the comprehensive and sustained approach required to address them. MRNWM-ML has been informed that it will not receive funding from the Australian Government after July 2015. We are therefore taking a pragmatic approach to what can be achieved in a 12 month period. We are also aiming to build a platform to enable other providers to continue taking the projects forward after our closure.

CNA Objectives and Methodology

The objectives of the CNA were to work with local stakeholders – including consumer and community groups, local government, GPs, and other health providers – to:

- assess and analyse the population's health status
- identify health inequalities across the catchment to inform further analysis of the social determinants of health
- review the local primary health care system's capacity and responsiveness to identify opportunities for improvement through better service coordination and integration
- consider evidence about the interventions available to address health issues and inequalities
- confirm priorities to inform the Medicare Local's strategy and activity development.

Figure 1. CNA development process



PHASE ONE: PLANNING

Phase one involved developing the CNA project plan which comprised:

- defining the CNA's objectives and scope
- establishing the Project Governance Strategic Leadership Group (SLG)
- identifying, mapping, and engaging stakeholders
- assessing resource needs and availability.

The SLG provided strategic direction, leadership, guidance, support and oversight during the CNA process. It had the following members:

- Dr Alastair Stark – General Practitioner and Chair, MRNWM-ML
- Dr Vanda Fortunato – CEO, MRNWM-ML
- Dr Arlene Wake – Executive Director, Western Health
- David Grace – Deputy Chief Executive, Djerriwarrh Health
- Professor Michelle Towstoless – Pro Vice Chancellor, Victoria University
- Dr Richard Bills – General Practitioner
- Dr Ruth Vine - Executive Director, North Western Mental Health
- Dr Iain Butterworth – Manager, Public Health and Western Area, North and West Metropolitan Region, Department of Health
- Craig Rowley – CEO, Lead West

A Stakeholder Engagement Strategy was developed to determine: which, when, to what extent, and how different stakeholders should be engaged in the process. Issues considered included stakeholders' interest in, and relevance to, the CNA's outcomes, as well as their ability and capacity to influence others.

PHASE TWO: ASSESSING NEEDS

Phase two involved profiling the population's health status, current service gaps, and the primary health care system's capacity and capability to respond to identified needs. Six work streams were established to undertake this task. They included:

- demographic profiling
- population health profiling
- service utilisation mapping
- workforce mapping
- health program mapping
- stakeholder consultation.

Stakeholder engagement during this phase included:

- consultation with 30 organisations
- 15 teleconferences
- 12 workshops
- distribution of 3,000 questionnaires to consumers, GPs and allied health professionals.

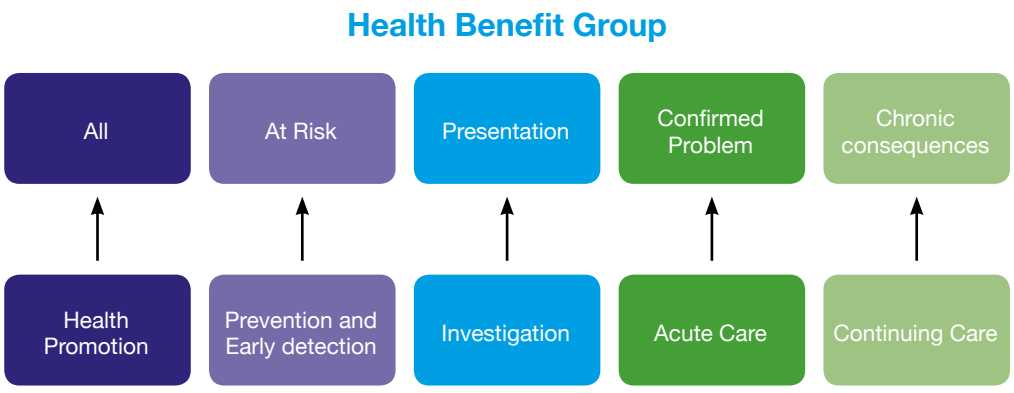
Data collected through these activities were used to analyse service accessibility, quality, and appropriateness. The specific needs of population sub-groups were also considered, particularly those demonstrating poor health outcomes, such as migrants, older Australians, Aboriginal and Torres Strait Islanders, those living with disability, and rural and remote residents.

PHASE THREE: ESTABLISH PRIORITIES

Phase three determined the region's health priorities and drew on the Health Benefit Group Approach (HBGA) to guide the process. The HBGA aims to match appropriate service packages with the corresponding population sub-group. It also considers the cost of the package and the population sub-group's capacity to benefit (see Figure 2 for an illustration).

The tool helped map current investment against best practice service delivery in the region. This enabled service gaps to be identified, as well as inefficiencies and opportunities for effective and high-value service improvements. Based on the findings, the SLG made recommendations to the MRNWM-ML Board. The health priorities proposed by the SLG were endorsed by the Board.

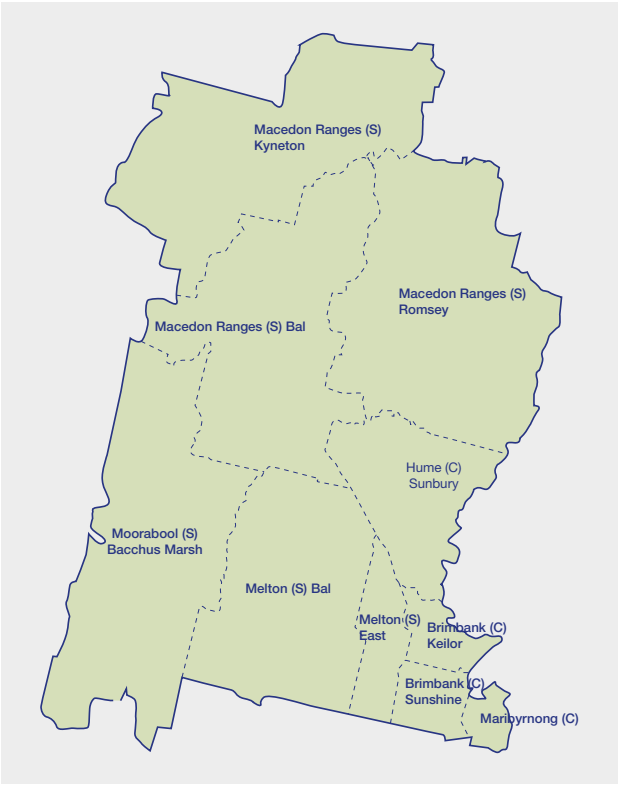
Figure 2. The Health Benefit Group Approach



Our Catchment

The MRNWM-ML region has over 500,000 residents spread across a diverse landscape, including a mix of inner and outer metropolitan suburbs and rural townships. The catchment stretches over 90 kilometres from Footscray in the inner western suburbs to Kyneton in the Macedon Ranges. It comprises six Local Government Areas (LGAs) and 10 Statistical Local Areas (SLAs).

Figure 3. Map of the MRNWM-ML catchment



INNER METRO

The inner metro region contains the LGAs Maribyrnong and Brimbank, and the suburbs of Footscray, Sunshine, St Albans and Caroline Springs. It has an estimated population of 274,000. The inner metro area is culturally and linguistically diverse with large numbers of migrants, refugees, and asylum seekers. Forty three percent of the population come from non-English speaking backgrounds, and 10–12 percent do not speak English well or at all. The region is socioeconomically disadvantaged, with unemployment rates of 8.3 percent. Brimbank and Maribyrnong have unemployment rates of 8 percent which is considerably higher than the state (5.6 per cent) and national (5 per cent) averages.

OUTER METRO

The outer metro region comprises the LGA of Melton and the township of Bacchus Marsh (which is in the Moorabool LGA). Its population is about 140,000. Melton has a relatively culturally and linguistically diverse population; 27.5 percent of its residents were born overseas, including 22 percent from non-English speaking countries and 3.5 percent who do not speak English well or at all. Bacchus Marsh has a comparatively small migrant population; 13.4 percent of its community were born overseas, which includes 5.5 percent from non-English speaking countries. Only 0.7 percent of people do not speak English well or at all. It does have a much higher older population with 18.3 percent of residents aged 65 years or over. Melton and Bacchus Marsh have unemployment rates of 6 percent and 4.3 percent, respectively, which are similar to the state and national averages.

RURAL

The rural region covers the LGA of Macedon Ranges, which includes the townships of Kyneton, Woodend, Gisborne and Romsey, and the township of Sunbury (which is in the Hume LGA). The region has an estimated population of 78,200. Neither Macedon Ranges nor Sunbury have high migrant populations, with 12.9 and 15.1 percent of residents being born overseas, respectively. They do however have a relatively high proportion of older Australians, representing 13.5 and 10.7 percent of their communities, respectively. Neither area is socioeconomically disadvantaged, with unemployment rates of 3.7 percent in Macedon Ranges and 3.9 percent in Sunbury. These are considerably lower than the state and national averages.

Health Priorities

The following six health priorities were identified using the criteria in phase three.

1. A GP EDUCATION CAMPAIGN ON PROVIDING CARE TO VICTIMS OF FAMILY VIOLENCE

Family violence is occurring at an unacceptable rate in the MRNWM region. Women's Health Victoria reported almost 600,000 incidents over a 12-month period in 2009 (see Table 1). The effects of family violence are profound. Victims often suffer severe and prolonged physical and psychological trauma. Their family and friends also often suffer from anxiety and fear as a direct result of the abuse. In many cases this includes the victims' children.

Table.1 Incidents of family violence by age group and Local Government Area (2009)

STATISTICAL LOCAL AREA	LOCAL GOVERNMENT AREA	FAMILY VIOLENCE						
		0-14	15-24	25-44	45-64	65-84	85+	TOTAL 2009
Hume (C) – Sunbury	Hume	38,761	26,782	49,774	37,959	13,134	1,130	167,540
Macedon Ranges (S) - **Kyneton** Macedon Ranges (S) - **Romsey**	Macedon Ranges	9,165	5,173	10,194	12,535	4,409	539	42,015
Maribyrnong (C)	Maribyrnong	11,639	9,984	27,611	14,407	6,662	1,220	71,523
Melton (S) - East Melton (S) Bal	Melton	24,098	13,899	34,769	21,285	5,331	618	100,000
Moorabool (S) - Bacchus Marsh	Moorabool	5,959	3,632	7,301	7,704	2,919	381	27,896
Brimbank (C) - Keilor Brimbank (C) - Sunshine	Brimbank	35,814	28,860	55,047	45,887	18,328	1,954	185,890

**Data was only available by LGA. Note that only part of the Hume and Moorabool LGAs are in the MRNWM-ML. Source:* Women's Health Victoria, 2013

Family violence is a complex issue that can be difficult to prevent and manage. The lack of service coordination among relevant service providers was identified as a clear issue facing the MRNWM community. Victims of family violence often need a wide range of services, such as medical and psychological treatment, accommodation assistance, legal aid, and social support. Poor coordination among these services can result in victims and their families falling through the gaps and not receiving the care they need.

General practices are a common entry point for victims of family violence into the health and social care systems. However, consultation with general practices, family violence experts, and community groups revealed that many GPs are ill-equipped to effectively identify, treat, and refer victims of family violence to appropriate services. To address this, MRNWM-ML will work with relevant stakeholders to develop and coordinate an education and training program. It will support GPs to better care for victims of family violence. The program will aim to give GPs, their patients, and the community confidence that victims of family violence are being identified early, given appropriate entry-level support, and referred to the necessary secondary services.

2. TARGETED COMMUNICATION AND EDUCATION STRATEGIES TO IMPROVE THE HEALTH LITERACY OF CONSUMERS ABOUT DRUG AND ALCOHOL ABUSE, SCREENING FOR CANCER AND CHRONIC DISEASES

There is a high rate of avoidable death and disease in the MRNWM-ML region. Life expectancy is two years below the state and national averages. Between 2009 and 2011, 150 potentially avoidable deaths and 2,815 potentially avoidable hospitalisations per 100,000 people occurred each year. In addition to the economic, social and psychological effects that this has on affected families and friends, it greatly impacts on the productivity and social cohesion of the broader community.

Table 2. Premature mortality by cause and infant death rate SLA/geographic area

STATISTICAL LOCAL AREA/ REGION	INFANT DEATH RATE PER 1,000	DEATH RATE FOR CHILDREN AGED ONE TO FOUR	AVERAGE ANNUAL ASR PER 100,000								
			EXTERNAL CAUSES	CHRONIC	RESPIRATORY	CEREBROVASCULAR DISEASE	ISCHAEMIC HEART DISEASE	CIRCULATORY SYSTEM DISEASE	CANCER	LUNG CANCER	COLORECTAL CANCER
Brimbank (C) – Keilor	5.0	..	21.8	18.4	11.7	10.0	23.6	46.2	101.1	21.7	9.6
Brimbank (C) – Sunshine	5.5	21.1	32.6	18.0	12.2	12.0	30.3	56.5	111.6	28.6	11.1
Maribyrnong (C)	4.1	0.0	28.2	26.2	16.8	10.0	35.5	59.6	104.1	22.2	13.4
Melton (S) – East	3.0	29.2	14.9	27.9	13.2	8.5	19.5	37.1	92.1	21.0	7.6
Melton (S) Bal	3.8	..	26.1	20.5	16.4	12.0	33.8	66.0	115.6	25.8	12.1
Hume (C) - Sunbury	4.2	..	32.2	31.5	14.9	5.8	19.5	41.1	100.4	16.9	10.8
Moorabool (S) - Bacchus Marsh	..	..	24.2	40.1	18.9	9.4	15.8	39.7	120.5	21.2	13.1
Macedon Ranges (S) - Kyneton	..	0.0	44.6	..	18.1	..	14.0	36.4	106.6	19.8	..
Macedon Ranges (S) - Romsey	..	0.0	24.1	..	..	..	26.6	42.2	74.9	15.2	..
Macedon Ranges (S) Bal	..	0.0	29.5	18.2	12.3	9.2	15.9	34.0	113.1	22.7	12.8
Macedon Ranges and North Western Melbourne	4.3	16.2	26.5	22.3	13.7	9.9	26.3	50.1	105.6	23.2	10.7
Victoria	3.7	16.9	27.6	19.7	11.9	8.7	24.4	45.1	100.8	19.8	10.3
Melbourne	3.4	15.5	24.5	16.3	10.5	8.6	22.3	41.9	96.4	19.0	9.7
Non-metropolitan Vic	4.7	21.0	35.9	26.5	15.1	8.7	28.9	51.9	110.9	21.5	11.8
Australia	4.3	20.1	29.9	21.9	14.1	9.3	27.9	50.1	102.5	21.3	10.0

Table 3. Selected potentially avoidable hospitalisations – MRNWM-ML compared with its National Health Performance Authority (NHPA) assigned Medicare Local peer group (Metro 3).

CONDITION	HOSPITALISATIONS PER 100,000 PEOPLE (CRUDE)	HOSPITALISATIONS PER 100,000 PEOPLE (AGE-STANDARDISED) MACEDON RANGES & NW MELB.	HOSPITALISATIONS PER 100,000 PEOPLE (AGE-STANDARDISED) METRO 3	MACEDON RANGES & NW MELB. RELATIVE TO METRO 3(b)	BED DAYS FOR MACEDON RANGES & NW MELB. - TOTAL BED DAYS	BED DAYS FOR HOSPITALISATIONS PER 100,000 PEOPLE (AGE-STANDARDISED) MACEDON RANGES & NW MELB. – HOSPITAL IN THE HOME BED DAYS(c)	SAME-DAY HOSPITALISATIONS(d)
Total(e)	2,628	2,815	2,735	3% higher	44,607	2,336	5,128
Chronic	1,156	1,294	1,249	4% higher	22,257	789	1,778
Angina	87	99	136	27% lower	804	NP	NP
Asthma	239	236	213	11% higher	1,789	NP	NP
Congestive cardiac failure	224	276	232	19% higher	6,749	NP	NP
Chronic obstructive pulmonary disease (COPD)	221	259	295	12% lower	5,652	NP	NP
Diabetes complications(f)	179	195	174	12% higher	5,317	NP	NP
Hypertension	30	34	32	7% higher	292	NP	NP
Iron deficiency anaemia and nutritional deficiencies(g)	167	186	159	17% higher	1,311	NP	NP
Rheumatic heart disease	9	10	10	2% lower	344	NP	NP
Acute(e)	1,384	1,430	1,399	2% higher	19,158	1,314	3,226
Dehydration and gastroenteritis	349	362	291	25% higher	3,135	NP	NP
Pyelonephritis	239	257	287	10% lower	3,791	NP	NP
Perforated bleeding ulcer	19	21	25	13% lower	538	NP	NP
Cellulitis	139	148	163	9% lower	3,348	NP	NP
Pelvic inflammatory disease	21	20	19	5% higher	225	NP	NP
Ear nose and throat infections	163	160	166	4% lower	1,013	NP	NP
Dental conditions	262	265	239	11% higher	1,368	NP	NP
Appendicitis with peritonitis	28	29	31	7% lower	709	NP	NP
Convulsions and epilepsy	131	133	151	12% lower	1,824	NP	NP
Gangrene	35	37	30	25% higher	3,325	NP	NP

a) Patients with multiple separations for selected potentially avoidable hospitalisations during 2011–12 are counted for each separation.
b) The relative percentage is based on unrounded age-standardised rates and on the relative difference rounded to two decimal places.
c) Hospital in the home days are days where the care to hospital admitted patients is provided in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.
d) A same day hospitalisation occurs when a patient is admitted and separated from hospital on the same date.
e) Components may not add to totals because separations for vaccine -preventable conditions, gangrene and appendicitis with peritonitis are based on both principal and additional diagnoses, and therefore may also count towards separations for other selected potentially avoidable hospitalisation conditions.
f) Excludes diabetes complications coded as an additional diagnosis.
g) Data combined due to low separation counts for nutritional deficiencies
h) Data for hospital in the home bed days and same-day hospitalisations have not been reported for individual conditions due to low counts
Source: National Health Performance Authority, 2013.

Contributing to the large number of avoidable deaths and hospitalisations is the high rate of chronic disease in the community.

Table 4. Chronic diseases and conditions by Statistical Local Area

STATISTICAL LOCAL AREA/ REGION	TYPE 2 DIABETES (ASR PER 100) 2007-2008 MODELLED ESTIMATE	CIRCULATORY DISEASE (ASR PER 100) 2007-2008 MODELLED ESTIMATE	RESPIRATORY SYSTEM DISEASE (ASR PER 100) 2007-2008 MODELLED ESTIMATE	ASTHMA (ASR PER 100) 2007-2008 MODELLED ESTIMATE	CHRONIC OBSTRUCTIVE PULMONARY DISEASE (ASR PER 100) 2007-2008 MODELLED ESTIMATE	MUSCULOSKELETAL SYSTEM DISEASES (ASR PER 100) 2007-2008 MODELLED ESTIMATE	ARTHRITIS (ASR PER 100) 2007-2008 MODELLED ESTIMATE	OSTEOARTHRITIS (ASR PER 100) 2007-2008 MODELLED ESTIMATE	MALES WITH MENTAL AND BEHAVIOURAL PROBLEMS (ASR PER 100) 2007-2008 MODELLED ESTIMATE	MALES WITH MOOD (AFFECTIVE) PROBLEMS (ASR PER 100) 2007-2008 MODELLED ESTIMATE	FEMALES WITH MENTAL AND BEHAVIOURAL PROBLEMS (ASR PER 100) 2007-2008 MODELLED ESTIMATE	FEMALES WITH MOOD (AFFECTIVE) PROBLEMS (ASR PER 100) 2007-2008 MODELLED ESTIMATE	HIGH CHOLESTEROL (ASR PER 100) 2007-2008 MODELLED ESTIMATE	HYPERTENSIVE DISEASE (ASR PER 100) 2007-2008 MODELLED ESTIMATE	HIGH OR VERY HIGH PSYCHOLOGICAL DISTRESS LEVELS (K-10) (MODELLED ESTIMATE), PERSONS AGED 18 YEARS AND OVER
Brimbank (C) - Keilor	3.5	17.4	25.4	8.0	2.0	28.4	13.4	7.6	9.3	6.1	9.8	9.2	5.2	9.6	14.2
Brimbank (C) - Sunshine	4.0	18.3	25.3	7.9	2.2	28.9	16.1	8.2	10.4	7.0	10.5	9.9	5.7	10.3	16.1
Maribyrnong	4.0	18.6	26.2	8.2	2.2	29.0	16.2	8.7	10.5	6.9	10.0	9.4	5.6	11.8	14.2
Melton (S) - East	3.3	15.7	26.1	8.1	1.9	28.2	13.0	7.7	8.6	5.5	8.6	8.3	5.0	9.8	13.0
Melton (S) Bal	3.5	18.3	28.1	9.8	2.6	30.7	15.0	8.7	10.8	6.3	11.0	10.0	5.3	10.4	13.7
Hume (C) - Sunbury	3.2	16.2	28.1	9.5	2.3	30.0	14.4	8.5	9.3	5.4	9.7	8.9	5.2	10.4	11.1
Moorabool (S) - Bacchus Marsh	3.3	18.1	32.0	9.9	2.5	31.6	14.9	10.2	10.2	5.8	9.9	9.2	5.3	10.4	10.8
Macedon Ranges (S) - Kyneton	3.3	17.9	32.3	10.1	2.5	31.5	15.0	9.8	11.3	6.6	10.3	9.5	5.4	10.2	11.5
Macedon Ranges	3.1	15.7	31.6	9.5	2.3	30.6	14.0	9.5	9.5	5.4	9.1	8.5	5.0	8.7	9.7
Macedon Ranges (S) Bal	3.0	15.7	30.2	9.4	2.1	30.1	13.6	9.4	9.1	5.2	8.8	7.0	5.1	8.8	8.6
MRNWM	3.6	17.6	26.9	8.5	2.2	29.3	14.8	8.4	9.9	6.3	11.0	9.2	5.3	10.3	13.6
Victoria	3.4	17.3	27.3	9.1	2.2	29.8	14.6	8.7	9.9	6.0	11.6	8.3	5.4	10.3	12.0
Metropolitan Vic	3.4	17.0	26.1	8.7	2.1	29.0	14.1	8.3	9.5	5.8	11.4	8.3	5.3	10.0	12.1
Non-metropolitan Vic	3.5	18.0	30.7	10.1	2.5	31.7	15.6	9.5	11.0	6.4	12.2	8.5	5.5	10.9	11.7
Australia	3.4	16	26.6	9.7	2.3	30.1	14.9	7.6	10.1	6	11.8	8.5	5.6	9.2	11.7

** Red shading highlights figures greater than the national average and green shading represents figures lower than the national average. Orange highlights the national average to draw attention to this basis of comparison.*

Table 4 illustrates the high rates of chronic disease across many parts of the catchment. Balance (Melton), Bacchus Marsh (Moorabool), and Kyneton (Macedon Ranges) all show particularly high rates of disease. These figures are attributed to a number of lifestyle factors of concern in the MRNWM community. Sixty-six percent of adults are either overweight or obese, 21.4 percent smoke daily, physical inactivity levels are high, poor diets are common, and alcohol and drug abuse is pervasive.

Table 5. Physical inactivity, overweight, obesity, and fruit consumption by Statistical Local Area

STATISTICAL LOCAL AREA/ REGION	AGE STANDARDISED RATE PER 100								
	PHYSICAL INACTIVITY (MODELLED ESTIMATE), PERSONS AGED 15 YEARS AND OVER	OVERWEIGHT (NOT OBESE) MALES (MODELLED ESTIMATE), 18 YEARS AND OVER	OBESE MALES (MODELLED ESTIMATE), 18 YEARS AND OVER	OVERWEIGHT (NOT OBESE) FEMALES (MODELLED ESTIMATE), 18 YEARS AND OVER	OBESE FEMALES (MODELLED ESTIMATE), 18 YEARS AND OVER	OVERWEIGHT (NOT OBESE) PERSONS (MODELLED ESTIMATE), 18 YEARS AND OVER	OBESE PERSONS (MODELLED ESTIMATE), 18 YEARS AND OVER	USUAL DAILY INTAKE OF TWO OR MORE SERVES OF FRUIT (MODELLED ESTIMATE), PERSONS AGED 5 TO 17 YEARS	USUAL DAILY INTAKE OF TWO OR MORE SERVES OF FRUIT (MODELLED ESTIMATE), PERSONS AGED 18 YEARS AND OVER
Brimbank (C) -Keilor	36.5	34.8	19.8	21.7	18.2	28.1	18.9	59.9	51.3
Brimbank (C) -Sunshine	44.2	32.1	16.7	21.4	17.8	26.7	17.3	59.6	50.5
Maribyrnong (C)	39	32.6	18.4	21.1	17.5	26.9	18.0	58.2	50.7
Melton (S) - East	35.6	35.5	16.3	22.4	15.3	28.9	15.8	63.3	49.9
Melton (S)- Bal	34.8	35.3	21.7	23.3	19.7	29.1	20.7	59.7	47.5
Hume (C) -Sunbury	31	37	17.2	23.4	16.2	30.0	16.7	64.6	49.1
Moorabool (S) -Bacchus Marsh	32	36.6	17.7	23.5	19.2	29.9	18.4	65.3	48.3
Macedon Ranges (S) - Kyneton	32.4	36.2	21.1	23.5	18.5	29.7	19.4	63.4	48.5
Macedon Ranges (S) - Romsey	30.5	37.4	17.3	23.5	15.9	30.4	16.6	64.3	48.9
Macedon Ranges (S) Bal	27.7	38.3	16.6	23.5	13.4	30.7	14.9	64.3	50.6
MRNWM-ML	37	34.4	18.3	22.1	17.5	28.2	17.9	61.2	50.1
Victorian mean	32.6	35.7	18	22.6	16	29.0	17.0	63.2	50.9
Melbourne metro	32.2	35.7	17	22.2	15.5	28.8	16.2	63.6	51.9
Non metropolitan Melbourne	33.8	35.8	20.7	23.6	17.4	29.6	19.0	62.1	48.9
Australia	34.3	36	19.6	22.7	16.4	29.2	18	61	50.2
ML RANK	18	60	45	50	28	55	40	34	19

** Red shading highlights figures greater than the Australian average and green shading represents figures lower than the Australian average. Orange highlights the national aver- age to draw attention to this basis of comparison.*
Source: Public Health Information Development Unit, 2013

Table 6. Smoking and alcohol consumption by Statistical Local Area (2011)

STATISTICAL LOCAL AREA/ REGION	AGE STANDARDISED RATE PER 100			
	MALE CURRENT SMOKERS (MODELLED ESTIMATE), 18 YEARS AND OVER	FEMALE CURRENT SMOKERS (MODELLED ESTIMATE), 18 YEARS AND OVER	CURRENT SMOKERS 18 AND OVER	ALCOHOL CONSUMPTION AT LEVELS CONSIDERED TO BE A HIGH RISK TO HEALTH (MODELLED ESTIMATE), PERSONS AGED 18 YEARS AND OVER
Brimbank (C) - Keilor	23.8	18.1	20.9	3.5
Brimbank (C) - Sunshine	26	19.2	22.6	3.3
Maribyrnong (C)	23.4	17.5	20.6	4
Melton (S) - East	23.7	18	20.9	3.9
Melton (S) Bal	26.1	22.2	24.2	5.1
Hume (C) - Sunbury	22.2	18.6	20.4	5
Moorabool (S) - Bacchus Marsh	23.8	19.7	21.7	5
Macedon Ranges (S) - Kyneton	25.3	20	22.6	5.1
Macedon Ranges (S) – Romsey	22.5	17.8	20.1	4.9
Macedon Ranges (S) Bal	19.2	16	17.6	4.7
MRNWM-ML	24.1	18.7	21.4	4
Victorian mean	21.9	17.8	19.8	4.6
Melbourne metropolitan	21	16.7	18.8	4.3
Non metropolitan Melbourne	24.5	20.9	22.7	5.4
Australia	17.1	14.7	15.9	4.6
ML RANK	32	38	38	59

** Red shading highlights figures greater than the Victorian average and green shading represents figures lower than the Victorian average. Orange highlights the national average to draw attention to this basis of comparison. Source:* Public Health Information Development Unit, 2013

Compounding the effects of unhealthy behaviors is the low participation in preventative health activities across the MRNWM catchment. Cancer screening for at-risk groups is an effective way of identifying and intervening early in cancer cases. It saves, extends and improves lives. Yet MRNWM has low comparative rates of participation across more than half of its LSAs, and an average participation rate lower than that of Victoria.

Table 7. Bowel and cervical cancer screening rates by Statistical Local Area

STATISTICAL LOCAL AREA/ REGION	BOWEL CANCER SCREENING PARTICIPATION 2010		CERVICAL CANCER SCREENING PARTICIPATION, FEMALES AGED 20 TO 69 YEARS 2009-2010	
	TOTAL PERSONS WHO WERE INVITED TO PARTICIPATE	PERCENT THAT PARTICIPATED	WOMEN AGED 20 TO 69 YEARS (BASED ON AVERAGE OF TWO YEARS' POPULATIONS)	PERCENT THAT PARTICIPATED
Brimbank (C) – Keilor	4,640	33.1	27,144	51.9
Brimbank (C) - Sunshine	4,206	32.4	28,191	65.4
Maribyrnong (C)	2,883	34.3	23,037	54.8
Melton (S) - East	2,003	33.1	16,593	41.0
Melton (S) Bal	2,272	31.4	13,968	47.3
Hume (C) - Sunbury	1,699	37.1	10,404	59.1
Moorabool (S) - Bacchus Marsh	909	37.8	4,965	60.0
Macedon Ranges (S) - Kyneton	684	38.2	2,463	61.2
Macedon Ranges (S) - Romsey	649	38.5	3,370	62.8
Macedon Ranges (S) Bal	1,154	40.6	5,948	71.8
MRNWM-ML	n/a	n/a	136,083	55.5
Victoria	n/a	n/a	1,586,163	60
Melbourne Metro	n/a	n/a	1,203,070	60.1
Non metropolitan Victoria	n/a	n/a	383,093	60.4
Australia	n/a	n/a	n/a	n/a

** Red shading highlights figures less than the Victorian average and green shading represents figures higher than the Victorian average. Orange shows the Victorian average to provide a basis for comparison. Source:* PHIDU 2014

Table 8. Breast cancer screening rates 2010-12 by Local Government Area

LOCAL GOVERNMENT AREA	2010-2012 TARGET AGE GROUP 50-69		
	POPULATION	THROUGHPUT	PARTICIPATION
Population	Throughput	Participation	53.70%
Macedon Ranges	5,526	3,276	59.30%
Maribyrnong	7,875	4,080	51.80%
Melton	13,948	7,395	53%
Sunbury	4,013	2,242	56%
Bacchus Marsh	2,240	1,181	53%
Victoria	n/a	n/a	54.70%

** Red shading highlights figures greater than the Victorian average and green shading represents figures lower than the Victorian average. Orange highlights the Victorian average to draw attention to this basis of comparison. Source:* Breast Screen Victoria, 2013.

To help people make healthier lifestyle choices and improve cancer screening rates in at-risk groups, the population needs a sufficient level of health literacy. Health literacy is the 'degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions'. People with inadequate health literacy have poorer levels of knowledge and understanding about their condition. This means they are less likely to attend appointments and follow instructions about medication and health behaviour advice.

MRNWM-ML will work with its local partners to develop and implement a health literacy program across the region. The program will target at-risk groups and consider the needs of different populations, such as migrants, refugees, and the homeless. Improved health literacy levels in the community will mean people are better informed and supported to make healthier lifestyle choices. They will also be more confident to manage their general health and any existing conditions, and to participate more readily in preventative health measures such as cancer screening.

3. IMPROVING INFORMATION FOR GPS ABOUT SERVICES AVAILABLE TO PATIENTS TO HELP THEM REFER PATIENTS TO THE RIGHT HEALTH SERVICES

Poor health service coordination can lead to patients missing out on necessary services or receiving them in an untimely manner. This can result in worse health outcomes, poor patient experience, system inefficiencies, and increased health care costs.

Consultation with GPs throughout the CNA process indicated that inadequate communication between health care providers was causing poor coordination in the region. Specifically, information about referral options for GPs was found to be inadequate and difficult to access.

To help address poor service coordination, MRNWM-ML will work with GPs and secondary health care providers to improve the information sources and systems available to GPs. Secondary health care providers include allied health professionals, medical specialists, and community and support networks.

4. INTEGRATING CARE FOR PATIENTS AS THEY ACCESS DIFFERENT HEALTH SERVICES FROM MULTIPLE PROVIDERS

Integrated care refers to service provision that is seamless, comprehensive, collaborative, consumer-centred, and delivered over the continuum of care, from birth to death. It involves more than the simple coordination of services. It requires a deeper level of collaboration and interdependence between providers. It is often achieved by setting common objectives, shared resources, and mutual responsibilities and accountabilities.

Evidence shows that high levels of service integration lead to greater efficiency, lower costs, better patient experience, and improved health outcomes. Consultation through the CNA process identified a number of barriers to realising integrated care in the region. The impediments include: poor communication and engagement across providers, and a poor understanding of the opportunities available for inter-professional and inter-sectoral collaboration.

MRNWM-ML will work towards integrated care by improving communication and engagement systems across all providers in the region. It will also act as a relationship broker between professions and sectors.

5. IMPROVING ACCESS TO MATERNAL AND CHILD HEALTH SERVICES

The years of early childhood development are arguably the most important in terms of health outcomes. A child's physical, psychological, and social health during these years will substantively impact on their opportunities to gain secure and meaningful employment as an adult, create and sustain healthy social bonds, and become active and productive members of society. For these reasons access to quality maternal and child health services are of utmost importance. This is especially the case for mothers and children who are at risk of poor health and development, such as first time mothers and those who are socioeconomically disadvantaged.

Mothers in the MRNWM region are finding it difficult to access maternal and child health services in a timely manner. Data collected through the CNA indicate that waiting times for these services are well in excess of best-practice. In some MRNWM areas people report waiting up to 51 weeks for paediatric occupational therapy, 54 weeks for speech pathology and eight weeks for physiotherapy services. Accessing general maternal and child health services, such as parenting advice and support, is also problematic. Families in some areas have to wait up to eight weeks for an initial consultation. The reasons for poor accessibility can be numerous and complex but often include workforce shortages, mal-distribution, and the inefficient use of the health workforce.

Table 9. Maternal and child health services by Local Government Area (2012)

SERVICE: MCHN	SLA	MCHN	ENHANCED MCHN
Brimbank (C) (Part LGA)	Brimbank (C) - Keilor Brimbank (C) - Sunshine	8	8
Hume (C) (Part LGA)	Hume (C) - Sunbury	2	2
Macedon Ranges (S)	Macedon Ranges (S) - Kyneton Macedon Ranges (S) - Romsey Macedon Ranges (S) Bal	1-3	1-3
Maribyrnong (C)	Maribyrnong (C)	4	2-4
Melton (C)	Melton (S) - East Melton (S) Bal	8	1-2
Moorabool (S)	Moorabool (S) - Bacchus Marsh	1-3	1-2

**The highlighted sections indicate waiting times of more than four weeks. Source:* MRNWM-ML

Table 10. Average paediatric allied health service waiting times (weeks) by Statistical Local Area (2012)

SERVICE: PAEDIATRIC	ISIS CHC (BRIMBANK(C) - SUNSHINE)	SUNBURY CHC (HUME (C) – SUNBURY)	COBAW CHC (MACEDON RANGES (S) – KYNETON)	WESTERN REGION HC (MARIBYRNONG (C))	DJERRIWARRH CHC (MELTON (S) BAL)
SLA					
Occupational therapy	33-51	0	3-8	10-12	13
Speech pathology	45-54	26	16	8-38	26
Physiotherapy	0	8	6	0	0

**The highlighted sections indicate waiting times of more than four weeks. Source:* MRNWM-ML, 2012.

Table 11. Childhood vulnerability screening rates and outcomes by Statistical Local Area

STATISTICAL LOCAL AREA/ REGION	EARLY CHILDHOOD DEVELOPMENT: AEDI, DEVELOPMENTALLY VULNERABLE ON 1 OR MORE DOMAINS (2009)		EARLY CHILDHOOD DEVELOPMENT: AEDI, DEVELOPMENTALLY VULNERABLE ON 2 OR MORE DOMAINS (2009)		EARLY CHILDHOOD DEVELOPMENT: AEDI, DEVELOPMENTALLY VULNERABLE (2009)	
	CHILDREN ASSESSED IN AEDI (FIRST YEAR OF SCHOOL)	% CHILDREN DEVELOPMENTALLY ASSESSED IN AEDI VULNERABLE ON 1 OR MORE DOMAINS (FIRST YEAR OF SCHOOL)	CHILDREN	% CHILDREN DEVELOPMENTALLY ASSESSED IN AEDI VULNERABLE ON 2 OR MORE DOMAINS	CHILDREN	% CHILDREN DEVELOPMENTALLY VULNERABLE IN PHYSICAL DOMAIN
Brimbank (C) - Keilor	1,160	25.6	1,161	11.9	1,161	7.3
Brimbank (C) - Sunshine	869	29.0	869	13.5	871	9.5
Maribyrnong (C)	671	25.3	672	12.8	673	10.8
Melton (S) - East	804	18.2	805	7.5	807	5.1
Melton (S) Bal	624	22.1	627	9.9	629	7.8
Hume (C)	429	15.9	429	7.5	429	5.6
Moorabool (S)	242	16.5	239	7.1	243	6.6
Macedon Ranges (S) -Kyneton	101	14.9	102	6.9	102	5.9
Macedon Ranges (S) -Romsey	137	13.9	137	10.9	137	6.6
Macedon Ranges (S) Bal	288	14.9	289	8.0	289	6.6
MRNWM-ML	5,325	22.3	5,330	10.5	5,341	7.6
Victoria	58,309	20.3	58,452	10.0	58,531	7.7
Melbourne metro	42,397	20.1	42,490	9.6	42,545	7.3
Non metropolitan Melbourne	15,912	20.8	15,962	10.9	15,986	8.5
Australia	252,462	23.6	252,922	11.9	253,283	9.4

** Red shading highlights figures greater than the Australian average and green shading represents figures lower than the Australian average. Orange highlights the national average to draw attention to this basis of comparison.*
Source: Public Health Information Development Unit, 2013.

To help address poor access to maternal and child health services, MRNWM-ML will partner with local stakeholders, including Western Health, local governments, and health workforce agencies, to identify the precise factors underpinning poor accessibility in the area. Following further consultation, MRNWM-ML will support and help coordinate activities to improve access. This may include commissioning additional services, or developing workforce and service models that increase existing service efficiency.

6. IMPROVING CONSUMERS' ACCESS TO MENTAL HEALTH SERVICES THROUGH THE ESTABLISHMENT OF MENTAL HEALTH NURSES IN GP CLINICS AND OTHER HEALTH SERVICES

Mental health is a major concern facing many Australians, with 45 percent of the population expected to experience a mental health issue at some stage over their lifetime. Even the most common mental health disorders like depression, anxiety, and those caused by alcohol and substance abuse, often have profound and long lasting effects on sufferers, along with their family and friends.

The MRNWM community has a relatively high proportion of people experiencing mental health disorders, with 13.6 percent of residents reporting high or very high levels of psychological distress. This is higher than the state and national averages. Moreover, refugee and migrant communities, people of low socioeconomic status, and older Australians all have a large presence in the MRNWM catchment. These groups are vulnerable to mental health conditions.

Mental health is a complex area with many potential underlying causes and treatment options. Nevertheless, the CNA identified timely access to mental health services as a significant issue facing the MRNWM population.

To help address poor access to mental health services, MRNWM-ML will work with general practices to explore the option of employing more mental health nurses in their clinics. In addition, local mental health stakeholders will be engaged to work on improving service efficiency. This may include examining changes to existing service models and exploring the use of IT support systems to aid coordination.

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