phn
NORTH WESTERN
MELBOURNE

An Australian Government Initiative

North Western Melbourne
Primary Health Network

Health Needs Assessment

2022 to 2025

Summary

SNAPSHOT OF THE NWMPHN REGION

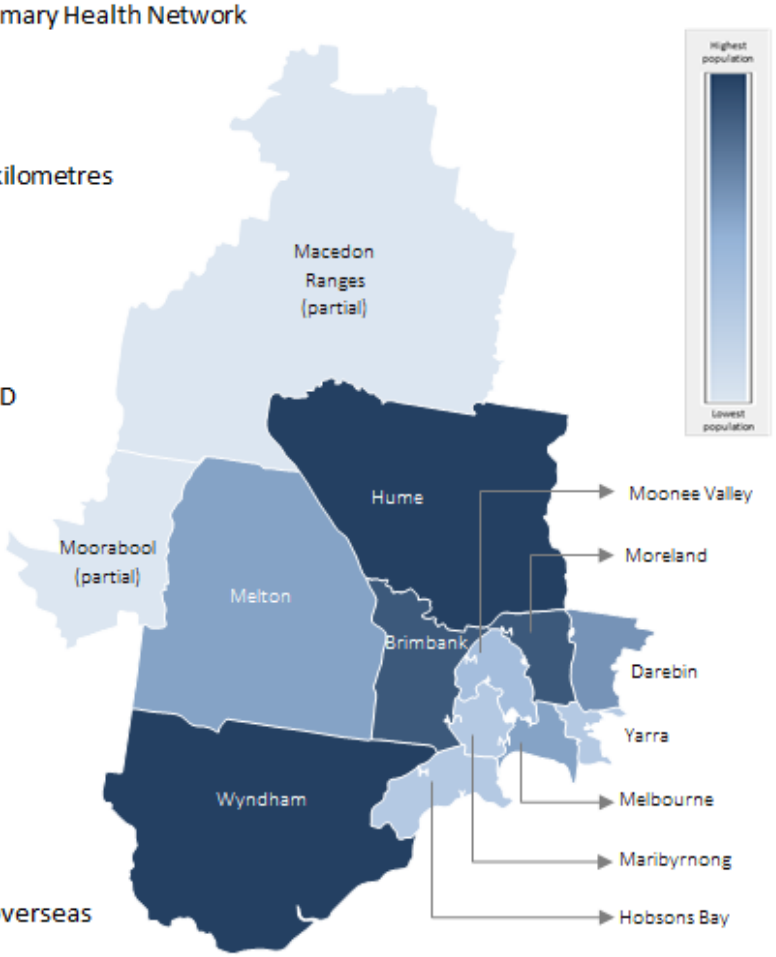
North Western Melbourne Primary Health Network comprises:

3,212 square kilometres

171 suburbs, including Melbourne's CBD

13 Local Government Areas

1.9+ million residents



- **632,000+** residents born overseas
- **200+** spoken languages
- **5** Indigenous nations
- **10,000+** Aboriginal and Torres Strait Islander residents
- **123,000+** of the population are LGBTIQ+
- **most** of Victoria's 5000+ bridging visa holders.
- **more humanitarian arrivals** than anywhere else in Victoria.

NWMPHN HEALTH SERVICES

561 General practice clinics

375 Pharmacies plus three Supercare Pharmacies

126 Residential Aged Care Facilities

12 Major hospitals

15 Private overnight hospitals

22 Mental health inpatient service providers

1327 Mental health outpatient and community service providers

PHIDU 2021a; VAHI, 2019.

SNAPSHOT OF NWMPHN POPULATION HEALTH STATISTICS

37% of the population reside in the growth areas of Wyndham, Hume and Melton.[1]

61% of the population is in Melbourne inner city and suburban areas. [1]

The NWMPHN population will grow by almost **28%** by 2030.[1]

In 2016 NWMPHN had overall higher levels of disadvantage than Victoria and there is socioeconomic inequity across and within LGAs.[1]

13% of adults in NWMPHN are daily smokers; more common among men (15%) compared to women (11%).[2]

5 of 13 LGAs had overall increased lifetime risk of alcohol-related harm greater than Vic average.[2]

20% of adults estimated to be obese (BMI >30), **30%** overweight (BMI 25-29).[2]

95.5% of 5-year-old children are fully vaccinated.[3]

58% of people reported living with at least one chronic disease.[2]

Around **28%** of adults have been diagnosed with anxiety or depression.[2]

2020-21 has seen a reduction in hospitalisations and ED presentations (influenced by lockdown period).[4]

The number of potentially preventable hospitalisations dropped by **18%** from 2019-20 to 2020-21.[1]

Health issues of most concern in our community are:

- Overall physical health
- Mental health
- Dental/oral health
- Chronic health conditions

Top barriers to accessing care when needed are:

- Cost
- Waiting time
- Didn't know where to go
- Can't get an appointment

[1]PHIDU, 2021a; [2]VAHI, 2021a; [3]DoH, 2021e; [4]VAHI, 2021b, 2021c.

HEALTH NEEDS ASSESSMENT – METHODOLOGY

What do we mean by 'need'?

A needs assessment implies there is a gap or discrepancy between the current conditions - 'what is' - and the ideal conditions - 'what should be'. This gap - the difference between the current condition and the ideal condition - is the 'need'.

Needs are relative, and what is necessary depends on your point of view. Need can be divided into four types.

1. **'Comparative',** which identifies measures to define need across a population or community. It highlights those not yet receiving services among those with common needs.
2. **'Felt',** which is defined by what people living in or accessing services in the region *want*. 'Felt' needs are often unexpressed. They are defined by social circumstance and personal perception.
3. **'Expressed',** which is what a 'felt' need becomes when it is communicated by a group or individual.
4. **'Normative',** which identifies needs defined by experts in the field. These are often measured against previously established standards.

Developing the Evidence Base

The Health Needs Assessment (HNA) uses three forms of evidence to understand each type of need across our region: analysis of population data, community consultation and market engagement.

POPULATION DATA

We approach population analysis using a structure known as *social determinants of health*: the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

This approach identifies a *base need* which exists across the entire population and then applies an *equity loading* based on disparities arising from the differences in how people live.

COMMUNITY CONSULTATION

We listened extensively to residents to hear about their perceived health and wellbeing, as well as their experience of accessing health care services. Data was gathered using a community survey, targeted focus groups, and input from key members of NWMPHN's People Bank (its large register of residents keen to provide feedback and insight on our activities).

MARKET ENGAGEMENT

We interviewed providers in the region across general practice, commissioned services, peak bodies, community health, acute health care and local government. We also offered an online survey to all service providers and held three online workshops for GPs.

Insights from the analysis of all the evidence gathered was used to identify health priorities for NWMPHN.

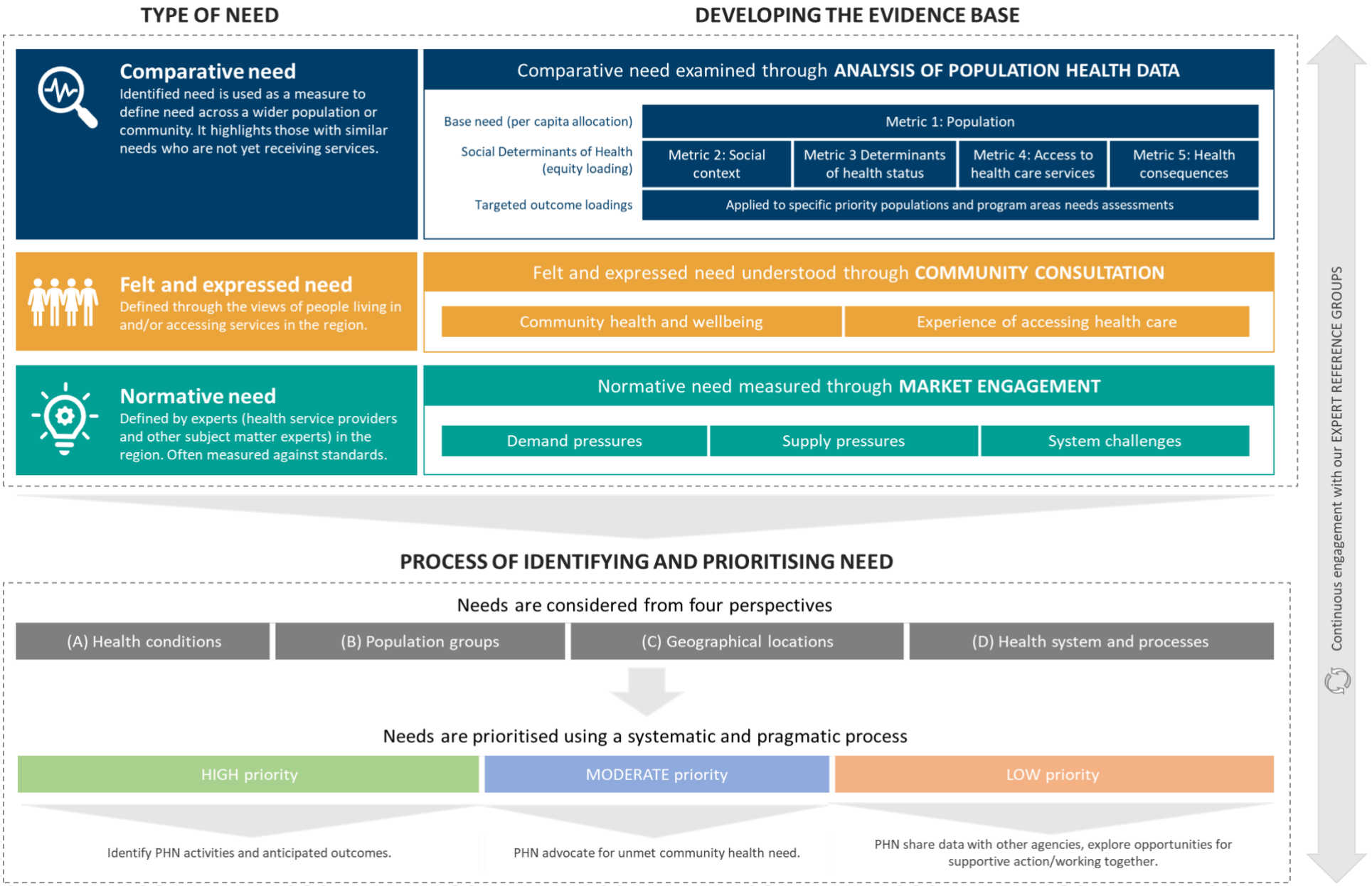
Figure 1 illustrates the *different types of need*, the *evidence base*, and the approach to *prioritising need*.

THE LIMITATIONS OF OUR MODEL

This HNA relies on many data sources, and while best attempts have been made to include all information and data relevant to the health and wellbeing of the community in NWMPHN there are limitations in accessing data for some population groups. As a result, the HNA may under-represent some populations, including non-binary, trans and intersex residents, and to a lesser extent people of Aboriginal and Torres Strait Islander heritage.

More detail can be found at the end of this document.

Figure 1. NWMPHN Health Needs Assessment Framework



KEY INSIGHTS

Here is a summary of key insights from the analysis of population health data. These have been grouped into 5 measures of need. We take a closer look at what we heard from the community consultation and market engagement exercises.

Population

This defines our community in terms of geographical area and identifies need based on where people are and projections of where they will be in the future.

Insights

- NWMPHN's region has the largest population of all 31 Primary Health Networks, with an additional large number of commuters.
- 61% of the population is in Melbourne's inner city and suburbs, but approximately half the geographic region is classified as rural.
- 3% of our population are in two peri-urban areas (Macedon Ranges and Moorabool). That is, they lie outside the city and have a mixture of town and country characteristics.
- 37% of our population reside in the growth areas of Wyndham, Hume and Melton.
- Population in the catchment area is expected to grow by almost 28% by 2030 and by 2036 will account for almost one-third of Victoria's population.

Social Context

This recognises that an individual's social position plays a key role in the health outcomes they are likely to experience.

Insights

The population of the NWMPHN region is as socially and culturally diverse as it is geographically varied.

- Almost a third of residents were born in predominantly non-English speaking countries, compared to 22% state-wide. However, this ranges widely, from 5% in Macedon Ranges LGA up to 49% in Melbourne and 44.7% in Brimbank.
- In some areas there are larger proportions of priority populations than in the rest of the catchment area, and Victoria in general. For instance, there are significantly higher estimates of children aged under 14 years in the growth area LGAs, and larger numbers of people who identify as LGBTIQ in Yarra, Moreland, Melbourne, and Darebin LGAs. There is a slightly higher proportion of Aboriginal and Torres Strait Island people in Moorabool, Melton and Darebin.
- Factors including income, employment and education combine to produce a ranking of disadvantage, measured on the Index of Relative Socio-economic Disadvantage (IRSD). According to 2016 Census data, the NWMPHN region population had an overall IRSD score of 994 compared with Victoria's 1010 and Australia's 1000.
- Highest levels of disadvantage were in Brimbank (IRSD 921), Hume (947), Melton (994) and Maribyrnong (995), with small pockets of extreme disadvantage (IRSD lower than 400) identified within the relatively more advantaged LGAs of Melbourne, Yarra and Moonee Valley.
- Higher levels of liveability are generally experienced by people in inner city areas. Six LGAs in the catchment – Brimbank and all LGAs in growth and peri-urban areas – are all rated below average on the Australian Urban Observatory Liveability Index in 2021, which combines six domains associated with health and wellbeing outcomes.

Determinants of Health Status

This explores how social context can result in different health-related behaviours and vulnerabilities to health-compromising conditions.

Insights

- The proportion of daily smokers was greater than the Victorian average in the Melton, Hume, Moorabool, Brimbank and Wyndham LGAs.
- Hume, Melton and Wyndham had a low proportion of adults meeting fruit and vegetable consumption guidelines.
- 5 of the 13 LGAs had an increased lifetime risk of alcohol-related harm - greater than the Victorian average.
- Adjusted for determinants of health status, Melbourne, Melton and Moorabool have the highest score for health risks but Wyndham, Hume, Brimbank and Melbourne are attributed the highest proportion of need because they have many more residents with high health risks.
- The areas with the lowest proportion of need are Moorabool and Macedon Ranges.
- There are some LGAs which have outlying high risk -- for example, alcohol and other drug risks in Yarra, reflecting the complexities of social determinants in health behaviours.

Access to Health Care Services

This recognises that the health system itself is a social determinant which plays an important role in the different consequences of illness in people's lives.

Insights

- Though the NWMPHN region has the highest population of all the Primary Health Networks, the number of Full-Time Equivalent General Practitioners (GPFTE) decreased in the 2020 calendar year, while the general practice services delivered per person are in line with other PHNs in Victoria.
- Despite Melbourne LGA having the highest number of GPs (523) it has the lowest number of GPFTE per 1000 residents (0.8). For Wyndham the figure is 1.3.
- The NWMPHN catchment has more male than female GPs, but a significantly higher proportion of the GP time is spent with female patients.
- Unsurprisingly, COVID-19 changed the way services were delivered in general practice. Overall, the number of face-to-face services by GPs decreased but there were big spikes in telehealth and phone consultations. GP attendances in residential aged care facilities in NWMPHN's catchment were higher than the national and Victorian averages.
- The percentage of Medicare-subsidised services in the NWMPHN region was lower than the national average. Subsidised services are not spread equally across the region. less than 50% of services in the Melbourne LGA are subsidised.
- According to the Australian Bureau of Statistics *2021 Patient Experience Survey*, most people in the region felt that in the preceding 12 months their GP often or always listened carefully (91.5%), showed respect for what they had to say (94.9%), and spent enough time during consultations (91.3%).
- Financial Year 2020-21 saw a reduced number in hospitalisations and Emergency Department presentations. The lockdown periods often resulted in a reduction in the use of these acute services.

- Certain conditions have produced dramatically increased hospitalisations, including haemorrhage in early pregnancy, viral pneumonia, chronic kidney disease, eating disorders, and suicidal ideation.
- The number of potentially preventable hospitalisations dropped by 18% from FY 2019-20 to FY 2020-21. Chronic conditions accounted for more than half of these.
- Hume has the largest number of hospitalisations and ED presentations combined. Accounting for population, Melton had the highest hospitalisation rate whereas Hobsons Bay had the highest ED presentation rate.
- People aged 70 years and over have the most hospital admissions and ED presentations, especially men aged 80+ years.

Health Consequences

This considers the relationship between social position and health outcomes across the region.

Insights

- 57.6% of people in the NWMPHN region reported living with at least one chronic disease, which is slightly below the Victorian average of 59.1%. 26% had two or more chronic conditions – again slightly below the Victorian average of 27.5%.
- Approximately 28% of people aged 18 or over in the NWMPHN region have been diagnosed with anxiety or depression. This is similar to the Victorian average of 30%.
- Non-fatal suicidal behaviours, such as intentional self-harm, appeared to be more common in females, particularly those aged between 12-29 years. The rate of ED presentation and hospitalisation for females between 12 and 29 years was almost double that for males across 2019 to 2021. A figure for non-binary, intersex and trans residents is not available, although other sources show that LGBTIQ+ people are more likely to experience mental health issues, including suicide ideation and self-harm.
- Hospitalisations due to dental conditions accounted for 5% of all the potentially preventable hospitalisations in the region across 2019 to 2021.
- The peri-urban LGAs and Hobsons Bay had the highest number of deaths from suicide and self-inflicted injury (per 100,000 population) during the period 2015-2019.
- In 2019, cancer, circulatory and respiratory diseases were the leading causes of death across the NWMPHN region. Among Aboriginal and Torres Strait Islander people, circulatory diseases were the leading cause, followed by cancer.
- Maribyrnong, Brimbank and Melton are the LGAs with the highest premature mortality rate and avoidable mortality rate.
- The average annual avoidable mortality rate in the NWMPHN region was significantly higher for males than females. The data for avoidable mortality rate for non-binary people is currently inadequately described.

For more information, including references and citations, please see the full *Health Needs Assessment 2022-2025* available on our website.

Community Consultation

More than 1,700 people responded to our community consultation survey. Here are the key insights.

The **cost of health care** – especially dental and oral care – is high and beyond the economic means of people living on lower incomes. Consequently, they are often reliant on bulk-billed services.

The demand for bulk-billed services exceeds supply, demonstrated by **long waiting times** and the **inability to get an appointment**. This means people on lower incomes are more likely to be unable to access primary health care when they need it, resulting in poorer health outcomes.

Distance to services, transportation costs and **ability to use transport** are significant issues for people reliant on public transport but live in areas poorly serviced by it, as well as those who are geographically distant from the services they need to access. This means that people on lower incomes, who are likely to be more reliant on public transport and living in less well-serviced localities, are more likely to find it difficult to access primary health care services when they need it, resulting in poorer health outcomes.

The immense diversity in our region means that health care funders and providers need to continue focusing on building their awareness and understanding to enable more **culturally safe and appropriate care** to be delivered. This will ensure that people from culturally diverse backgrounds, LGBTIQ+ and Aboriginal and Torres Strait Islander communities can access the primary health care they need and enjoy health outcomes on par with the wider community.

Stigma is a significant issue affecting all members of the community and makes people more likely to hide symptoms or illness, delay seeking health care, and prevents individuals from adopting healthy behaviours.

Some people **don't know where to go for health care** or **how to navigate the health system.** This often means they don't get the treatment they need, or end up at an Emergency Department. This is particularly so for people with limited English language proficiency, young people, people who have experienced incarceration, and people who are experiencing housing instability or homelessness. There is a need to build health literacy through more information delivered in appropriate languages and formats, greater outreach and engagement. This includes a "no wrong door" approach for accessing services, and services which are flexible enough to meet people where they need to be met.

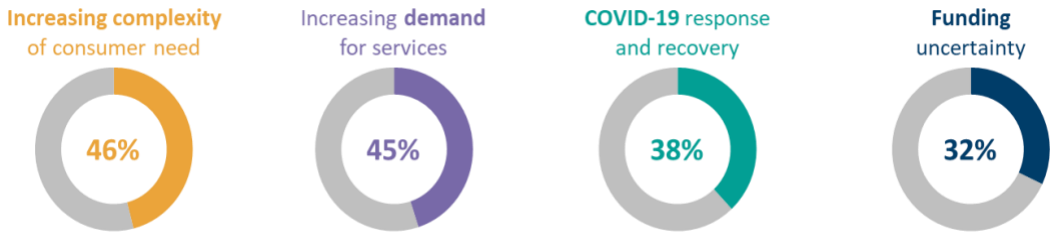
COVID-19 restrictions were reported to be a **barrier to accessing the care needed** during the past 12 months. This was most significant for people aged 35 or older, those who do not identify with a priority population, females or those who live in the suburban and growth areas LGAs.

Market analysis

Market engagement included 30 interviews with 28 providers, 418 survey responses from providers, and several GP workforce planning workshops.

Providers highlighted a range of demand and supply pressures and broader system challenges impacting population health and the ability of the market to meet growing health needs.

The most significant challenges facing providers include:



These are the high-level insights from our engagement.

Demand pressures

1. **Increasing complexity** of client needs, including more presenting with comorbid conditions, or longer-term conditions. These create additional demand pressures because they require more intensive, coordinated and long-term treatment.
2. **Increasing demand** for mental health services was consistently highlighted as a critical priority by all provider types, with unmet demand across both primary and tertiary care.
3. **Population growth** was highlighted as a major pressure by many providers throughout the region, leading to increased demand for services. Growth areas were identified as also presenting a challenge.
4. **Increasing diversity** of the population and changing population cohorts, including clients with diverse backgrounds such as culture, language, gender and sexuality and ability. The impacts of social disadvantage were also highlighted along with the need to consider the social determinants of health in service planning.
5. **COVID-19** is continuing to have major impacts on the market through increased demand for services and reductions in provider capacity. Providers are also anticipating longer term demand issues.

Supply pressures

1. **Supply gaps by service type** include mental health, alcohol and other drugs, especially clients with dual diagnosis. Other gaps included a growing prevalence of chronic disease, particularly patients with multiple chronic conditions. There are also some gaps in cancer care and dental services.
2. **Supply gaps by population cohort** include children, young people and families, services for Aboriginal and Torres Strait Island communities, culturally appropriate services and languages for diverse communities, and services catering for LGBTIQ+ communities.
3. **Supply gaps by geographic area** include growth areas (Hume, Wyndham and Melton), outer catchment areas (Macedon Ranges and Moorabool), pockets of entrenched disadvantage in inner city areas and areas of social disadvantage in several other LGAs.
4. **Workforce shortages** including recruitment and retention issues for general practice and community health. In addition, shortages were flagged in workforce areas such as community nurses and community allied health.
5. **Funding shortages** include providers indicating that as client needs increase in complexity, funding arrangements do not enable them to adequately manage this complexity.

System challenges

1. **Barriers to access** include availability, affordability and appropriateness of some services, challenges of access due to travel requirements, health literacy and navigation challenges for some clients.
2. **Sector fragmentation** resulting in a lack of coordination of care, service planning and exacerbation due to the competitive nature of commissioning and siloed funding streams.
3. **Lack of system integration** included the lack of operability across information systems, inconsistent processes and communication around care transfer and a lack of aligned strategic and operational planning between settings of care.

NWMPHN PRIORITY AREAS

The NWMPHN Health Needs Assessment summarises the identified needs into four groups: health conditions, population groups, geographical locations and health system and process. Needs are then prioritised using a systematic and pragmatic process which helps eliminate the value-driven and subjective bias that sometimes occurs when making decisions about what actions to take.

Specific and targeted programs may be developed in response to medium and high priority issues. Low priority issues may be addressed through our overall population health activities and by sharing information with other organisations.

Please note that **issues identified as a low priority are <u>not</u> low priority health issues**. Rather, they have been classified as such based on their alignment with existing PHN priorities, and whether other organisations are working to address the issue. For these issues, the PHN will share data with other agencies and explore opportunities to work together towards improving outcomes.

Key: High Priority Medium Priority Low Priority

Health conditions	Population groups
Mental Health	Aboriginal and Torres Strait Islanders
Alcohol and other drug services	Culturally and linguistically Diverse (CALD)
Immunisations	LGBTIQ+
Smoking cessation	Children, Young People and Families
Comorbid conditions	Older adults
Preventative health checks	People experiencing unstable housing/ homelessness
COVID-19	People who have been incarcerated
Chronic conditions	International students
Blood borne viruses and sexually transmitted diseases	People living with a disability
Oral health	
Healthy eating	
Physical activity	

Geographical locations	Health system and process
Wyndham: Highest per capita need and high rates of potentially preventable hospitalisations (PPH)	Access barriers to mental health and AOD services
Hume: High per capita need and high rates of chronic disease and acute service use	Culturally safe and appropriate care
Brimbank: High per capita need and high rate of PPH	Stigma
Melton: Highest rate of need across all social determinants and high acute service use.	System navigation
Melbourne: High need for AOD, PPH, and mental health	Workforce shortages
	Health literacy
	Climate change
	Cost of health care
	Waiting times
	Transportation

LIMITATIONS OF THIS HNA

While every effort was made to include all information and data relevant to the health and wellbeing of the community in the NWMPHN region, there are limitations which need to be acknowledged.

Data gathered by third-party sources results in constrained health information for several cohorts, including:

- LGBTIQ+ people, and particularly people who are non-binary, trans or intersex;
- people who have experienced incarceration and people who are experiencing homelessness; and
- Aboriginal and Torres Strait Islander people.

Some data, including those for mental health and alcohol and other drug treatments (AOD), are drawn from hospitals and services funded by NWMPHN. They do not include information from services funded from other sources. NWMPHN is trying to address these issues, where possible, by working with the relevant data custodians.

Broad data on demographics and population numbers are drawn from the 2016 Census. When data from the 2021 Census and other data sources are made available, the HNA will be reviewed and amended as needed.

Finally, our community and market HNA surveys were conducted online, were opt-in and only available in English. This approach may have resulted in a degree of sampling bias. We will continue to build on this approach to make it easier for people in our region to take part in future consultations.

For more information, including references and citations, please see the full *Health Needs Assessment 2022-2025* available on our website.

References

1. PHIDU (Public Health Information Development Unit) (2021a) Social Health Atlas of Australia: Data by Primary Health Network (including Local Government Areas) [data set], phidu.torrens.edu.au, accessed 25 November 2021

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