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2024 HEALTH NEEDS ASSESSMENT

2025-2028

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ACKNOWLEDGEMENTS

We acknowledge the Commonwealth Government as the principal funding body for Primary Health Networks (PHNs).

We acknowledge the Bunurong and Wurundjeri peoples of the Kulin Nation, the Traditional Owners and Custodians of the lands, waters and skies in which we work. We pay our respects to their Elders past and present. We also acknowledge all First Nations peoples with whom we work. Sovereignty was never ceded.

We acknowledge and celebrate diversity in all its forms and recognise the contribution people from diverse backgrounds and life experiences make to a strong, healthy and resilient community. We welcome everyone in the community as part of the SEMPHN organisation.

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Acronym	Meaning
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
ACSC	Ambulatory Care Sensitive Condition
ADHD	Attention Deficit Hyperactivity Disorder
ADIS	Alcohol and Drug Information Service
AIHW	Australian Institute of Health and Welfare
AIR	Australian Immunisation Register
AOD	Alcohol and Other Drugs
AODTS	Alcohol and Other Drugs Treatment Services
AMHS	Area Mental Health Service
APNA	Australian Primary Health Care Nurses Association
ASGS	Australian Statistical Geography Standard
ASMR	Age-Standardised Mortality Rate
ASR	Age-Standardised Rate
ATO	Australian Taxation Office
ATS	Australian Triage Scale
AWP	Activity Work Plan
BAC	Blood Alcohol Concentration
BPD	Bipolar Disorder
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Services
CBD	Central Business District
CDM	Chronic Disease Management
CHS	Community Health Services
CHSP	Commonwealth Home Support Programme
CKD	Chronic Kidney Disease
CMHN	Community Mental Health Nurse
COPD	Chronic Obstructive Pulmonary Disease
CRM	Customer Relationship Management System
CPC	Community Palliative Care
CVD	Cardiovascular Disease
DALY	Disability-Adjusted Life Year
DDACL	Dandenong & District Aborigines Co-Operative Limited
DoHAC	Australian Department of Health and Aged Care
DoH	Australian Department of Health
DVA	Department of Veterans Affairs
ED	Emergency Department
ERP	Estimated Resident Population
FTE	Full-Time Equivalent
FY	Financial Year
GP	General Practitioner
IARE	Indigenous Area
ICD-10	International Classification of Diseases 10th Edition
IRSD	Index of Relative Socio-economic Disadvantage
IRSEO	Indigenous Relative Socioeconomic Outcomes Index
LAC	Local Area Coordination

Acronym	Meaning
LGA	Local Government Area
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Gender Diverse, Intersex, Queer, Asexual and Questioning
LHN	Local Health Network
MATOD	Medication Assisted Treatment for Opioid Dependence
MBS	Medicare Benefits Schedule
MCQI	Multicultural Data Quality Improvement Program
MH	Mental Health
MHCSS	Mental Health Community Support Services
MORT	Mortality Over Regions and Time
NBCSP	National Bowel Cancer Screening Program
NCSP	National Cervical Screening Program
NHDS	National Health Services Directory
NDIS	National Disability Support Scheme
NES	Non-English Speaking
NMDS	National Minimum Dataset
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NP	Not provided (data)
NPS	National Psychosocial Support
NWMP	National Wastewater Drug Monitoring Program
PBS	Pharmaceutical Benefits Scheme
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PMHC	Primary Mental Healthcare
PMHC-MDS	Primary Mental Health Care Minimum Data Set
PTSD	Post-Traumatic Stress Disorder
MDA	Methylenedioxyamphetamine
MDMA	Methylenedioxymethamphetamine
MDS	Minimum Dataset
OECD	Organisation for Economic Cooperation and Development
POLAR	Population-Level Analysis and Reporting Tool
RACGP	Royal Australian College of General Practitioners
RPBS	Repatriation Pharmaceutical Benefits Scheme
SA2	Statistical Area Level 2
SA3	Statistical Area Level 3
SDOH	Social Determinants of Health
SEIFA	Socio-Economic Indexes for Areas
SEMPHN	South Eastern Melbourne Primary Health Network
SHS	Specialist Homelessness Services
SPC	Specialist Palliative Care
VAED	Victorian Admitted Episodes Dataset
VAHI	Victorian Agency for Health Information
VEMD	Victorian Emergency Minimum Dataset
YLL	Years of Life Lost

Chapter 1 Introduction

South Eastern Melbourne Primary Health Network (SEMPHN) is a leader, facilitator and influencer towards the shared goal of better primary healthcare. SEMPHN fosters and supports a more equitable, person-centred and seamless health system to positively impact the health outcomes for our communities. Reporting to an independent Board, our vision is for the people of south east Melbourne to have the opportunity to live their healthiest lives possible. Our local focus is to positively impact population health and service demand, consumer-focused healthcare, primary health services, innovation and system reform, and organisational excellence and sustainability.

We support this by providing:

- evidence, planning and influencing services to meet population health needs
- capacity building services to grow primary healthcare and its workforce in our region
- commissioning services to translate national and state policy into local services and the regional health system.

Purpose of this document

The Australian Department of Health and Aged Care (DoHAC) requires PHNs to conduct a health needs assessment of the region on an annual basis to inform population health planning. Health needs assessments support evidence-informed decision-making around service commissioning and capacity building activities for general practices and healthcare providers. This document has been developed to assist SEMPHN and service providers in the region undertaking population health planning.

Eight priority policy and practice areas have been identified by the Commonwealth for the improvement and innovation of primary care These priority areas form the basis of a comprehensive analysis of the health and service needs across the region.

PHN priority areas

- CALD
- First Nations
- Older Persons
- Homelessness
- Mental Health (MH)
- Alcohol and Other Drugs (AOD)
- Chronic Disease
- Workforce Capacity and Enablement

How to use the health needs assessment

Each chapter presents best-available data to generate insights that can inform decision-making for the design and delivery of programs and services across key priority areas to improve the health and well-being of the south east Melbourne population. The report presents data from population-level to primary and tertiary care statistics.

The report is divided into 4 main sections.

- Overall population health of our region (Chapter 2).
- Priority populations (Chapters 3 to 6).
- Priority health issues (Chapters 7 to 9).
- Workforce capacity and enablement (Chapter 10).

SEMPHN vision and strategic plan 2023-28

To enact SEMPHN's vision of creating opportunities for people in south east Melbourne to live their healthiest lives, we undertake population health planning to design initiatives that address the needs of our community. These activities are a core component of SEMPHN's Strategic Plan 2023-28, **Path to Impact,** a roadmap to guide our organisation to foster and support a more equitable, person-centred and seamless health system that positively impacts health outcomes in our community.

- Our vision is to create opportunities for people in south east Melbourne.
- Our purpose is to foster and support a more equitable, person-centred and seamless health system to positively impact the health outcomes for south east Melbourne communities.

To create measurable, high-quality outcomes, our strategic plan is built upon 5 key pillars. The first one is key to demonstrating our commitment to improving health outcomes, reducing costs and enhancing overall well-being of our community.

- **Population health and service demand:** We focus on understanding the health needs of our population and designing initiatives that address those needs effectively and equitably.
- **Consumer-focused healthcare:** Our strategy places a strong emphasis on delivering care that aligns with what matters most to our consumers, improving their health outcomes and overall experiences.
- **Vibrant primary healthcare services:** We work towards building a strong primary healthcare sector that delivers quality, accessible and integrated care, enhancing the well-being of our community.
- **Innovation and system reform:** We actively seek innovative solutions and drive and influence system reform to improve the efficiency and effectiveness of healthcare delivery.
- **Excellence and sustainability:** We strive for excellence in our operations and promote sustainability to ensure the long-term impact and success of our organisation.

Methodology and approach

A health needs assessment is a systematic process for identifying health and social needs or issues within a specific population or location and determining priorities for action (Smart 2019). The SEMPHN Health Needs Assessment for this year was shaped by 2 guiding conceptual frameworks: Bradshaw's Taxonomy of Need and the Social Determinants of Health (SDOH).

The assessment was conducted under the governance of the SEMPHN Executive Leadership Group and Project Working Group, with significant updates driven by the availability of new data and insights into the evolving health landscape.

This year, SEMPHN embraced a values-based healthcare approach to deepen our understanding of priority populations, and their health experiences and outcomes. By leveraging local data, including general practice patient data and service mapping, we are improving data accuracy and relevance through targeted consultations. These advancements strengthen SEMPHN's ability to address community health needs and deliver meaningful, impactful change.

Taxonomy of Need

Understanding need is essential for effective health planning and prioritisation. Bradshaw's Taxonomy of Need (2013) categorises need into 4 types: comparative, felt, expressed and normative (Figure 1.1).

This needs assessment integrated data from diverse sources to ensure all 4 dimensions of need are considered. By doing so, SEMPHN can accurately identify and prioritise actions to support those with the greatest need.

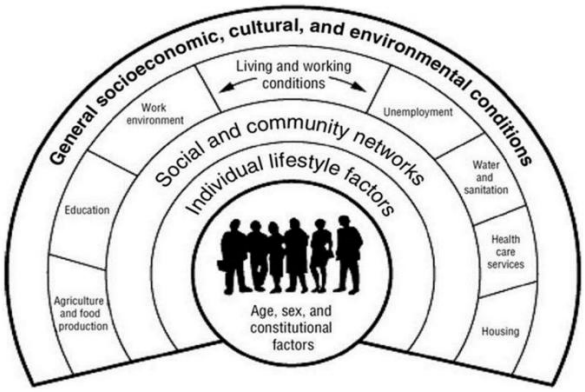
Figure 1.1 Taxonomy of Need

Type	Descriptor	Data source example
Comparative	Comparisons are made between and within population groups.	*Publicly available national, state and PHN data*
Felt	Identified by individual or community member perceived need.	*Community consultations*
Expressed	Identified by individual or community using services.	*Service utilisation*
Normative	Measured against standards, research or expert opinion.	*Clinical standards*

Social Determinants of Health (SDOH)

The SDOH describes the social and economic circumstances (non-medical factors) that influence health throughout the life course and influence health inequalities (WHO, 2018). The Dahlgren-Whitehead model (Göran & Whitehead, 1991) (Figure 1.2) was applied in the planning, analysis, and translation stages of this needs assessment to anchor each priority area (presented by chapter), acknowledging the connection between individual and behavioural factors to community and environmental factors. It also helped to conceptualise need in the context of inequalities.

Figure 1.2 Dahlgren-Whitehead model of health (1991)



Data sources informing this report

The development of this report was informed by a diverse range of data sources to ensure a comprehensive understanding of population health status and service usage. Key data inputs included:

- publicly available datasets
- general practice data collected via a population-level analysis and reporting tool (POLAR)
- mental health (MH) consumer data from rediCASE
- the SEMPHN customer relationship management system (CRM).

These sources were identified and validated based on previous needs assessments and through collaboration with SEMPHN staff to incorporate new and relevant data.

Stakeholder consultations formed a critical component of this assessment. Input was gathered from general practitioners (GPs), healthcare providers, health service consumers, the SEMPHN community and staff members. Where possible, service mapping activities were conducted using HealthMap, complemented by qualitative insights obtained from stakeholder engagement surveys and consultations.

Data were analysed at the smallest available geographical level to enhance relevance. However, where granular data were unavailable, state- or national-level findings were utilised. Comparative needs were assessed by benchmarking local data against PHN-, state- and national-level estimates where available.

Qualitative insights from focus groups and workshops, where conducted, were integrated to assess expressed needs. Additionally, the application of a triangulation matrix provided by the DoHAC enabled SEMPHN to consolidate and verify findings across multiple sources, highlighting key issues and themes.

Limitations exist in the availability of evidence at the PHN catchment level, which challenges the analysis of health and service needs for specific local geographies and population segments. In such cases, local prevalence was derived using synthetic estimates based on demand/utilisation data, as well as state- and national-level surveys and risk factors.

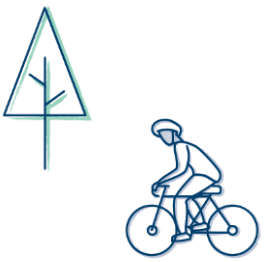
Table 1.1 summarises the data sources used for this report. Where applicable, local data were prioritised and integrated with publicly available datasets to identify health needs and service gaps in the SEMPHN region.

Table 1.1 Summary of data sources

Data source	Description
Patient data from GP	SEMPHN receives primary care data from approximately 370 GPs, representing around three-quarters (76.9%) of all general practices across SEMPHN. As of June 2024, there were approximately 1,556,000 unique active patients who had a recorded GP consultation in the past 2 years spanning July 2022 to June 2024. This criterion was utilised to represent both the temporary and permanent patient cohort for the SEMPHN region, for the purposes of service utilisation and wider population health planning.
Emergency and hospital data **(FY2019-2023)**	SEMPHN receives emergency department (ED) data (Victorian Emergency Minimum Dataset – VEMD) and hospital data (Victorian Admitted Episodes Dataset – VAED) from the Victorian Department of Health annually. These datasets contain de-identified, demographic, administrative and clinical data detailing presentations at Victorian public hospitals, including hospitals with designated EDs. Hospital admissions and ED presentations, where applicable, were linked to the International Classification of Diseases 10th Edition (ICD-10), to determine the type and specific reason for the hospital admission or ED presentation (e.g. F00-F99 Mental and Behavioural Disorders). Both hospital admissions and ED presentations can reflect the unmet needs of the community in cases where primary care was not available or sought out but may also reflect times of increased severity where an ED response or hospital admission was needed.
Consultations	Key consultations conducted in 2024 included: • **stakeholder engagement survey** • **MH providers** (May) • **individuals with lived experience**, including focus groups with people experiencing homelessness and those from culturally and linguistically diverse (CALD) backgrounds (May and June) • **general practice teams**, focusing on the use of referral pathways and e-referrals • **aged care service providers** across the SEMPHN catchment.
Service maps	Service maps were developed using data from Healthdirect Australia to visually highlight the locations of available services and identify existing service gaps.
Public data	Population health status and service usage were mostly scoped through publicly available data sources provided by the Australian Bureau of Statistics (ABS), Public Health Information Development Unit (PHIDU), and the Australian Institute of Health and Welfare (AIHW).
Consumer data	Consumer data from approximately 3,643 clients who used SEMPHN-commissioned MH services in FY2023-24.

References

Smart J (2019) *Needs assessment: Families and Children Expert Panel practice resource*, Australian Institute of Family Studies.



Chapter 2 Our region

- **Population Growth:** the South East Melbourne community represents 24% of Victoria's population (1.6M residents), projected to reach 2M by 2030, with rapid growth in the south east corridor - Greater Dandenong, Casey, and Cardinia.
- **Youth and Families:** Casey (39.6%) and Cardinia (36.8%) have the highest proportions of families with children under 15, while couples without children tend live in Port Phillip (53.4%), Stonnington (49.8%) and Mornington Peninsula (45.1%).
- **Older Residents:** Mornington Peninsula and Bayside have the highest proportions of residents aged 65 and over.
- **Refugee and Asylum Seekers:** Greater Dandenong and Casey host the largest refugee populations, with Greater Dandenong having the highest concentration of asylum seekers.
- **Socioeconomic Disadvantage:** Greater Dandenong experiences the highest disadvantage, followed by Casey and Frankston, with elevated JobSeeker and Disability Support Pension recipient numbers in Casey and Greater Dandenong.

The SEMPHN region covers a total geographical area of 2,935 square kilometres across 10 local government areas (LGAs) (Figure 2.1). The catchment also includes 4% of the City of Monash (the suburb of Hughesdale)[1]. Our catchment shares geographic borders with Eastern Melbourne PHN, Gippsland PHN and North Western Melbourne PHN.

Within our catchment there are 3 hospital networks (Alfred Health, Monash Health and Peninsula Health). As of August 2023, there were 493 general practices, 155 residential aged care facilities, 410 pharmacies and 2 Aboriginal community-controlled health organisations[2] in the catchment.

Figure 2.1 Map of SEMPHN catchment and LGA boundaries

[1] For the purposes of this report, data from the City of Monash is excluded (unless otherwise stated). The City of Monash is captured within Eastern Melbourne PHN's Annual Health Needs Assessment.

[2] Dandenong and District Aborigines Co-operative Limited and Ngwala Willumbong Aboriginal Cooperation.

Population density and growth

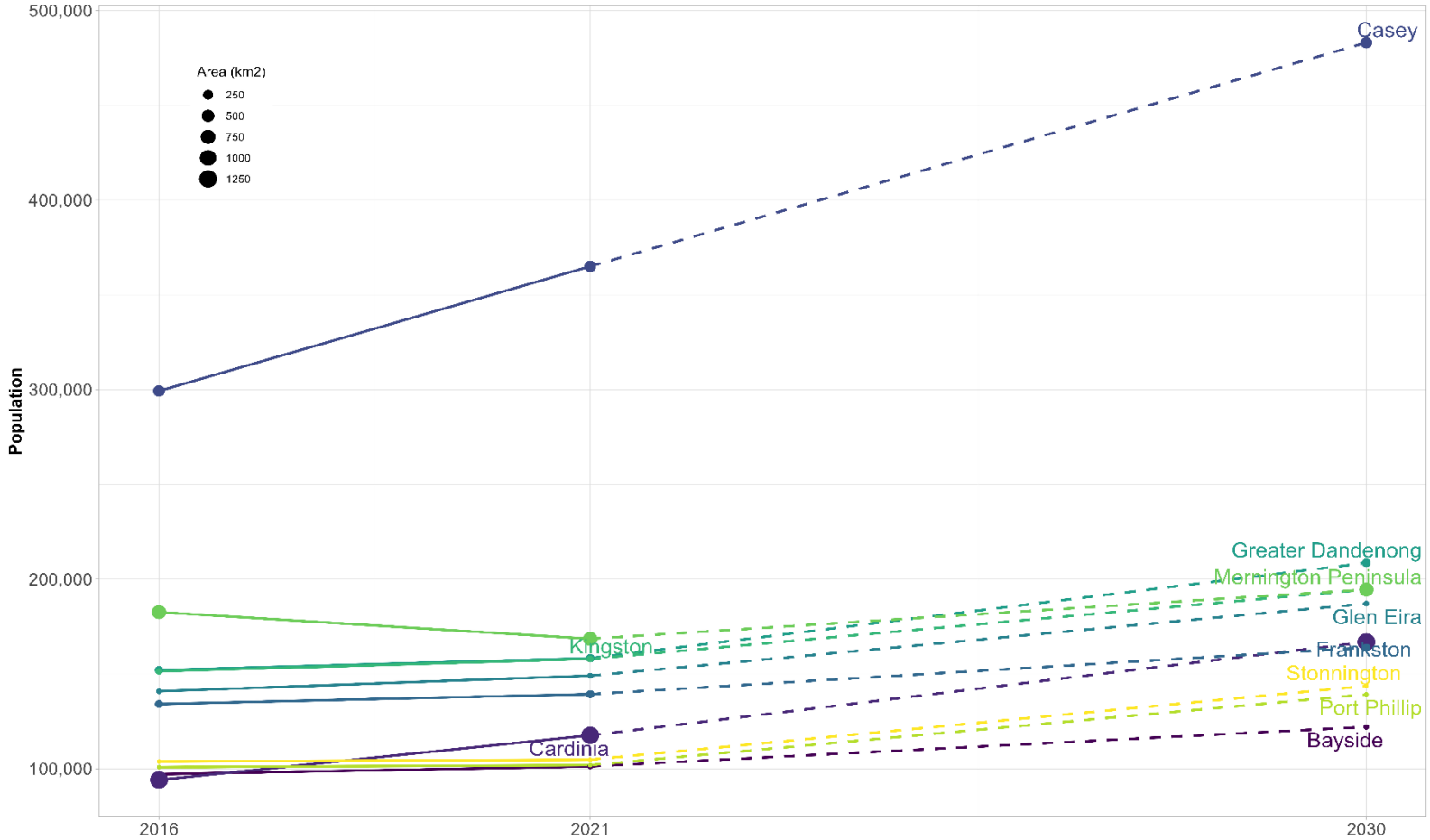
Based on 2021 census data, the SEMPHN catchment is home to an estimated 1,563,818 residents (Statistics 2021a), which equates to approximately one-quarter (24%) of the Victorian population (Figure 2.2, Appendix Table 1.1.1). From 2016 to 2021, there was a 7.4% increase in population in the catchment, slowing from the 10% increase over the previous 5 years (2012-2016).[3] Stonnington, along with Port Phillip, are the smallest LGAs by land area in the catchment. Both LGAs have slower population growth rates compared with other LGAs (0.9% and 1.1% respectively). Mornington Peninsula is the only LGA that experienced a decline in population (-7.7%) from 2016 to 2021 (Statistics 2021a, 2021b).

The fastest growing area in our catchment has been defined as the 'South East Growth Corridor', which includes the City of Dandenong, City of Casey and Cardinia Shire (Victorian Planning Authority 2012). The catchment was home to 2 of Victoria's top 10 fastest growing LGAs in 2021-22: Cardinia (5th, 2.9%) and Casey (9th, 2.4%). By population, Casey is the largest LGA (23.3%) in the catchment and was the second fastest growing LGA (22.0%) from 2016 to 2021. This was just behind Cardinia Shire's 25% population growth rate, covering the largest geographic area in the catchment.

Casey is the sixth most populous LGA in Australia. Four of the top 20 fastest growing Statistical Area Level 2 (SA2) in Australia were located in the Casey LGA, specifically Casey – South, and most notable suburbs were Clyde and Cranbourne with growth rates ranging from 9.7% and 19.7% between 2021 and 2022. Population projections indicate that the catchment will be home to more than 2 million people by 2030, with Casey being home to the largest population in the catchment (32.3%).

[3] Estimated resident population (ERP) for the region in 2021 was 1.6 million people (Australian Bureau of Statistics, 2021b). This decrease in population estimate may be attributed to population movement from the COVID-19 pandemic, where a proportion of Victorian residents moved to regional and rural areas of Victoria or outside of the State to avoid lockdown regulations.

Figure 2.2 Current and estimated population by LGA, 2016, 2021, 2030

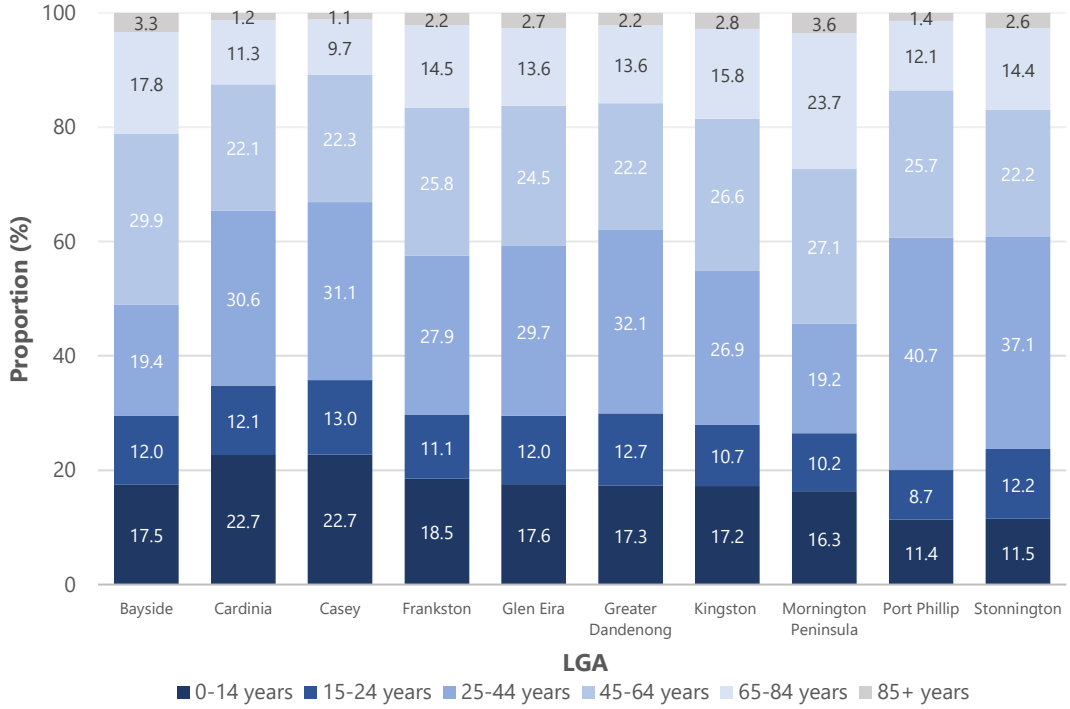


Source: ABS Census 2021 (June 2022), G01 Selected person characteristics by sex, accessed 20 August 2022. PHIDU 2022, Torrens University Australia (June 2022), Population projections: persons, accessed 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within SEMPHN catchment (4%).

Age composition

Figure 2.3 shows the age distribution of the populations in the catchment by LGAs. There are higher proportions of older people (65 years and over) living in Mornington Peninsula and Bayside, while the outer LGAs such as Casey and Cardinia have larger younger populations (under 24 years).

Figure 2.3 Population age distribution by LGA, 2021

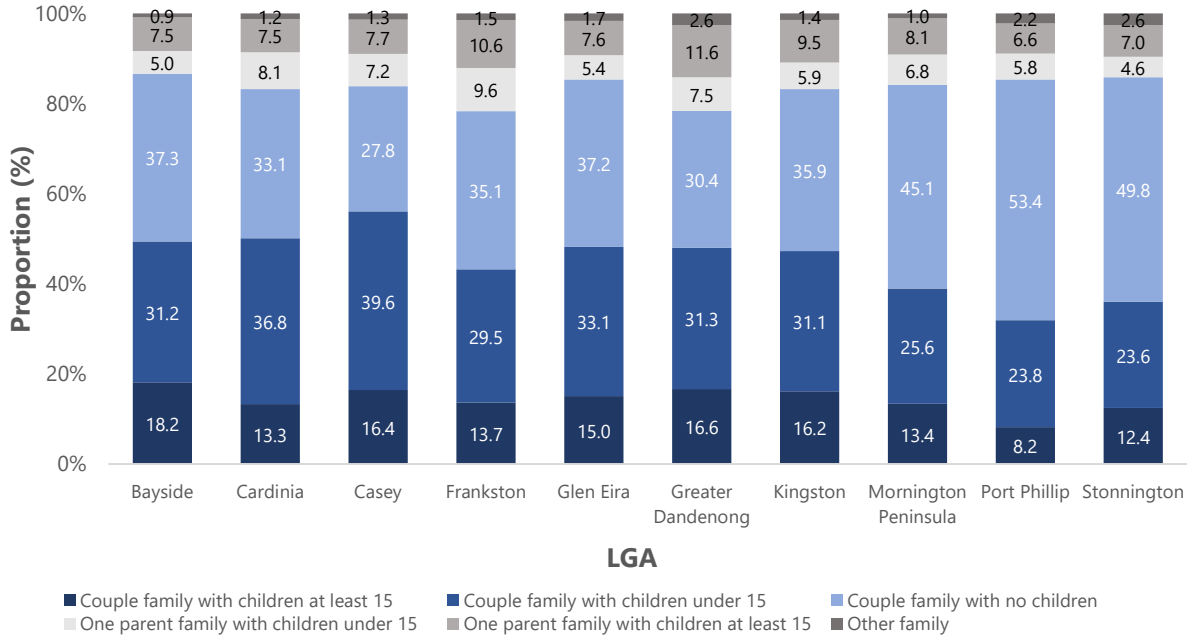


Source: ABS Census 2021 (June 2022), G04 Age by sex, accessed on 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within SEMPHN catchment (4%).

Family composition

The family composition of our community varies across LGAs in the catchment (Figure 2.4). The highest proportion of couples with at least one young child under 15 years of age reside in Casey (39.6%) and Cardinia (36.8%). LGAs with the highest proportion of single-parent families with at least one child under 15 are Frankston (9.6%) and Cardinia (8.1%). LGAs with the highest proportion of couples without children are Port Phillip (53.4%), Stonnington (49.8%) and Mornington Peninsula (45.1%). These variations may indicate different primary healthcare service needs across the catchment.

Figure 2.4 Family composition by LGA, 2021



Source: ABS Census 2021 (June 2022), accessed on 5 September 2023. Please note Monash LGA is excluded due to the small proportion of the LGA falling within SEMPHN catchment (4%).

Refugees and asylum seekers

South east Melbourne is home to a large proportion of Victoria's refugee and asylum seeker population. Refugees and asylum seekers often have multiple and complex health needs requiring unique healthcare support, including improved access, coordination and quality of healthcare (Joshi et al. 2013).

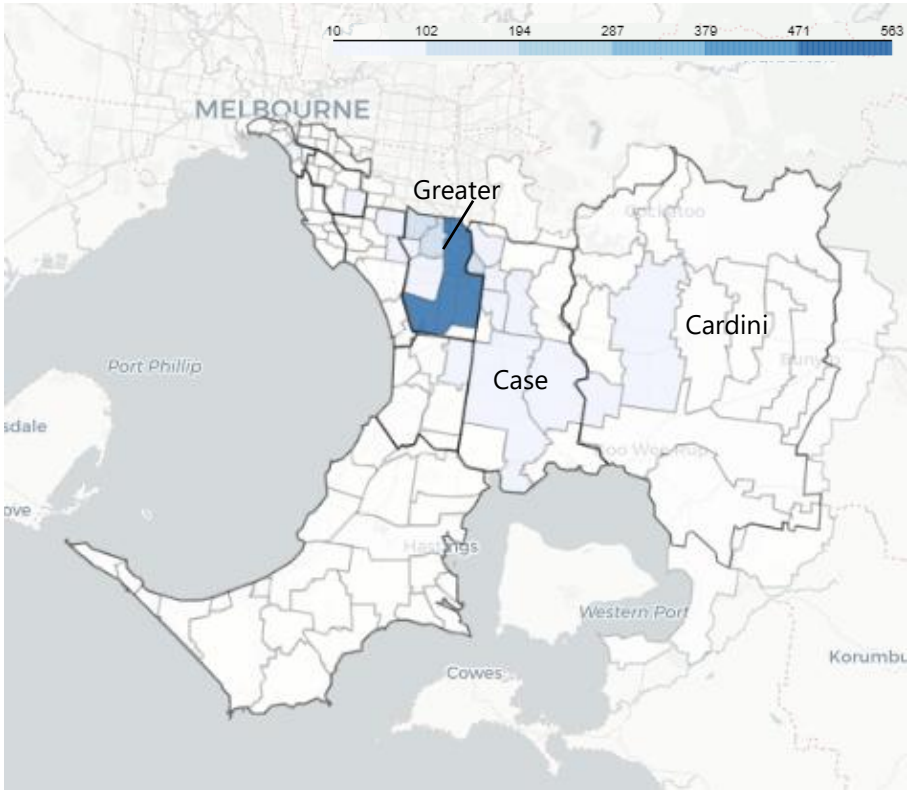
Government data from 2000 to 2021 shows that the SEMPHN catchment settled 25,342 permanent migrants under the Offshore Humanitarian Program, which was 28.9% of all humanitarian entrants in Victoria (Public Health Information Development Unit 2024).

- The region's proportion of permanent migrants under the Offshore Humanitarian Program (1.3%) was comparable to that of Victoria (1.4%) and greater than the Australian proportion (1.1%).
- The majority (87.9%) of humanitarian migrants in our catchment settled in Casey and Greater Dandenong.
- Casey welcomed 14,608 humanitarian migrants, which represented 4.0% of the LGA's total population.
- Greater Dandenong welcomed 7,673 humanitarian migrants, which represented 4.8% of the LGA's total population.

As of 31 March 2023, Victoria was home to 4,697 asylum seekers granted Bridging Visa E, which allows them to lawfully remain in Australia while arranging to go home, finalising immigration matters or awaiting a decision. This group represented 43.4% of Australia's total of 10,828 Bridging Visa E holders (Refugee Council of Australia, 2023). Within the SEMPHN catchment, the highest concentration of asylum seekers was in Greater Dandenong, with the largest amount residing in Dandenong (563), Springvale (148) and Noble Park (136), as shown in Figure 2.5. Unlike asylum seekers held in detention, those living in the community do not receive housing and have limited access to support services

including healthcare. Most asylum seekers in Victoria come from Sri Lanka (1,416, or 30.1% of the Victorian total) and Iran (1,380, or 29.4%).

Figure 2.5 Concentrations of asylum seekers on Bridging Visa E in SEMPHN LGAs, 31 March 2023



Source: Refugee Council of Australia. Accessed via https://www.refugeecouncil.org.au/asylum-community/8/ on 30 August 2023. Bridging Visa E allows holders to lawfully stay in Australia while making arrangements to leave, finalise immigration matters or wait for an immigration decision.

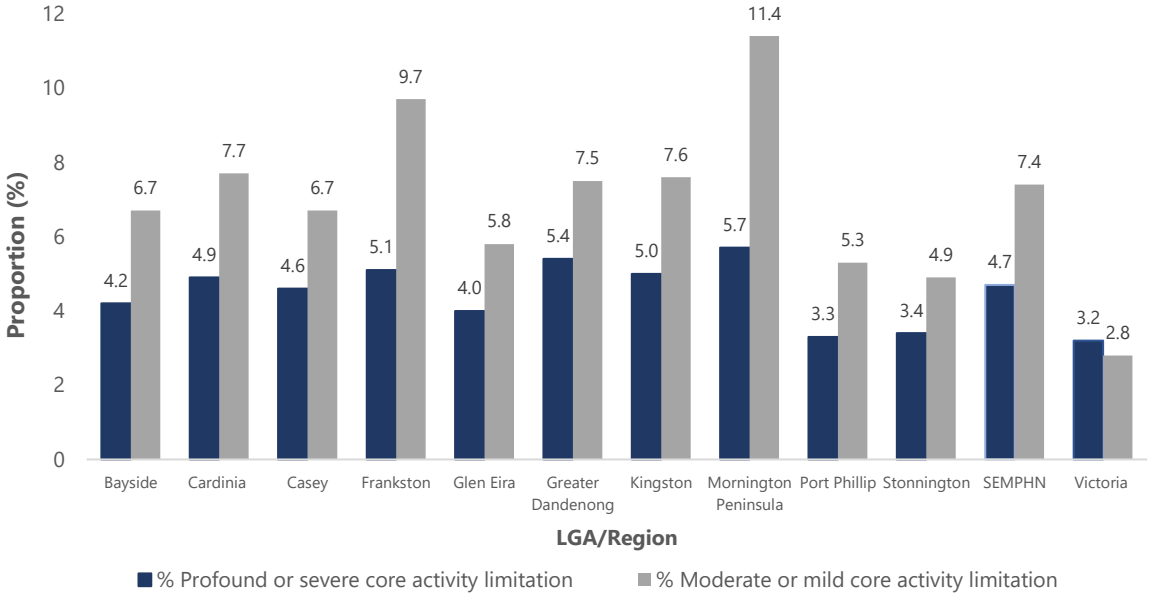
Disability

All LGAs in the SEMPHN catchment have higher proportions of people with core activity limitation compared to the rest of Victoria. Core activity limitation is categorised into 4 domains:

- profound limitation (people with the greatest need for help or who are unable to do an activity)
- severe limitation (people who sometimes need help and/or have difficulty)
- moderate limitation (people who need no help but have difficulty)
- mild limitation (people who need no help and have no difficulty but use aids or have limitations).

Based on the most recent ABS 2018 Survey of Disability, Ageing and Carers, Mornington Peninsula has the highest proportion of people living with a moderate or mild (11.4%) and profound or severe disability[4] (5.7%), which can be partially attributed to an older population (Figure 2.6, Appendix Table 1.1.2). Casey has the most people with mild or moderate core activity limitation (n=22,804) and profound or severe core activity limitation (n=15,713).

Figure 2.6 Persons living with core activity limitation by LGA, 2018



Source: Survey of Disability, Ageing and Carers for Local Government Areas 2018, ABS, Table 2.3 Local government areas (LGAs): Persons with profound or severe core activity limitation by age; Table 3.3 Local government areas (LGAs): Persons with moderate or mild core activity limitation by age, accessed on 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

While data on persons with psychosocial disability is not available at the LGA level, the ABS 2018 Survey of Disability, Ageing and Carers estimated that 294,000 out of 1,098,200 persons (26.8%) in Victoria had a psychosocial disability in 2018.

Lesbian, Gay, Bisexual, Transgender, Gender Diverse, Intersex, Queer, Asexual and Questioning (LGBTIQA+)

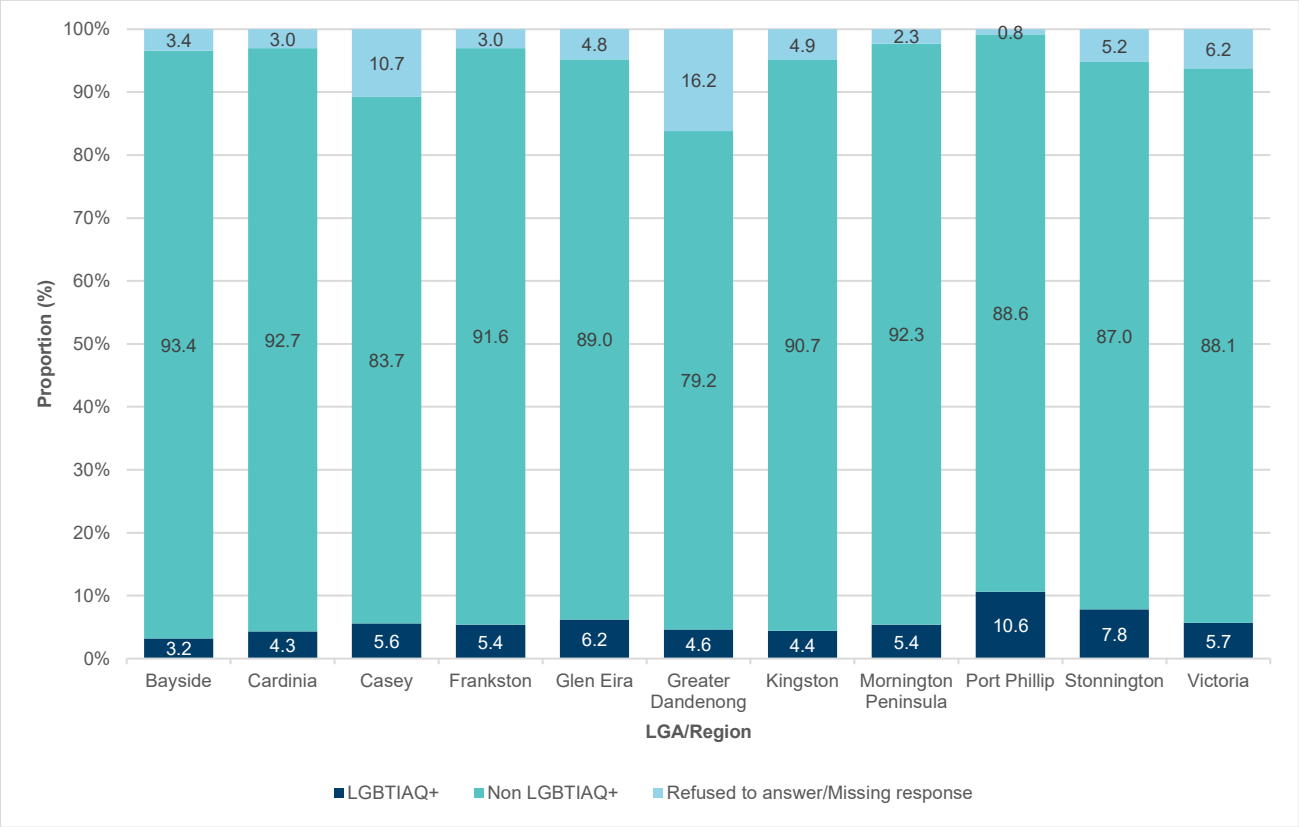
As shown in 2017 the Victorian Population Health Survey estimated that one in 20 people (5.7%, n=1,300) in the SEMPHN catchment identified as LGBTIQA+[5] (Figure 2.7, also see Appendix Table 2.1.5). The SEMPHN catchment estimates are comparable with Victorian estimates. The proportion of adults identifying as LGBTIQA+ was highest among those aged 18–34 years. Port Phillip (10.6%),

[4] Core activity limitation: core activities are communication, mobility and self-care. For core activity limitations, ABS provides data on 4 levels of severity—profound limitation (people with the greatest need for help or who are unable to do an activity); severe limitation (people who sometimes need help and/or have difficulty); moderate limitation (people who need no help but have difficulty); mild limitation (people who need no help and have no difficulty, but use aids or have limitations).

[5] Due to COVID-19, this data was not updated in the 2020 survey, and the related survey question has not been included in the survey since 2017.

Stonnington (7.8%) and Glen Eira (6.2%) reported LGBTIQA+ populations higher than the Victorian average.

Figure 2.7 LGBTIQA+ community by LGA, 2017



Source: Victorian Population Health Survey 2017, VAHI (2020), Table 4: Proportion of the adult (18+ years) population, by LGBTIQA+ status and by metropolitan local government area, Victoria, 2017, accessed on 18 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA within the SEMPHN catchment (4%).

Socioeconomic disadvantage

Socioeconomic position is commonly associated with health behaviours, morbidity and mortality. That is people with lower socioeconomic status commonly have poorer health outcomes and live shorter lives. The Socio-Economic Indexes for Areas (SEIFA) ranks areas across Australia according to different census variables, including income, education levels, employment and housing conditions. The Index of Relative Socio-economic Disadvantage (IRSD)[6] is a composite measure for disadvantage. The IRSD summarises a range of information about the economic and social conditions of people and households within an area. A low score indicates relative greater disadvantage, and high scores indicate relative lack of disadvantage. SEIFA IRSD scores were explored across the SEMPHN catchment to identify lower socioeconomic groups at greater risk of poor health, illness, disability and death (Australian Institute of Health and Welfare 2021).

Figure 2.8 highlights the variation of IRSD across the LGAs in the catchment and suggests that the outer areas experience greater levels of disadvantage. For example, Greater Dandenong, with an IRSD

[6] This Index has a base of 1,000 for Australia, and scores above 1,000 indicate a relative lack of disadvantage and those below indicate relatively greater disadvantage.

score of 887, was found to be the most disadvantaged LGA in the catchment, while Bayside was found to have the least disadvantage (IRSD score of 1,090). Beyond disparities in employment, education and housing status, socioeconomic disadvantages are most likely to be experienced by those in the community who are most under-serviced, such as First Nations people and LGBTIQA+ (Australian Institute of Health and Welfare 2020).

Figure 2.8 Socioeconomic disadvantage (as IRSD) by LGA, 2021

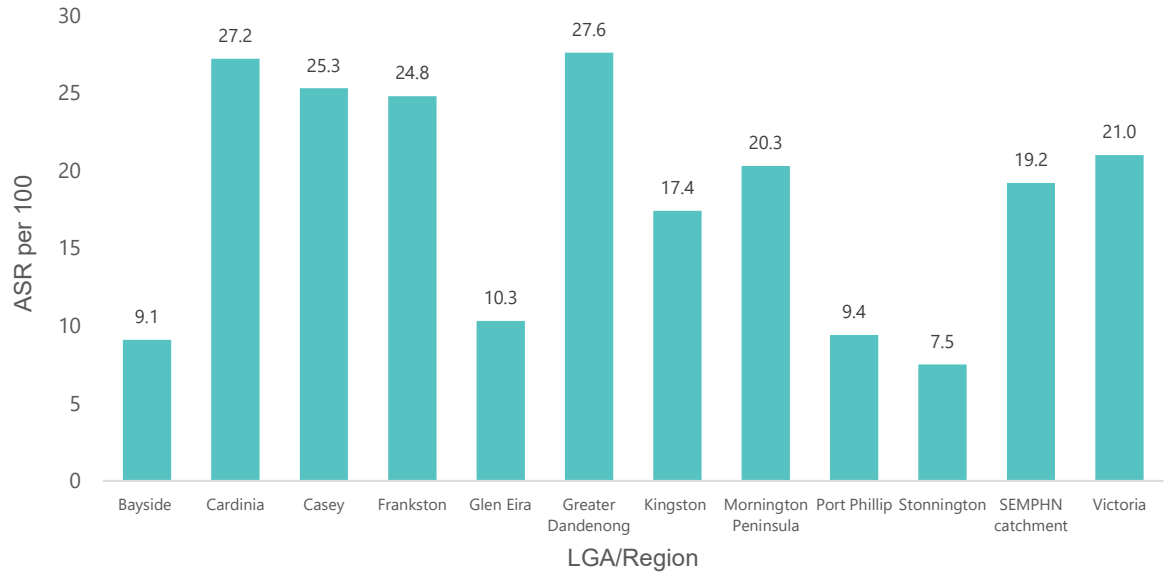
Region/LGA	IRSD Score	IRSD Decile
Bayside	1,090	10
Cardinia	1,021	7
Casey	995	5
Frankston	1,003	6
Glen Eira	1,075	10
Greater Dandenong	887	1
Kingston	1,044	9
Mornington Peninsula	1,038	8
Port Phillip	1,061	9
Stonnington	1,084	10

Source: PHIDU Social Health Atlas of Australia, Public Health Network (including local government areas) of residence, 2023, accessed on 17 August 2023 at https://phidu.torrens.edu.au/current/maps/sha-aust/phn_lga_area_profile/atlas.html. Note that IRSD Decile is relative to LGAs within Victoria.

Education

Education is a key social determinant of health, commonly associated with life expectancy, morbidity and health behaviours. Education attainment has also been linked with better employment opportunities and increased income (The Lancet Public Health 2020). Across the SEMPHN catchment, there was considerable variability in school leaver status. Figure 2.9 indicates lower formal education levels in Greater Dandenong (27.6 per 100 people), Cardinia (27.2 per 100 people) and Casey (25.3 per 100 people) (Public Health Information Development Unit 2021) (also see Appendix Table 1.1.3). LGAs with rates the highest proportions of people who left school after Year 10 were the City of Stonnington (7.5 per 100), Bayside (9.1 per 100) and Port Phillip (9.7 per 100). This compares to the Victorian rate of 21.0 per 100 people.

Figure 2.9 School leavers at Year 10 or below by LGA, 2021



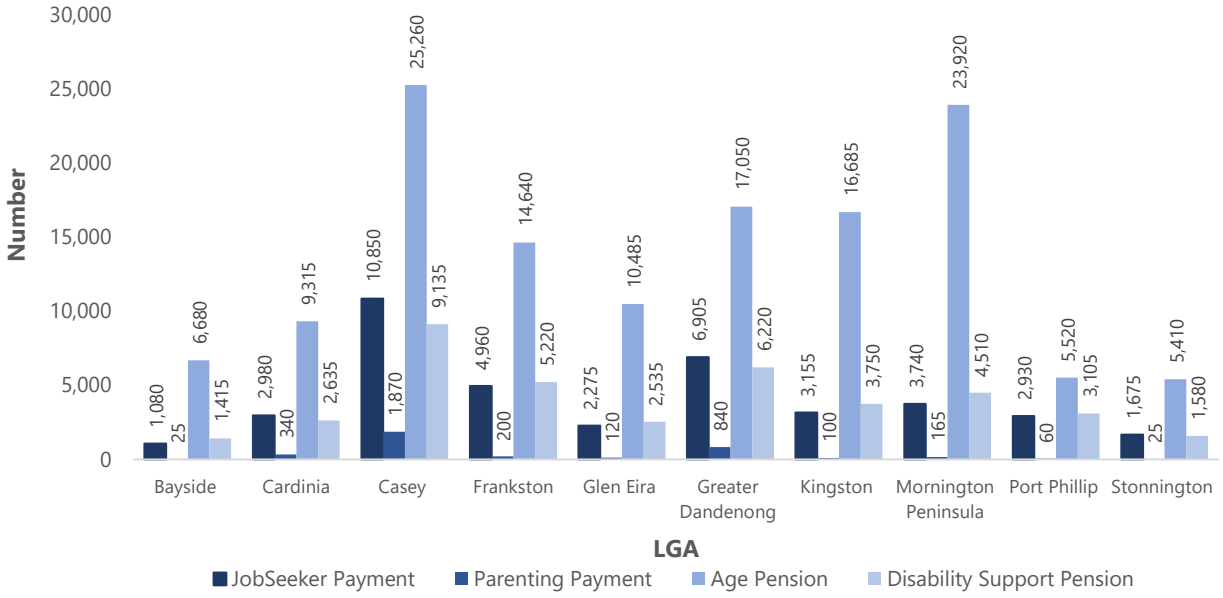
Source: PHIDU 2022, Torrens University Australia (June 2022), ASR=age-standardised rate. Education: People who left school at Year 10 or below, or did not go to school (2016 URP), accessed 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Income support

Income support payments help with living costs and depends on life circumstances (Services Australia 2022). Figure 2.10 shows income support payments received by residents across LGAs in the SEMPHN catchment in a certain time period (Department of Social Services 2022) (also see Appendix Table 1.1.4).

- The JobSeeker payment is the main income support payment for recipients aged over 22 years who are unemployed and looking for work, or who temporarily cannot work or study because of an injury or illness. Casey recorded the highest number of people receiving JobSeeker payments in March 2023 (n=10,850; 26.8% of all receiving JobSeeker payments in SEMPHN catchment), followed by Greater Dandenong (n=6,905, 17.0%).
- Parenting payments are available for parents or guardians unable to work full-time due to caring for a young child. This provides income support for parents or guardians to help with the cost of raising children. Casey accounted for almost 50% of all people receiving parenting payments in the SEMPHN catchment (n=1,870, 49.9%).
- Age pension is a support payment for people aged 65 years and above. In March 2023, Casey (n=25,260) and Mornington Peninsula (n=23,920) had the most people receiving age pensions, accounting for 18.7% and 17.7% of all people receiving age pensions in the SEMPHN catchment.
- Disability support pension is an income support payment for people who are unable to work for 15 hours or more per week at or above the relevant minimum wage, independent of a Program of Support due to permanent physical, intellectual or psychiatric impairment. The largest number of people receiving disability support pensions were from Casey (n=9,135) and Greater Dandenong (n=6,220).

Figure 2.10 Payment recipients by payment type and LGA, March 2023



Source: DSS Payment Demographic Data 2023, Department of Social Services (March 2022), Table: LGA (extracted on 31 March 2023), accessed on 16 August 2023.

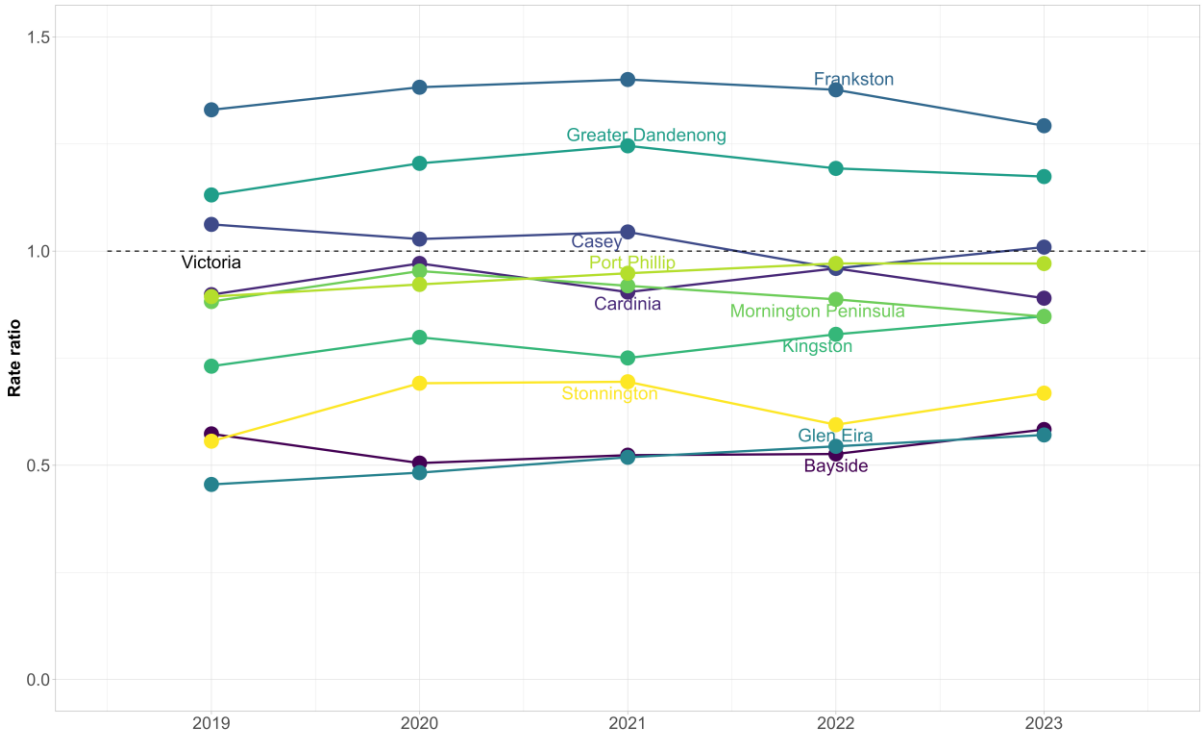
Family and community safety

Family and community safety are important determinants of health and well-being. Family violence has been shown to have long-term negative effects on employment, MH and incarceration rates (Caruso 2017). Evidence suggests that women report a lower sense of safety and security than men, and Australian women's perceptions of safety are among the lowest in developed countries (Georgetown Institute for Women Peace and Security 2019).

Data from the Victorian Crime Statistics Agency (Figure 2.11) shows the rate ratios of family incidents in SEMPHN LGAs compared to all of Victoria[7] (Crime Statistics Agency 2023). In the year ending March 2023, compared to the rate of family incidents for Victoria (1,377.7 per 100,000), the rates for the LGAs of Frankston (1,781.0 per 100,000) and Greater Dandenong (1617.5 per 100,000) were markedly higher (1.3 times and 1.2 times respectively). Compared with Victoria, rates of family incidents in the years ending March from 2019 to 2023 continued to increase for the LGAs of Port Phillip, Cardinia, Kingston, Glen Eira and Bayside.

Figure 2.11 Rate ratios of family incidents by LGA, years ending March 2019 to 2023

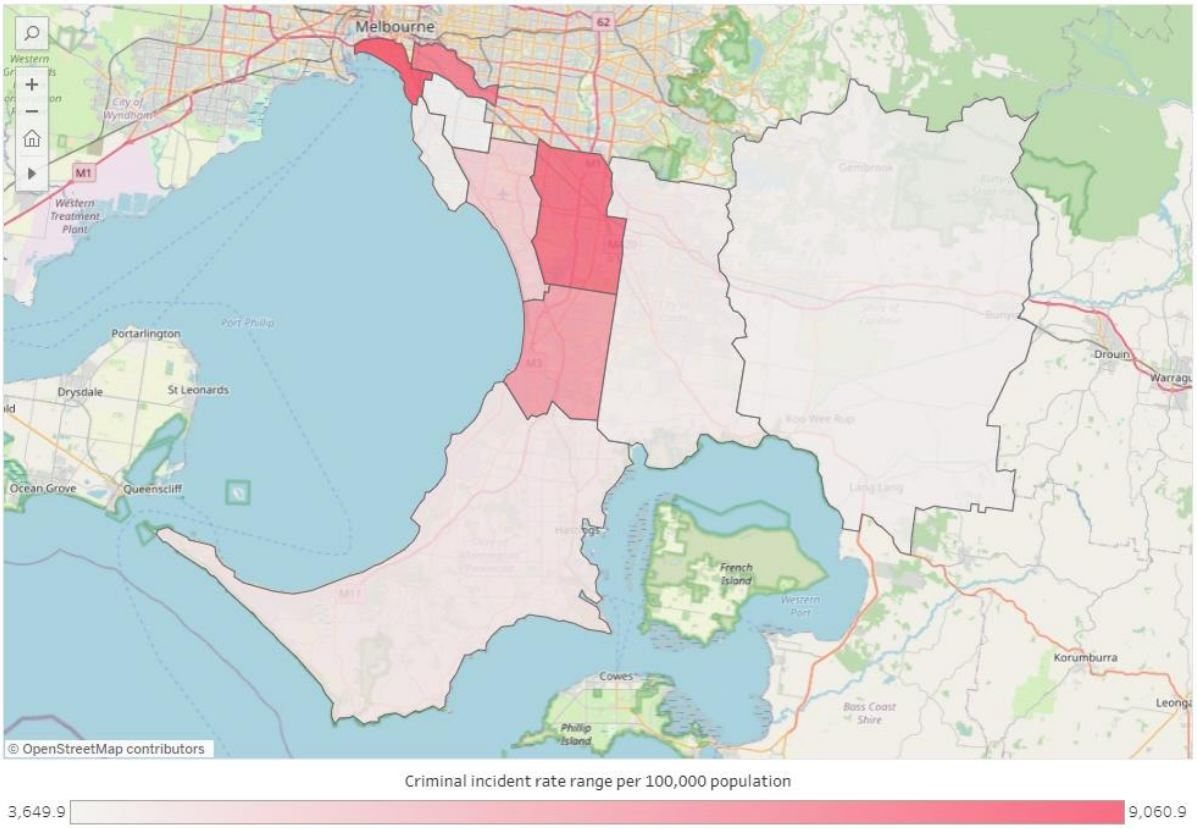
[7] Rate ratio was calculated by dividing rate of family incidents (per 10,000) for each LGA by total rate of family Incidents (per 10,000) for all of Victoria. If the rate ratio is 1 (or close to 1), it suggests no difference or little difference in rates (rate of family incidence is the same). A rate ratio greater than 1 suggests an increased rate of family incidents in the LGA compared to Victoria. A rate ratio lesser than 1 suggests a reduced rate in the LGA compared to Victoria.



Source: Crime Statistics Agency 2023, June 2023, Table: Family incidents year ending March 2023, accessed on 17 August 2023.

In the year ending March 2023, compared with the rates of criminal incidents in Victoria (5,344.6 per 100,000) and in the SEMPHN catchment (5,296.1 per 100,000), higher rates were observed in the LGAs of Port Phillip (9,060.9 per 100,000), Greater Dandenong (8356.6 per 100,000), Stonnington (7,797.1 per 100,000) and Frankston (6,695.5 per 100,000) (see Figure 2.12).

Figure 2.12 Map of criminal incidents across SEMPHN catchment, year ending 30 March 2023

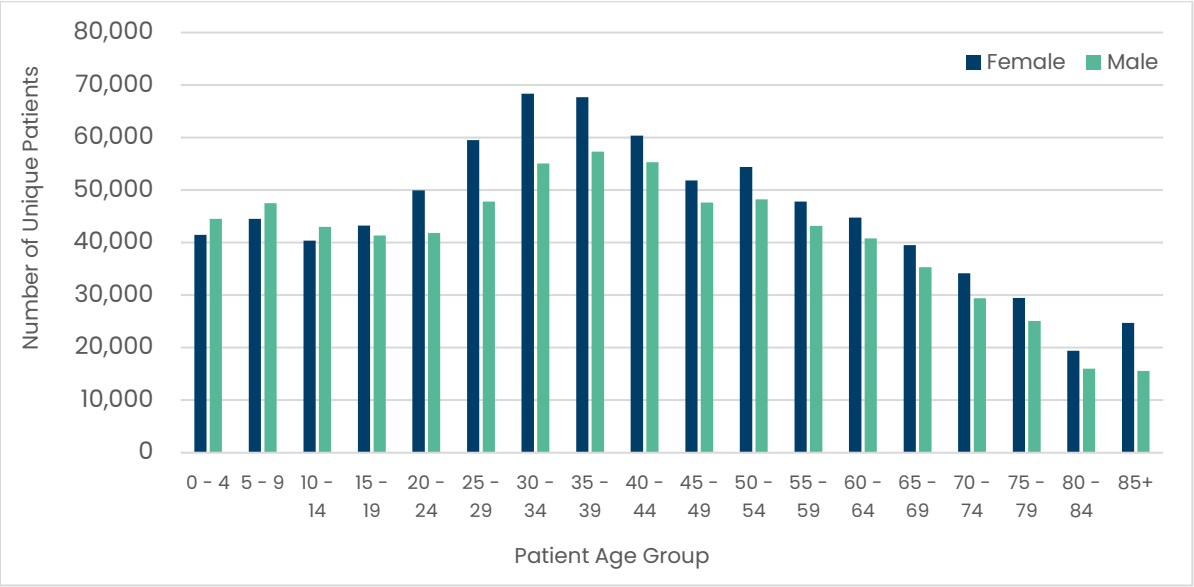


Source: Crime Statistics Agency 2023, June 2023, accessed on 17 August 2023.

Primary care insights

Patient data from general practices across the region (Figure 2.13) indicate that among the approximate 1.6 million active patients from May 2022 to May 2024, females comprised a slight majority (52.8%) compared with males (47.2%). The largest group of patients accessing general practice services were aged 35-39 years (9.7%), followed by 30-34 years (9.3%) and 40-44 years (9.3%). This age distribution aligns closely with the demographic profile of the broader SEMPHN catchment.

Figure 2.13 SEMPHN patients by age group and gender, May 2024

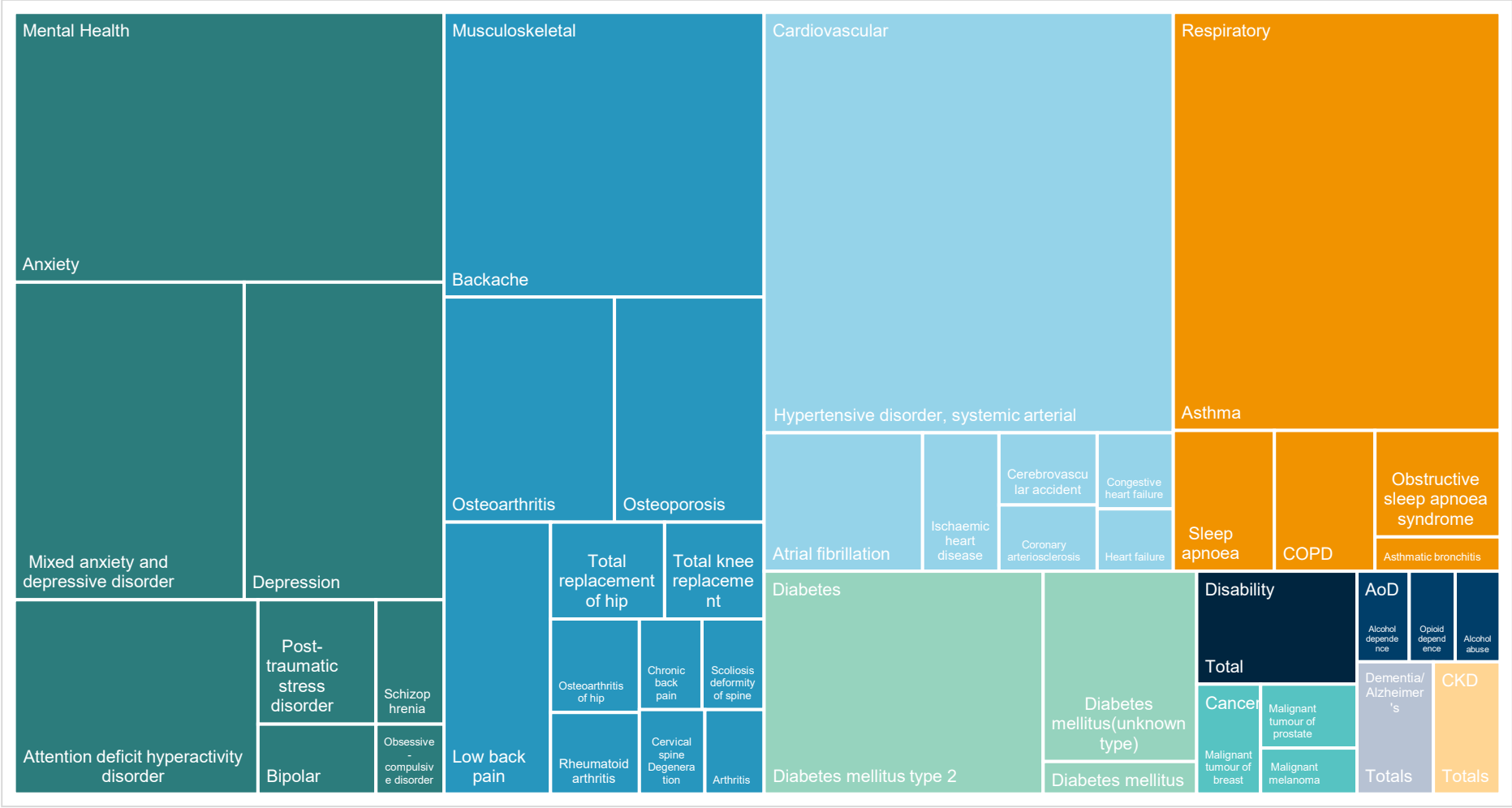


Brief summary of most prevalent diagnoses

Between July 2023 and July 2024, over 205,000 patients across the SEMPHN catchment received new chronic-disease-related diagnoses from general practices. Collectively, these patients accounted for more than 325,000 diagnoses during this period.

Figure 2.14 shows MH diagnoses were the most frequent, representing 27.5% (approximately 89,000) of all categorised diagnoses, followed by musculoskeletal (20.2% / 65,500) and cardiovascular diagnoses (20.2% / 65,400). Systemic arterial hypertension was the single most diagnosed condition across the SEMPHN catchment, followed by asthma and anxiety. An overview of the prevalence of chronic disease across the SEMPHN catchment can be found in Chapter 9: Chronic Disease.

Figure 2.14 Chronic disease diagnoses, 2023-2024



Source: SEMPHN primary care diagnosis data (POLAR), July 2023 – June 2024. AOD=alcohol and other drugs; CKD=chronic kidney disease; and COPD=chronic obstructive pulmonary disease. Each main diagosis category is represented by a different colour. The size of the square corresponds to the proportion of diagnoses within that category, with larger squares indicating a higher proportion of diagnoses.

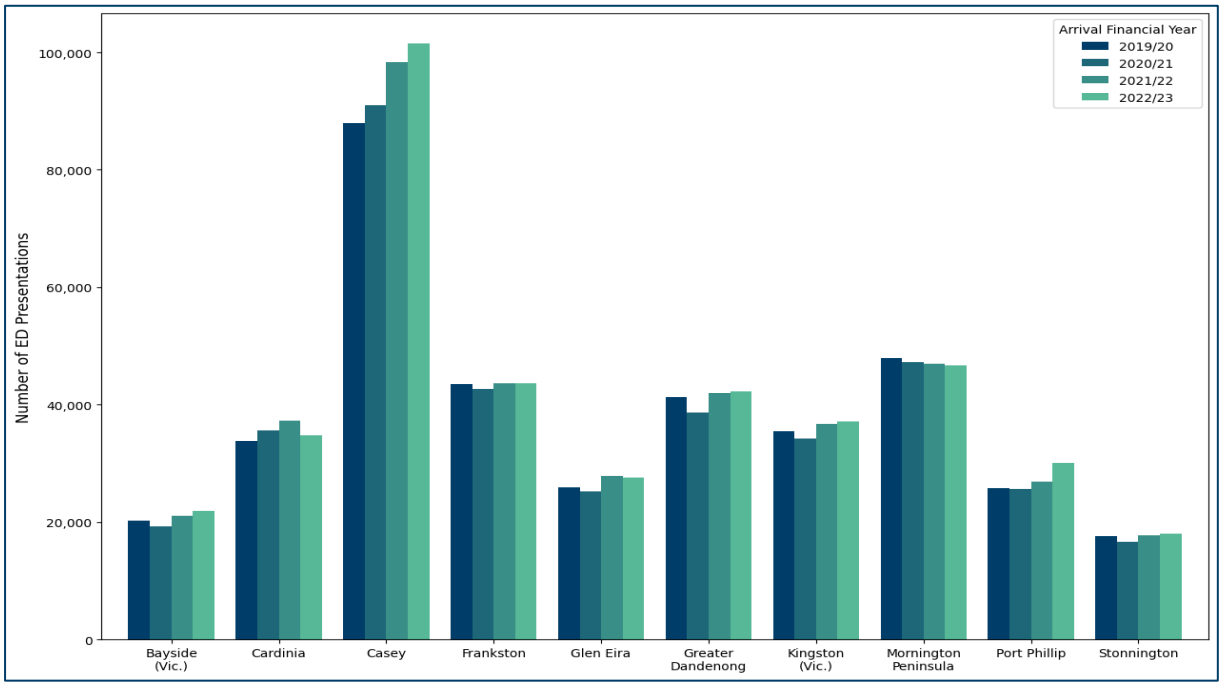
Tertiary care insights

ED PRESENTATIONS

ED presentations across south east Melbourne have increased by 6.2% (n=23,754) between the financial years (FYs) 2019-20 and 2022-23, with an average annual increase of approximately 1.6% (Figure 2.15). A small decrease was observed in the FY 2020-21, likely due to the COVID-19 lockdown period.

Casey has had a significant proportion (~25%) of all ED presentations across south east Melbourne over the last 4 FYs, partly due to its large population. In the FY 2022-23, Casey residents accounted for 25.2% of all south east Melbourne ED presentations, followed by Mornington Peninsula (11.6%), Greater Dandenong (10.8%) and Frankston (10.5%), which is reflective of the total population of each LGA (Figure 2.15).

Figure 2.15 ED presentations by year and LGA, FY2019-2023

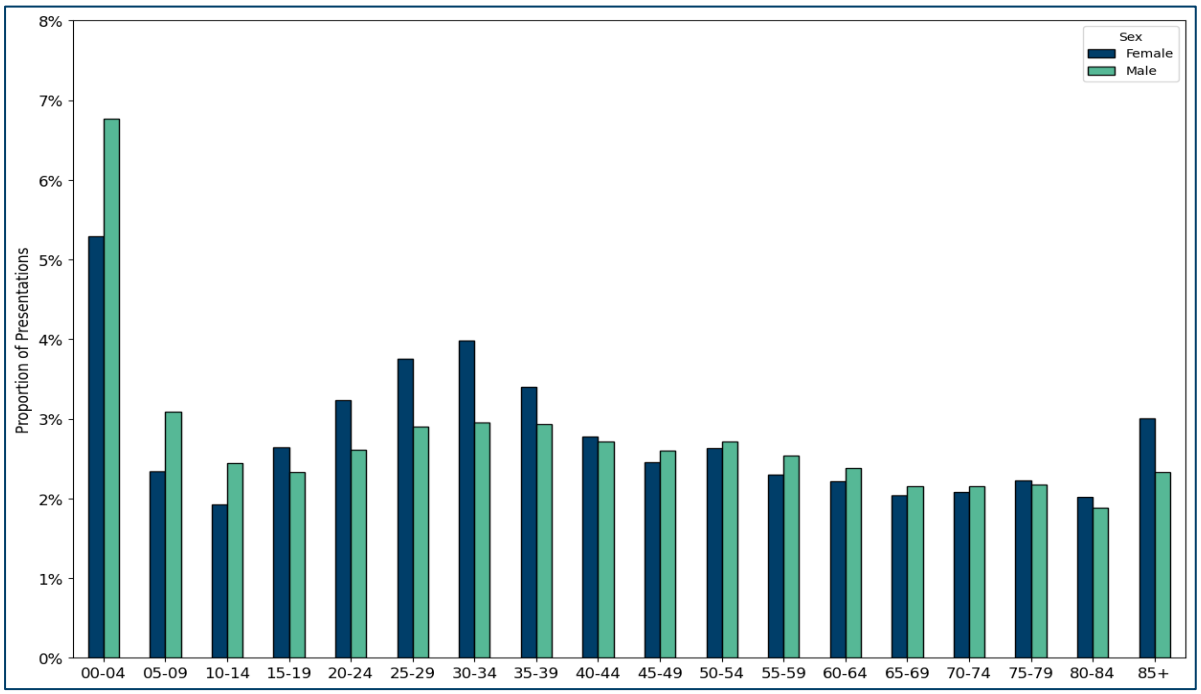


Source: VEMD, Department of Health – Victoria, 2022/23.

The number of ED presentations varied across FYs and by LGA, with all LGAs except Mornington Peninsula (-0.9%) experiencing an increase between 2019 and 2023 (Figure 2.15). Port Phillip experienced the highest rate of growth at 5.4%, followed by Casey (4.9%) and Bayside (2.8%).

In the 2022-23 FY there were 403,651 ED presentations, which was an increase of 5,080 from the previous FY. Of these, 50.3% were female, 49.6% were male and 0.08% were intersex. Patients aged 0-4 and 85+ years were overrepresented when compared with the wider south east Melbourne population, comprising 12.1% and 5.3% of ED presentations respectively (Figure 2.16).

Figure 2.16 ED presentations by age and gender, FY2022-23

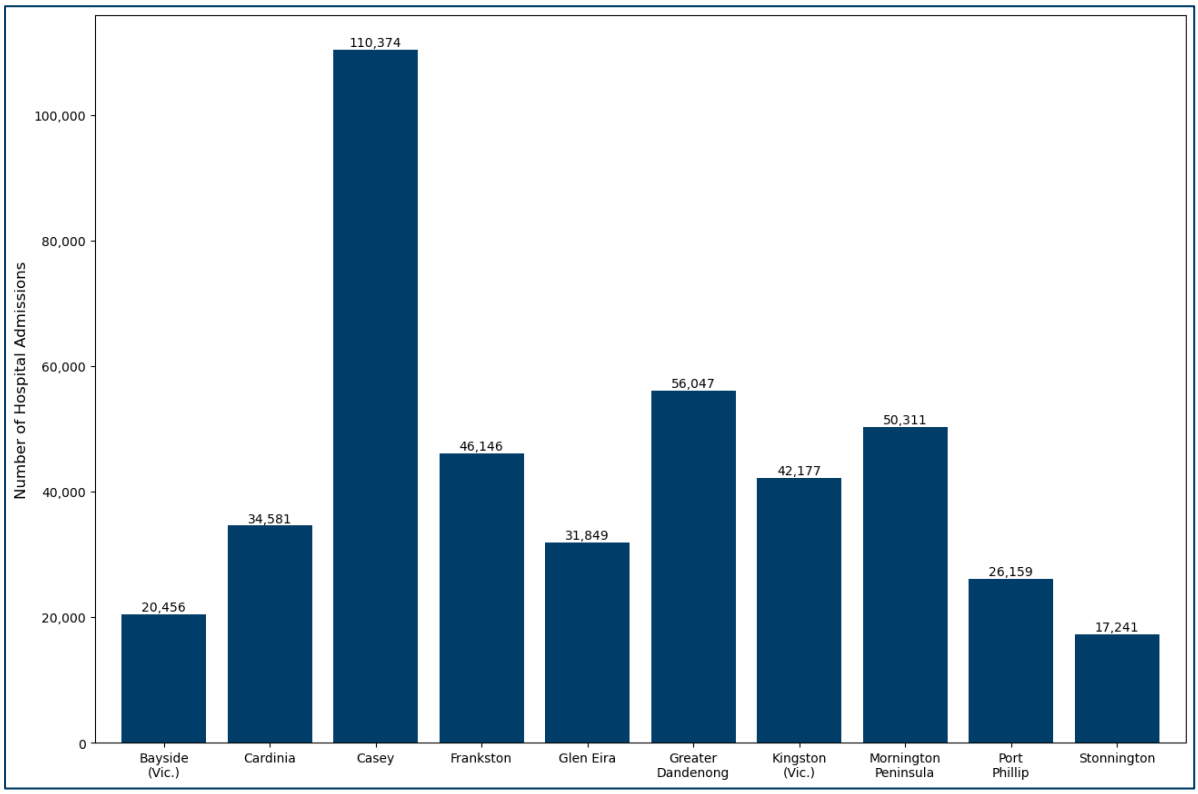


Source: VEMD, Department of Health – Victoria, 2022/23.

HOSPITAL ADMISSIONS

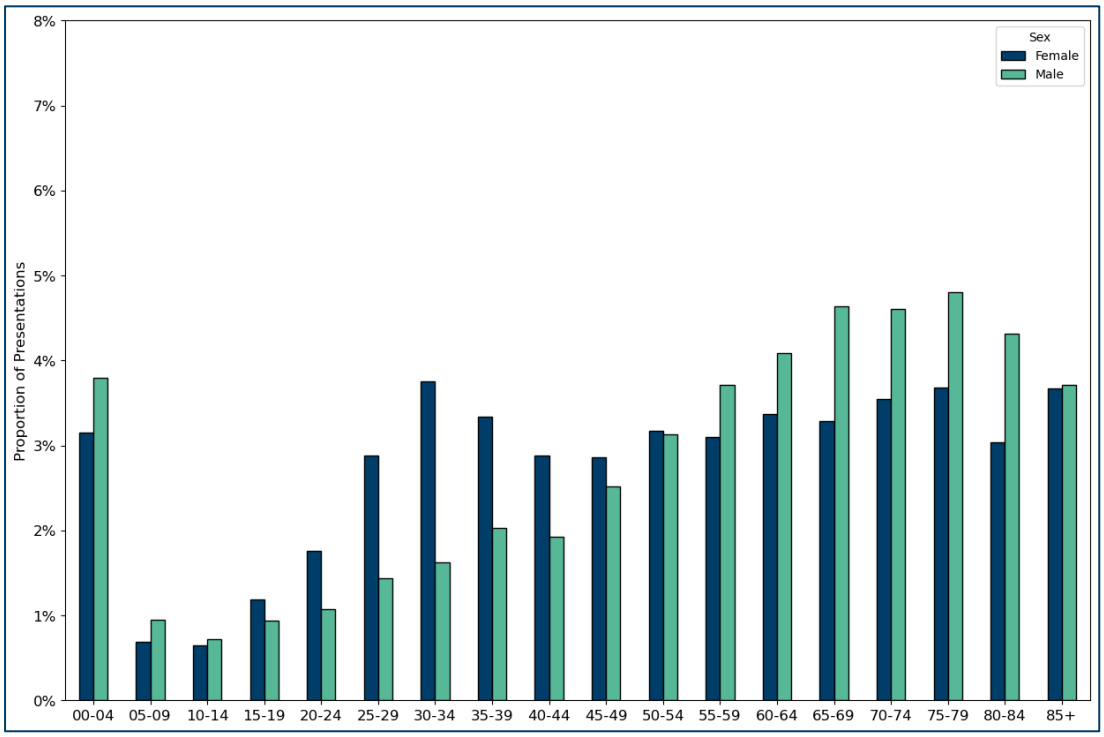
In the FY 2022-23, there were just over 435,000 hospital admissions by south east Melbourne residents. Of these, approximately half were female and half male (~50.0%). A disproportionate number of admissions were from those aged under the age of 5 (7.0%), and those aged over 65 (39.2%) when compared to the age distribution of south east Melbourne. Casey recorded the highest amount of hospital admissions in south east Melbourne (n=110,374), representing approximately one-quarter of all admissions, followed by Greater Dandenong (n=56,047) and the Mornington Peninsula (n=50,311) (Figure 2.17).

Figure 2.17 Hospital admissions by LGA, FY2022-23



Source: VAED, Department of Health – Victoria, FY2022-23.

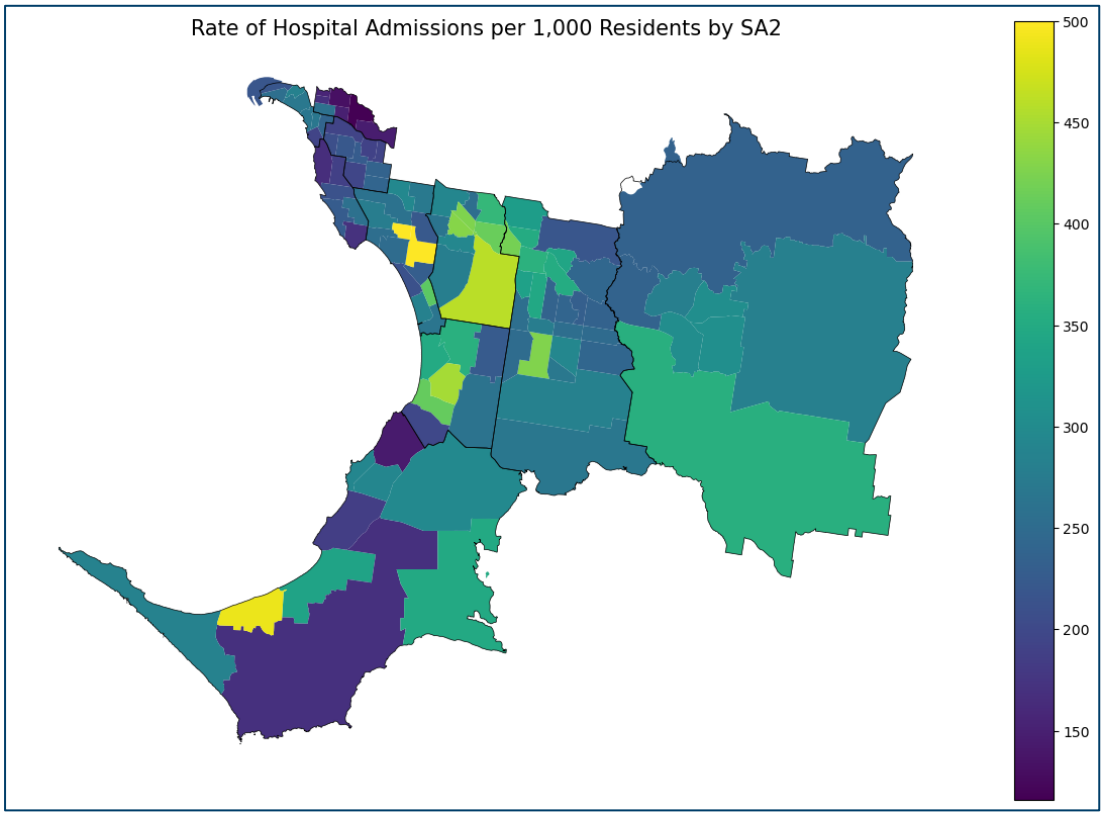
Figure 2.18 Hospital admissions by age and gender, FY2022-23



While the rate of hospital admissions in FY2022-23 varied by location, on average there were 265 hospital admissions per 1,000 residents across the SEMPHN catchment (2023 ERP=1,641,614) (Figure 2.19). Specific localities (SA2 or suburbs) experienced hospital admission rates approximately twice as

high as the overall rate for the SEMPHN region. Particularly high rates were in Rosebud – McCrae (Mornington Peninsula LGA) with 467 admissions per 1,000 residents, Doveton (Casey LGA) with 380 admissions per 1,000 residents, and Hallam (Casey LGA) with 314 admissions per 1,000 residents. Localities with a higher proportion of residents aged under 4 (e.g. Cranbourne) and 65 or older (e.g. Rosebud – McCrae) frequently had higher rates of hospital admissions, potentially as a result of the increased primary and tertiary care needs within these age groups (Figure 2.18).

Figure 2.19 Rate of hospital admissions per 1,000 residents by SA2



References

Australian Institute of Health and Welfare (2020) *The first year of COVID-19 in Australia: direct and indirect health effects*, Australian Institute of Health and Welfare,.

——— (2021) 'Health of people experiencing homelessness Snapshot'.

Caruso G (2017) 'Public health and safety: The social determinants of health and criminal behavior', *Gregg D. Caruso*.

Crime Statistics Agency (2023) *Data Tables Family Incidents Visualisation Year Ending March 2023* [data set], https://files.crimestatistics.vic.gov.au/2022-06/Data_Tables_Family_Incidents_Visualisation_Year_Ending_March_2022.xlsx.

Department of Social Services (2022) *DSS Demographics - March 2022* [data set], https://data.gov.au/data/dataset/cff2ae8a-55e4-47db-a66d-e177fe0ac6a0/resource/b67aa3d6-063a-4e55-8941-6ca291754523/download/dss-demographics-march-2022-final.xlsx.

Georgetown Institute for Women Peace and Security (2019) *Australia's Performance on the Women, Peace, and Security Index* [data set], https://giwps.georgetown.edu/country/australia/.

Joshi C, Russell G, Cheng I-H, Kay M, Pottie K, Alston M, Smith M, Chan B, Vasi S and Lo W (2013) 'A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination', *International Journal for Equity in Health*, 12(1):1-14.

Public Health Information Development Unit (2021) *2021 Census data by Primary Health Networks - with component LGAs* [data set], https://phidu.torrens.edu.au/current/data/sha-aust/census/phidu_data_phn_lga_aust_census.xlsx.

——— (2024) *Social Health Atlas of Australia - Data by Primary Health Network (incl. Local Government Areas)* [data set], accessed 16 July 2021.

Services Australia (2022) *Income support payment*, https://www.servicesaustralia.gov.au/income-support-payment?context=60271.

Statistics ABo (2021a) *General Community Profile* [data set], https://www.abs.gov.au/census/find-census-data/datapacks/download/2021_GCP_all_for_VIC_short-header.zip.

——— (2021b) *QuickStats*, Australian Bureau of Statistics,, https://www.abs.gov.au/websitedbs/D3310114.nsf/Home/2016%20QuickStats

The Lancet Public Health (2020) 'Education: a neglected social determinant of health', *The Lancet. Public Health*, 5(7):e361.

Victorian Planning Authority (2012) *Growth Corridor Plans: Managing Melbourne's Growth*.

Chapter 3 Cultural and linguistic diversity (CALD)

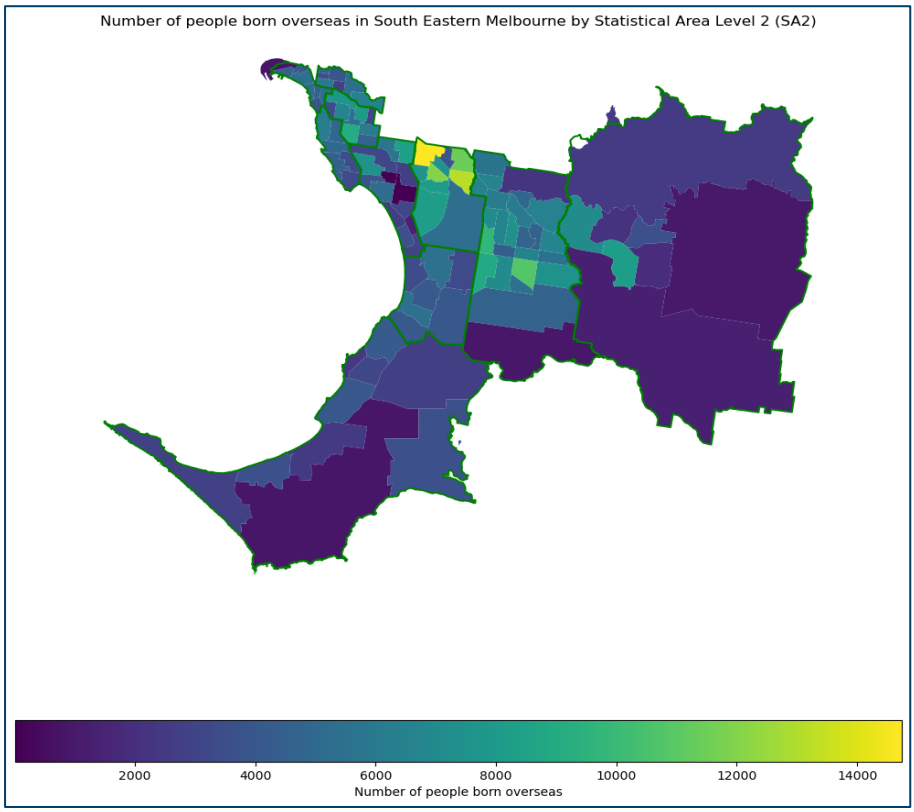
- **Incidence**: one in 3 residents born overseas, mainly in Casey and Greater Dandenong.
- **Countries of Origin**: primarily from India, England, China, New Zealand, and Sri Lanka but vary across LGAs; Casey has mainly from India, Sri Lanka, and Afghanistan; Greater Dandenong from Vietnam, India, and Cambodia.
- **English Proficiency**: 26% of CALD residents born in non-English speaking (NES) countries; lowest levels of English proficiency in Greater Dandenong, Casey, and Kingston.
- **ED Presentations**: 17% increase (2019-20 to 2022-23) in non-English speaking (NES) individuals; highest in Greater Dandenong, Casey, and Glen Eira (also holds true for hospital admissions).
- **Top Preferred Languages**: ED presentations - Dari, Greek, Mandarin, Vietnamese; Hospital admissions - Greek, Vietnamese, Dari, Khmer.

Population insights

Cultural and linguistic diversity (CALD) describes people who were born overseas, speak languages other than the official national languages, and/or have lower proficiency of native or national languages. In Australia this population can be best defined using several criteria that include those people born overseas, those born in predominantly non-English speaking (NES) countries, those who have arrived in Australia within the past 5 years, and those born overseas with limited English proficiency.

According to the 2021 ABS Census, 530,517 people in the south east Melbourne region were born overseas, representing approximately one in 3 residents. Casey had the largest population of people born overseas in south east Melbourne, with 153,566 residents, accounting for 41.6% of Casey's total population in 2021 (n=369,558). Greater Dandenong had the highest proportion of residents born overseas at 57.4%, and the second highest total number of overseas-born residents (n=91,864). The 3 SA2s with the largest overseas-born population were all located in Greater Dandenong: Springvale (n=14,741), Dandenong – North (n=13,153) and Noble Park – West (n=12,010) (
Figure 3.1).

Figure 3.1 South east Melbourne map of people born overseas, 2021



Source: Census 2021, ABS (June 2022).

The 2021 ABS Census also showed that the SEMPHN region had a diverse population of overseas-born residents. The top countries of origin across the region were India (15.0%, n=69,373), England (12.5%, n= 57,755), China (7.0%, n=57,755), New Zealand (6.2%, n=25,523) and Sri Lanka (6.1%, n=3.1). The top countries of origin for overseas-born residents varied across different SEMPHN LGAS.

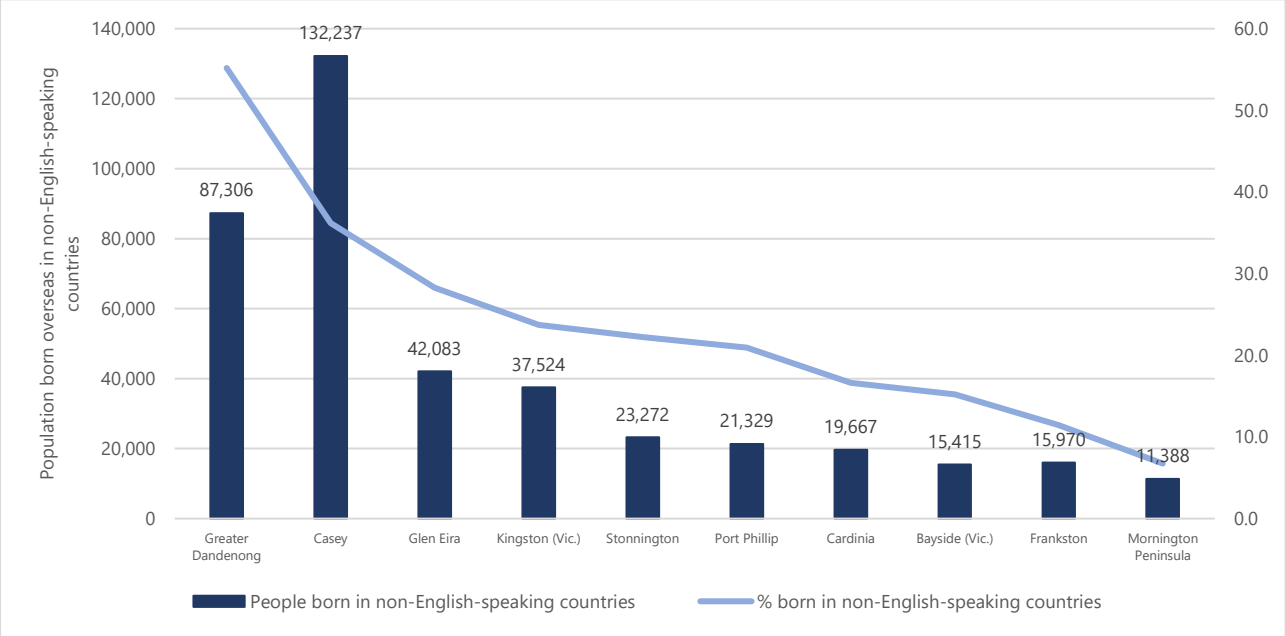
In Bayside, one in 3 overseas-born residents originated from England (22.5%, n=6,104) and China (9.0%, n=2,436). In Cardinia, one-third of its overseas-born residents were from India (18.5%) and England (15.2%, n=4,204). Casey had 2 in 5 of its overseas-born population from India (21.1%, n=32,355), Sri Lanka (9.8%, n=15,026) and Afghanistan (9.6%, n=14,679). Frankston's overseas-born residents were predominantly from England (24.3%, n=7,224) and New Zealand (10.1%, n=2,994), constituting one-third of its total overseas-born residents. Glen Eira's overseas-born residents were mostly from China (12.4%, n=6,732), India (12.1%, n=6,549) and England (7.5%, n=4,065), accounting for one-third of this population.

In Greater Dandenong, one in 5 of the overseas-born residents were from Vietnam (16.0%, n=14,693), India (13.0%, n=11,898) and Cambodia (9.4%, n=8,671). Kingston saw one in 3 of its overseas-born residents from England (12.2%, n=6,117), India (11.4%, n=5,712) and China (8.9%, n=4,449). The Mornington Peninsula had half of its overseas-born population originating from England (39.3%, n=11,690), New Zealand (7.8%, n=2,319) and Scotland (5.2%, n=1,560). In Port Phillip, one in 3 of overseas-born residents came from England (14.9%, n=4,989), New Zealand (8.0%, n=2,684) and India (6.3%, n=2,131). Stonnington's overseas-born residents were primarily from China (12.1%, n=3,962), England (11.6%, n=3,820) and India (7.6%, n=2,497), accounting for one-third of this population.

The diverse origins of overseas-born residents in the SEMPHN region highlight the considerable amount that came from NES countries. Out of all overseas-born residents in the SEMPHN region, approximately 393,000 (26.0%) were born in countries where English is not the predominant language (PHIDU 2024). The largest amount of these residents lived in Casey (n=132,237), followed by Greater

Dandenong (n=87,306) and Glen Eira (n=42,083). However, when comparing against the total SEMPHN population, Greater Dandenong had the highest proportion of residents born in predominately NES countries, with over one in 2 residents (55.2%) in this category (Figure 3.2).

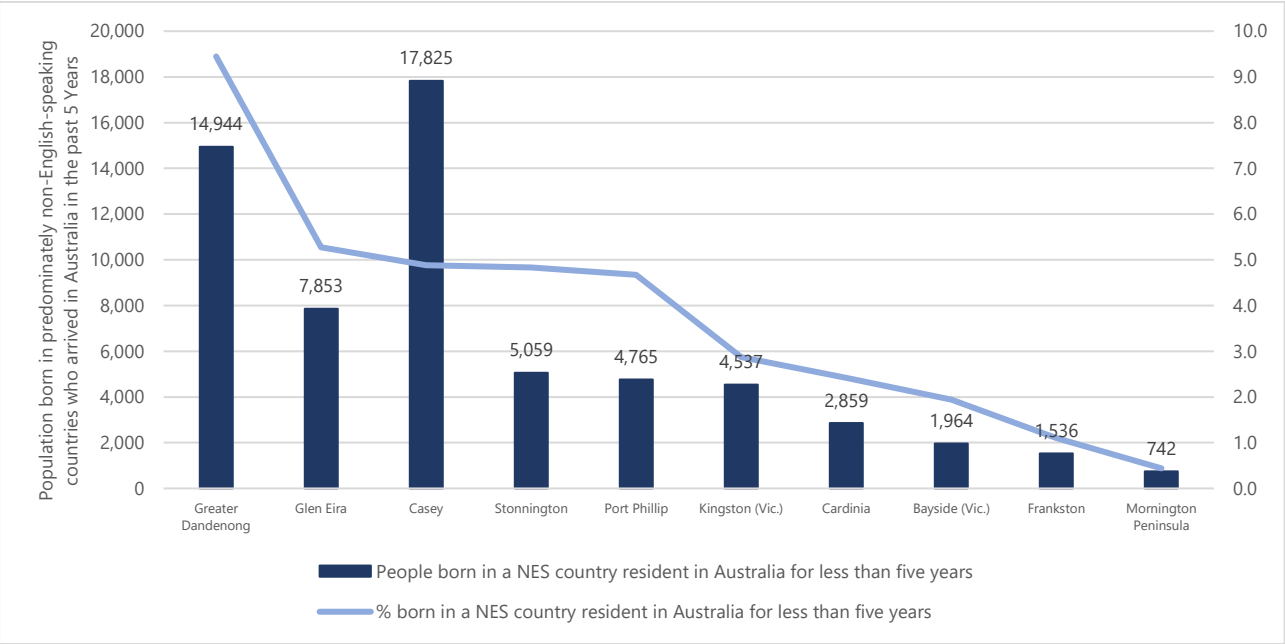
Figure 3.2 Residents born in predominately NES countries by LGA, 2021



Source: PHIDU, 2024.

Furthermore, Casey (n=17,825, 4.9%), Greater Dandenong (n=14,944, 9.4%) and Glen Eira (n=7,853, 5.3%) consistently had the largest total numbers and proportions of their populations born in predominately NES countries who had arrived in Australia within the past 5 years (Figure 3.3).

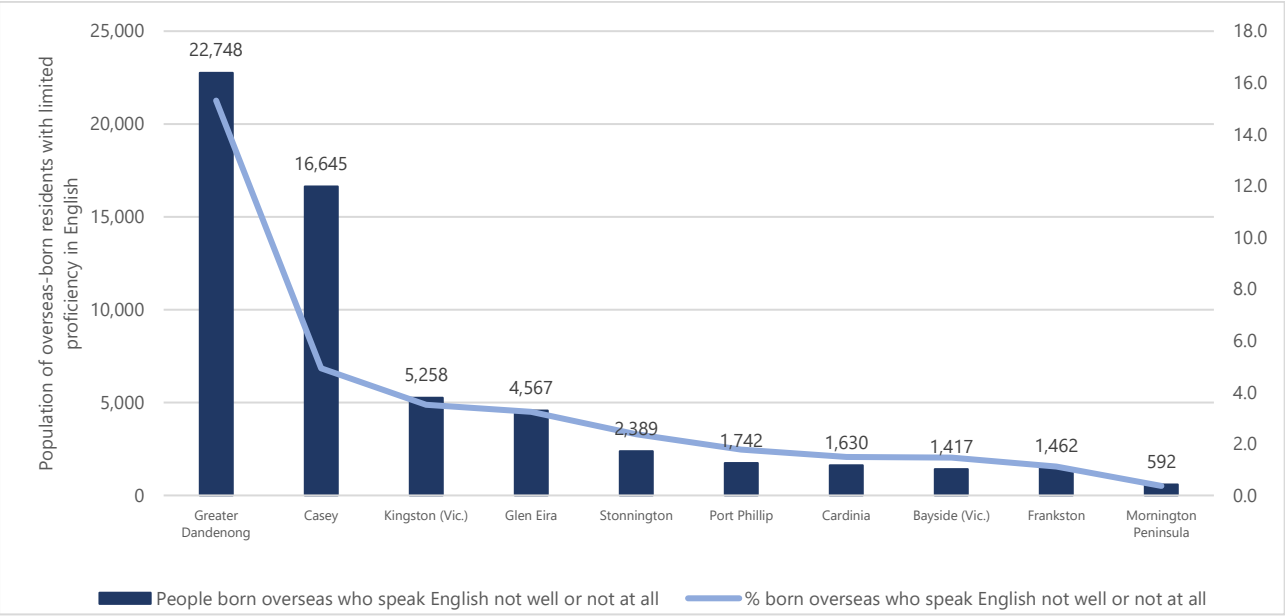
Figure 3.3 Residents born in predominately NES countries who arrived in Australia in past 5 years by LGA, 2021



Source: PHIDU, 2024.

Greater Dandenong had the highest total number (n=22,748) and proportion (15.3%) of residents born overseas with no or limited proficiency in English in south east Melbourne. Casey had the second-highest amount (n=16,645), followed by Kingston (n=5,258) (Figure 3.4).

Figure 3.4 Overseas-born residents with limited proficiency in English by LGA, 2021



Source: PHIDU, 2024.

Primary care insights

The data from general practices provide an estimate of the size and location of communities based on the 'ethnicity' field reported. Of the 1,550,000 million unique active patients who visited a POLAR-registered general practice in south east Melbourne between May 2022 and May 2024, approximately 337,000 (21.5%) had recorded an ethnicity other than 'Australian', 'not specified' and 'not recorded'. These patients primarily resided in Casey (n=126,120) and Greater Dandenong (n=22,748), consistent with the population of overseas-born residents across south east Melbourne. [8]

In south east Melbourne, just over 243,000 patients (72.1%) had at least one active diagnosis from a general practice. Approximately 40,000 of these had at least one active recorded MH diagnosis (16.3%), comparable with the prevalence of MH diagnoses among all south east Melbourne patients who attended a POLAR-registered general practice.

To enhance ethnicity reporting across primary care in the region, SEMPHN implemented a data quality improvement program. The program successfully improved the recording of ethnicity in for 97.9% of selected practices, with increases of up to 75.1% in the recording of ethnicity among these practices.

Tertiary care insights

ED PRESENTATIONS

The VEMD collects information on the preferred language of individuals presenting to public hospital EDs across Victoria. To better understand the usage of tertiary services by CALD communities in south east Melbourne, an analysis was conducted on ED presentations by residents who reported a preferred language other than English.

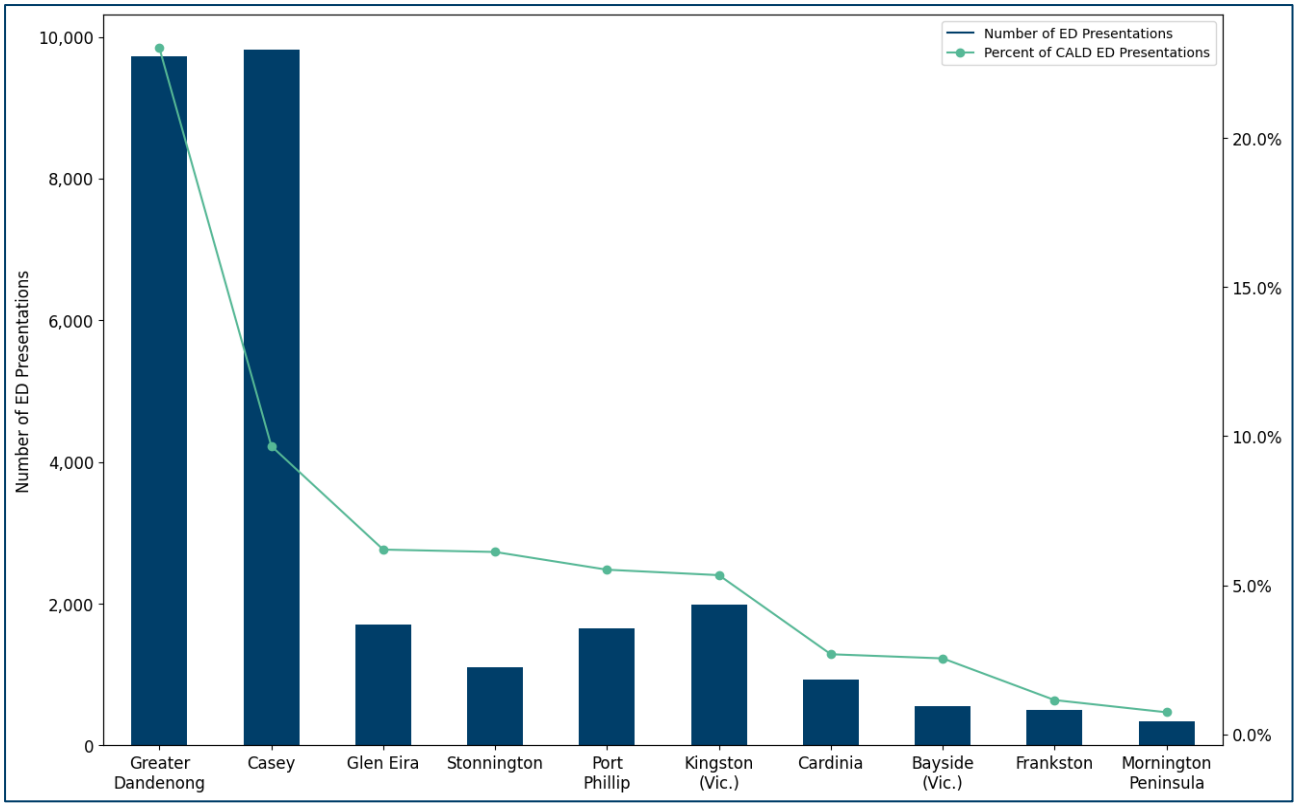
Between the 2019-20 and 2022-23 FYs, ED presentations across south east Melbourne by those whose preferred language was not English increased by 16.6% (n=4,053), with an annual increase of approximately 4.2%.

Throughout the 2022-23 FY, there were 28,000 ED presentations where the resident reported a preferred language other than English, with 54.6% being female and 45.4% male. The top preferred languages reported were Dari (n=4,110), Greek (n=2,867), Mandarin (n=2,258) and Vietnamese (n=2,094). Greater Dandenong had the highest proportion of ED presentations where the preferred language was not English at 23% (n=9,727), followed by Casey at 9.6% (n=9,818) and Glen Eira at 6.2% (n=1,706) (

Figure 3.5). Approximately 500 ED presentations were MH-related, representing 1.8% of all ED presentations where the resident's preferred language was not English, which was lower than the average of all ED presentations across south East Melbourne (3.3%).

[8] SEMPHN commissioned several general practices as part of the Multicultural Data Quality Improvement Program (MCQI) to improve ethnicity reporting across primary care in the region.

Figure 3.5 ED presentations where preferred language was not English by SEMPHN LGA, FY2022-23

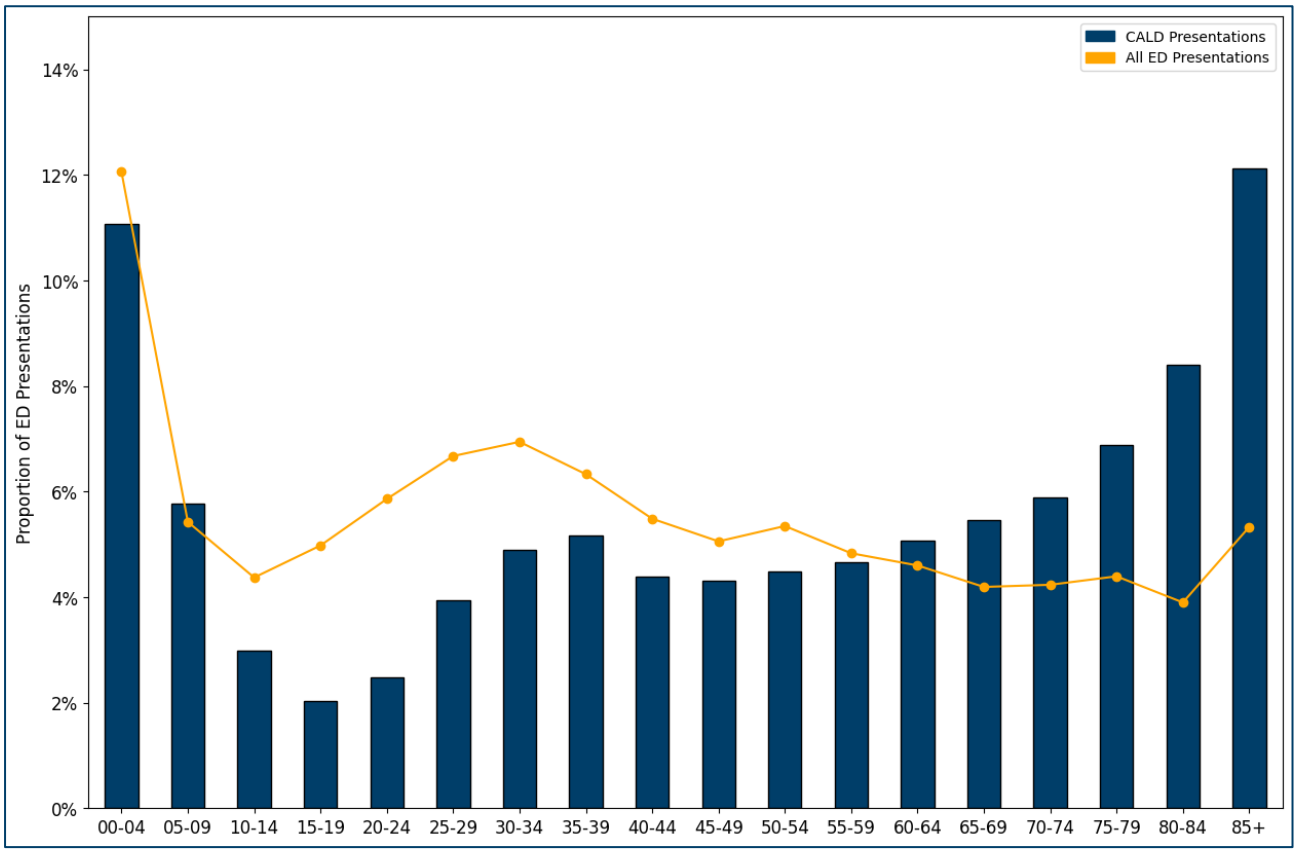


Source: VEMD, Department of Health – Victoria, 2022/23.

Among those residents whose preferred language was not English, the age distribution differed from that of all ED presentations, particularly for those aged 65 and older. This older age group constituted approximately 40% of ED presentations where the preferred language was not English, which was almost double the proportion (22%) of all ED presentations for patients aged 65 and older across south east Melbourne hospitals (

Figure 3.6).

Figure 3.6 SEMPHN ED presentations where preferred language was not English by age, FY2022-23



Source: VEMD, Department of Health – Victoria, 2022/23.

Table 3.1 CALD ED presentations by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Number of ED presentations	Proportion of ED presentations
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	9,052	32.0
Injury, poisoning and certain other consequences of external causes	4,123	14.6
Diseases of the respiratory system	1,633	5.8
Certain infectious and parasitic diseases	1,617	5.7
No recorded diagnosis	1,575	5.6
Diseases of the circulatory system	1,570	5.5
Diseases of the digestive system	1,453	5.1
Diseases of the genitourinary system	1,354	4.8

Category (by principal diagnosis)	Number of ED presentations	Proportion of ED presentations
Diseases of the musculoskeletal system and connective tissue	1,297	4.6
Diseases of the skin and subcutaneous tissue	581	2.1

Excluding the broad category groupings of 'factors influencing health status and contact with health services' and 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified', the 5 most common primary broad category diagnoses for ED presentations from CALD patients across SEMPHN were (Table 3.1) :

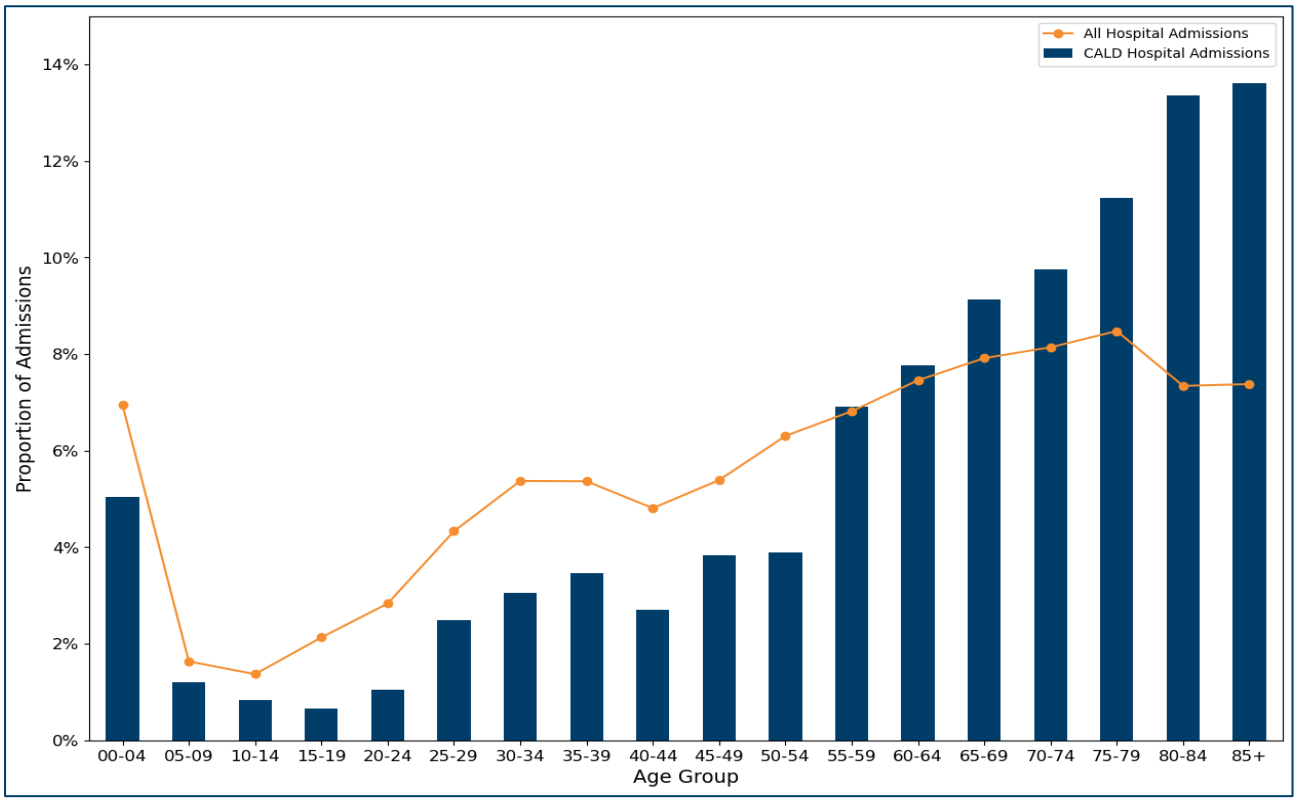
- injury, poisoning, and certain other consequences of external causes
- diseases of the respiratory system
- certain infectious and parasitic diseases
- diseases of the circulatory system
- diseases of the digestive system.

The average wait time to treatment for ED presentations where the preferred language was not English was 34.3 minutes, which was marginally shorter than the average of 35.4 minutes for all SEMPHN ED presentations. Two-thirds (66.3%) of these presentations were categorised as resuscitation, emergency or urgent, and the remaining third as semi-urgent or non-urgent cases, which is comparable with the proportion observed across all ED presentations in SEMPHN.

Hospital admissions

In the 2022-23 FY, there were just over 48,000 hospital admissions of south east Melbourne residents whose preferred language was not English (VAED 2022/23). The most commonly reported preferred language was Greek (n=7,726), followed by Vietnamese (n=4,457), Dari (n=3,996) and Khmer (n=3,154). Of these hospital admissions, approximately 52.0% were for females and 48.0% for males. A larger proportion of these hospital admissions were for those aged 65 and over (56.9%) when compared with all hospital admissions across south east Melbourne (39.2%) (Figure 3.7).

Figure 3.7 CALD hospital admissions by age, FY2022-23

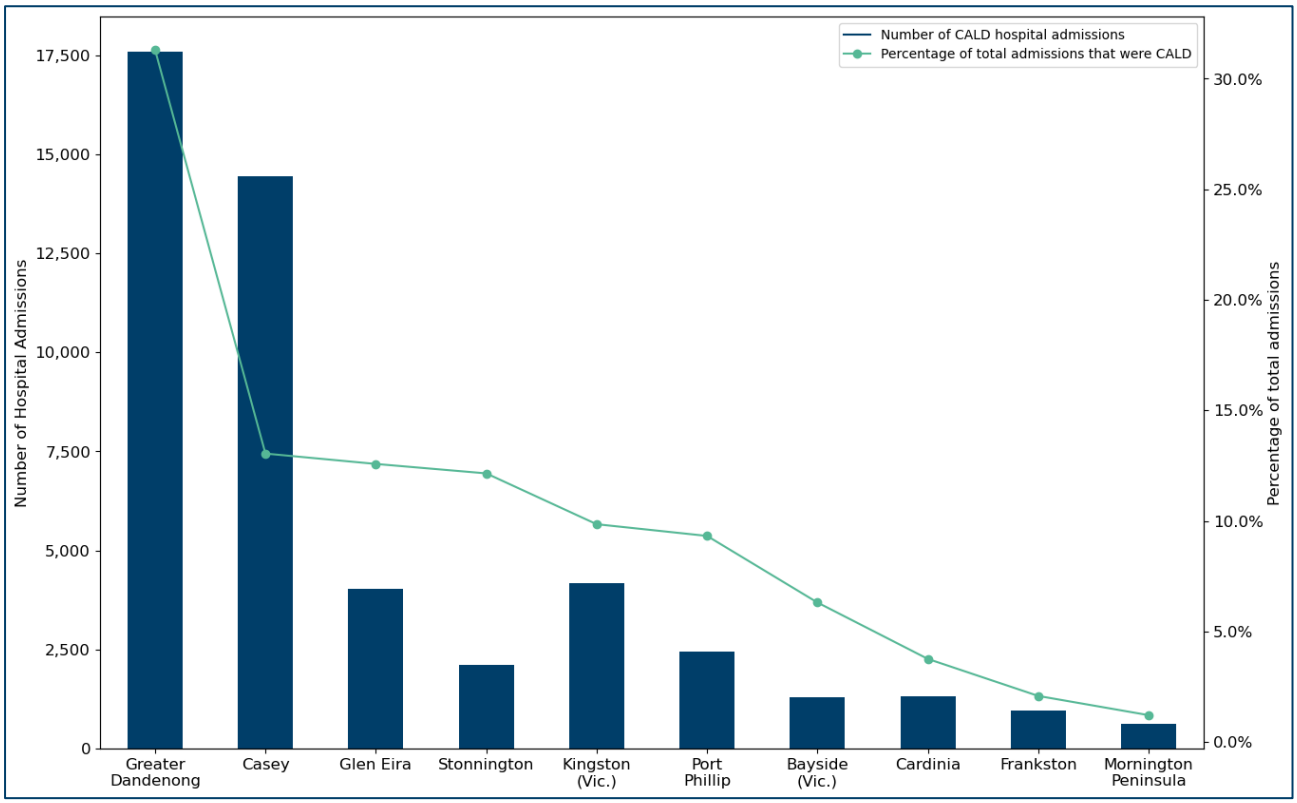


Source: VAED, Department of Health – Victoria, 2022/23.

Greater Dandenong recorded the highest amount of hospital admissions from CALD communities in south east Melbourne, at just over 17,500, which represented more than one-third (36.0%) of all CALD admissions in the region. Greater Dandenong also had the highest proportion of hospital admissions from CALD communities at approximately 31.1%, followed by Casey (13.1%) and Glen Eira (12.6%) (

Figure 3.8).

Figure 3.8 CALD hospital admissions by LGA, FY2022-23



Source: VAED, Department of Health – Victoria, 2022/23.

SEMPHN hospital admissions where the preferred language was not English were most frequent in the SA2s (and surrounding suburbs) of Greater Dandenong, specifically Springvale, Noble Park – West and North/Central Dandenong.

Figure 3.9 illustrates the total number of hospital admissions in the SEMPHN catchment where the preferred language was not English (CALD) by SA2.

Figure 3.9 CALD hospital admissions by SA2, FY2022-23

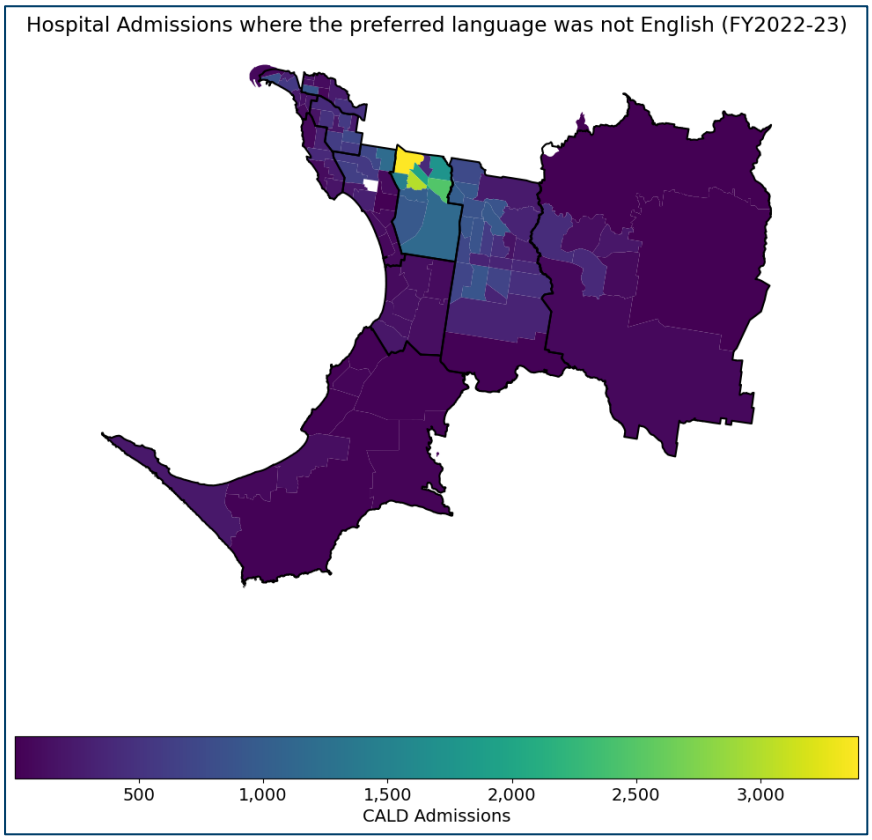


Table 3.2 provides the top 10 primary diagnoses of CALD hospital admissions among SEMPHN residents in the FY 2022-23.

Table 3.2 CALD hospital admissions by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Number of hospital admissions	Proportion of hospital admissions
Factors influencing health status and contact with health services	19,064	39.0%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	4,163	8.5%
Injury, poisoning and certain other consequences of external causes	2,729	5.6%
Diseases of the digestive system	2,630	5.4%
Neoplasms (cancer)	2,594	5.3%
Diseases of the circulatory system	2,467	5.1%
Pregnancy, childbirth and the puerperium	2,157	4.4%
Diseases of the genitourinary system	1,989	4.1%

Category (by principal diagnosis)	Number of hospital admissions	Proportion of hospital admissions
Diseases of the respiratory system	1,702	3.4%
Diseases of the eye and adnexa	1,611	3.3%

Excluding broad category groupings such as 'factors influencing health status and contact' and 'symptoms, signs and abnormal clinical and laboratory findings', the 5 most frequent primary broad category diagnoses for CALD hospitalisations across the SEMPHN region were:

- injury, poisoning and certain other consequences of external causes
- diseases of the digestive system
- neoplasms (cancer)
- diseases of the circulatory system
- pregnancy, childbirth and the puerperium.

A higher proportion of CALD hospital admissions related to neoplasms (cancer) and pregnancy, childbirth and the puerperium when compared with all hospital admissions across SEMPHN. Care involving dialysis (Z49, ICD-10) made up 29.8% of hospital admissions where the patient's preferred language was not English, followed by other medical care (5.5%), other cataract (2.0%) and single spontaneous delivery (1.6%). The average length of stay for CALD hospitalisations was 2.97 days, which was marginally longer than the overall average of 2.89 days for all SEMPHN hospital admissions. Approximately 65% of CALD admissions were same day stays, 10% were overnight stays and 25% were multi-day stays.

Chapter 4 First Nations people

- **Geographic and Age Distribution**: largest populations in Casey (23.4%), Frankston (18.4%), and Mornington Peninsula (17.5%), with median age of 25; 32.1% are under 15, with 21.7% aged 0-9 years.
- **Disability**: higher rates than the Victorian average, especially in Greater Dandenong, Frankston, and Casey.
- **Socio-economic Disadvantage**: Indigenous Relative Socioeconomic Outcomes Index (IRSEO) score of 25 for First Nations peoples (compared to a lower score of 14 for Victoria). Lowest scores in Greater Dandenong, Cranbourne-Narre Warren, Cardinia, and Mornington Peninsula.
- **Education**: higher ASR for First Nations peoples compared to non-First Nations peoples in most LGAs except Cardinia and Greater Dandenong. Highest vocational education rates in Port Phillip (an ASR of 5.3 per 100 First Nations people), followed by Stonnington (4.8), Frankston (4.2) and Glen Eira (3.6).
- **Employment**: lower engagement of 15-24 years in education, work, or training in Greater Dandenong (68.5%), Cardinia (75.5%), and Cranbourne-Narre Warren in Casey (79.1%), compared to the 80.4% catchment average (2021).
- **Household Income:** lower median personal weekly income compared to non-First Nations households in most LGAs, but higher household income in Bayside ($2,729 vs $2,486), and in Stonnington ($2,271 vs $2,209) and Kingston ($1,970 vs $1,914).
- **Housing**: highest percentage of households renting private dwelling needing extra bedrooms in Greater Dandenong (18.0%), followed by Casey (13.8%) and Cardinia (12.1%).
- **MH**: most common chronic condition; highest rates in Port Phillip (23.3%), Frankston (22.0%), and Greater Dandenong (21.4%) - above the Victorian average of 18.3%.

The traditional custodians of the lands and waterways of the SEMPHN catchment are the Boon Wurrung and Wurundjeri people (The Australian Institute of Aboriginal and Torres Strait Islander Studies 2022). The lands of the Bunurong people are from the Werribee River in the north west to Wilson's Promontory in the south east (The Nepean Historical Society 2022). The lands of the Wurundjeri people are the Birrarung Valley (Yarra River), covering much of Narrm (Melbourne). Over the past 50 years, Aboriginal Community Controlled Health Services (ACCHS) have provided a wide range of health, social and emotional well-being services. There are currently 2 ACCHS within the SEMPHN catchment: Dandenong & District Aborigines Co-Operative Limited (DDACL) and First Peoples' Health and Well-being. These organisations provide support for the First Nations community in the region, aiming to improve access to affordable primary healthcare and other unmet needs.

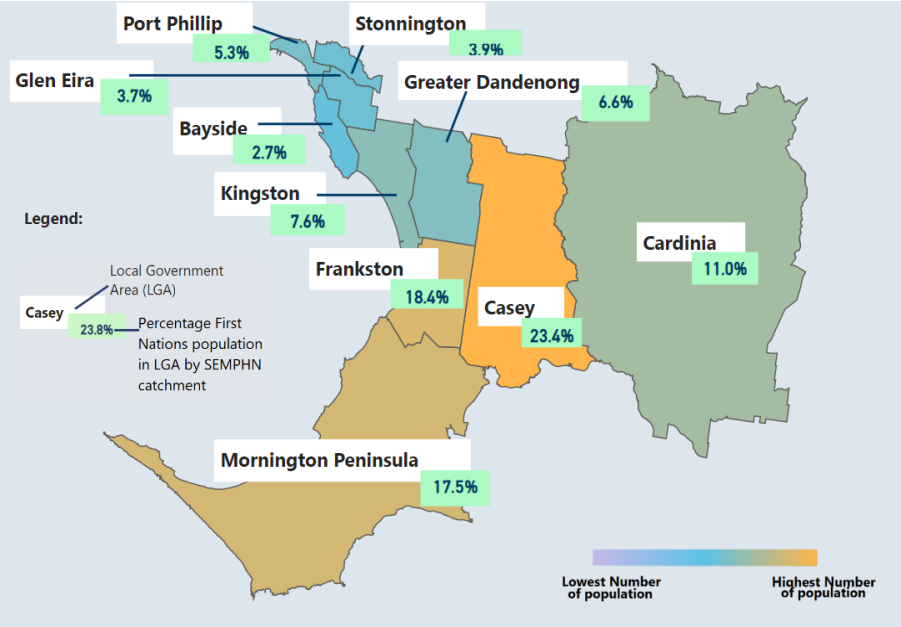
Population

According to the 2021 Census (Australian Bureau of Statistics 2023c), it was estimated that First Nations people make up 0.8% (n=12,114) of the population in the SEMPHN region. Figure 4.1 shows their estimated population distribution by LGA. Between the 2016 and 2021 census periods, the estimated First Nations population in the region grew from 0.6% to 0.8%. Frankston experienced the largest population growth, rising from 1.2% in 2016 to 1.6% in 2021. Casey LGA had the largest proportion in the region in 2023, with a total of 2,845 (23.5%) residents identifying as Aboriginal and/or Torres Strait Islander peoples. This was an increase from the 1,941 residents (21.6% of the regional First Nations population) recorded in 2016 (see Appendix Table 1.2.1 for further detail).

First Nations residents had a median age of 25 years, which was lower than the median age of 37 years for all residents in the SEMPHN region. Nearly one-third (32.1% or 3,890 individuals) of the First

Nations people in the SEMPHN region were aged under 15 years, indicating a relatively young population, while around one in 9 First Nations people were aged 55 years and over[9] (11.8%, n=1,433) (Public Health Information Development Unit 2024). The largest proportion of First Nations people in the SEMPHN catchment were aged between 0 and 9 years of age, which is one in 5 (21.7%, n=2,627).

Figure 4.1 Estimated proportion of residents who identified as First Nations people by LGA, 2021



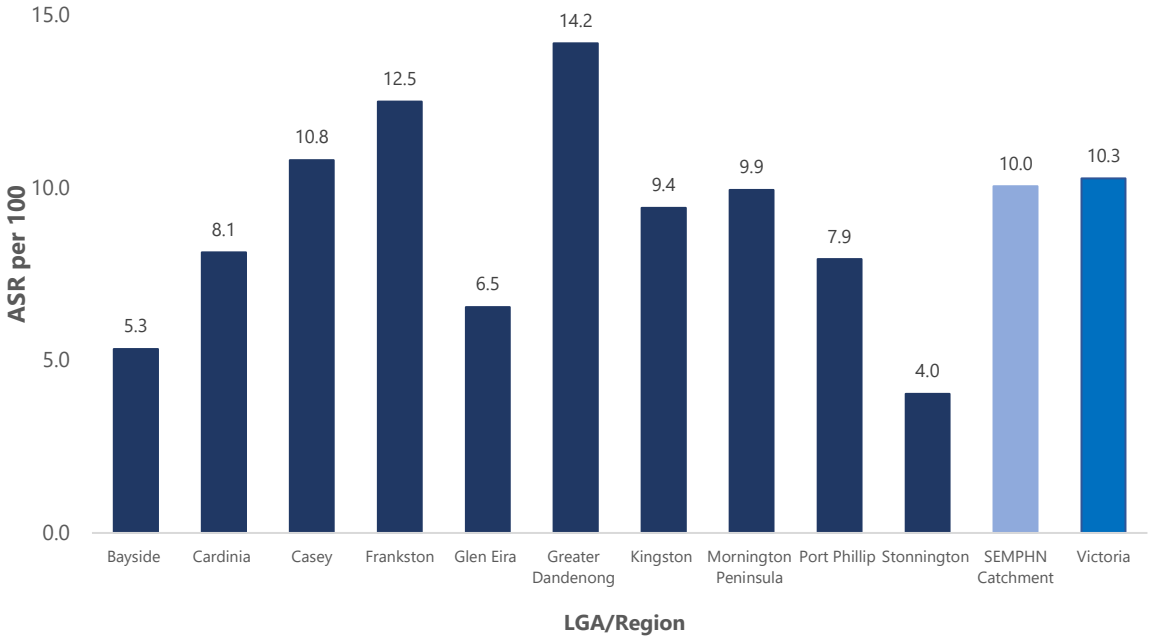
Source: 2021 Census, ABS (June 2022), TableBuilder: LGA (UR) and State (UR) by INGP indigenous status, generated on 7 October 2024. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Disability

People with a profound or severe core activity limitation are those who may need assistance with self-care, mobility and/or communication because of a long-term health condition, disability or due to old age. According to the 2021 ABS Census, as shown in Figure 4.2, some LGAs within the SEMPHN region had a higher rate of First Nations people that required core activity assistance compared with the average rate for Victoria. The LGAs with the highest rates of First Nations people needing assistance were Greater Dandenong (14.2 per 100 First Nations people), Frankston (12.5 per 100 First Nations people) and Casey (10.8 per 100 First Nations people). All 3 LGAs had rates higher than the Victorian average of 10.3 per 100 First Nations residents requiring assistance (see Appendix Table 1.2.2 for further detail). This information is valuable for service providers and governments to plan and provide appropriate local facilities, services and support tailored to the needs of First Nations communities. Such support may include in-home assistance, respite care and carer support services (Australian Bureau of Statistics 2021).

[9] Due to restrictions in the combined age categories provided by ABS (45-55 years, 55 -65 years, etc), number of First Nations people above the age of 50 years (older First Nations people) cannot be accurately estimated.

Figure 4.2 Core activity assistance required for First Nations people by LGA, 2021



Determinants of health

Socioeconomic disadvantage

The Indigenous Relative Socioeconomic Outcomes (IRSEO) index is a measure that indicates the level of advantage or disadvantage experienced by First Nations people (Aboriginal and Torres Strait Islander peoples) within specific geographic areas that are called indigenous areas (IAREs)[10]. This index ranges from 1 to 100, with a score of one representing the most advantaged area and a score of 100 indicating the most disadvantaged area.

As shown in Table 4.1, First Nations people living within the SEMPHN catchment generally experienced greater socioeconomic advantage compared with those across Victoria. The IRSEO score for the SEMPHN catchment was 14, which was lower than the score of 25 for Victoria, indicating a higher level of advantage. Although Greater Dandenong had an IRSEO score of 57, suggesting that First Nations people in this area experienced relatively higher levels of socioeconomic disadvantage compared with other catchment areas.

[10] Indigenous areas (IAREs) are geographical units that provide a balance between spatial resolution and population size.

Table 4.1 IRSEO by IARE and LGA, 2021

IARE	IRSEO score	First Nations population (2021 ERP)
Cardinia	15	1,145
Cranbourne – Narre Warren	17	2,395
Frankston	9	2,524
Greater Dandenong	57	615
Melbourne – East (part b)	1	1,032
Melbourne – Port Phillip	2	506
Mornington Peninsula	15	1,724
SEMPHN catchment	14	9,196
Victoria	25	65,646
LGAs covered in the IARE are Cardinia (Cardinia Shire), Cranbourne – Narre Warren (City of Casey), Frankston (City of Frankston, City of Kingston), Greater Dandenong (City of Greater Dandenong), Melbourne – East (part b) (City of Bayside, City of Glen Eira, City of Stonnington), Melbourne – Port Phillip (City of Port Phillip), and Mornington Peninsula (Mornington Peninsula Shire).		

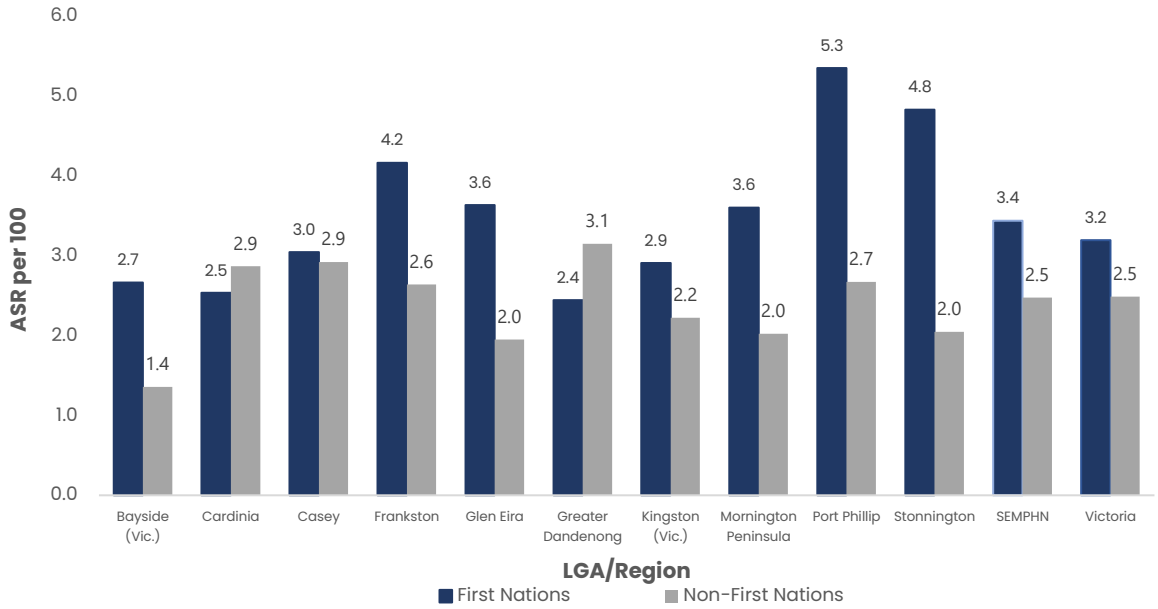
Source: PHIDU (September 2024), accessed on 7 October 2024, Table: Summary measure of indigenous outcomes. https://phidu.torrens.edu.au/social-health-atlases/maps/#aboriginal-torres-strait-islander-social-health-atlas-of-australia. IRSEO = Indigenous Relative Socioeconomic Outcomes and ERP=estimated resident population. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Education

Higher levels of education have been associated with better health and well-being, improved health literacy, higher income, better employment opportunities, improved working conditions, and a range of other social benefits (Hart et al. 2017). The national agreement on Closing the Gap has identified early childhood education, Year 12 or equivalent, tertiary education, and post-school educational attainment as areas for action and improvement. The ABS 2021 Census data in

Figure 4.3 highlights that First Nations people had higher participation rates in vocational education and training compared with non-First Nations people. In 2021, the highest vocational education and training participation rates for First Nations people were in Port Phillip, with an age-standardised rate (ASR) of 5.3 per 100 First Nations people, followed by Stonnington with an ASR of 4.8, Frankston with an ASR of 4.2 and Glen Eira with an ASR of 3.6. These participation rates were higher for First Nations people compared with non-First Nations people in all SEMPHN LGAs except Cardinia and Greater Dandenong. The participation rates in vocational education and training for both First Nations people and non-First Nations people in the SEMPHN catchment were comparable with the rates in Victoria.

Figure 4.3 Vocational education and training participant rates for First Nations people, 2021



Source: 2021 Census, ABS (June 2022), TableBuilder: LGA (UR) by TYPP type of educational institution attending by INGP indigenous status, generated on 7 October 2024. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Figure 4.4 reports on the proportion of First Nations and non-First Nations populations attending various levels of educational institutions across the SEMPHN catchment. Due to the difference in age cut-offs for attending different educational institutions, only numbers and percentages are reported across various LGAs. According to the ABS 2021 Census, there were 403 First Nations children attending preschool (children under 5 years) across all LGAs in the SEMPHN catchment. The highest proportions were in Casey (25.7%, n=342) and Frankston (19.6%, n=260). There were 1,329 First Nations children attending primary school (5 years or over) and 971 attending secondary school (usually between 12 and 20 years of age) across the SEMPHN catchment. The data is also presented in Appendix Table 1.2.3.

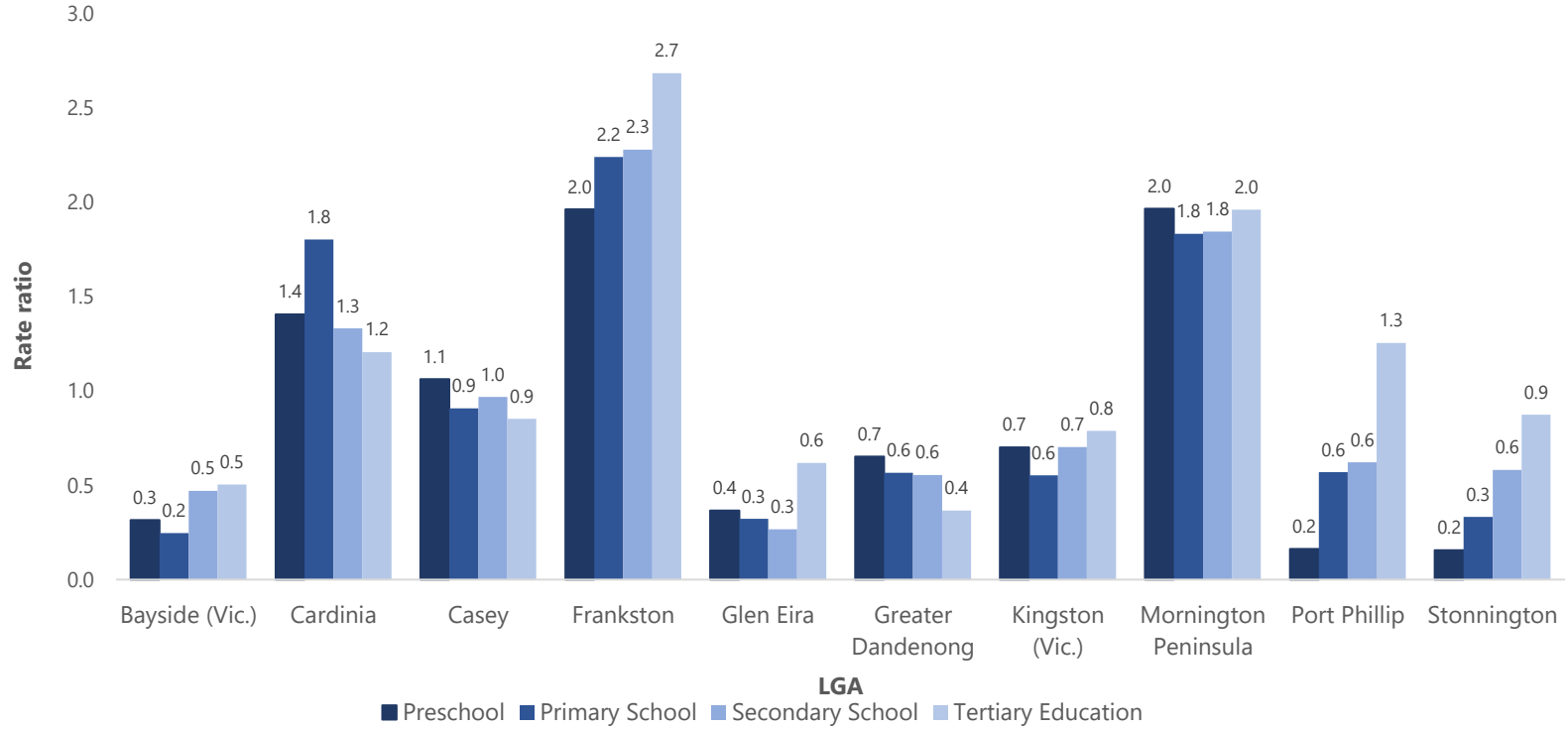
Rate ratios were calculated to compare the rates of school attendance across various educational levels for both First Nations people and non-First Nations groups in the SEMPHN catchment[11]. The overall SEMPHN rate ratios for preschool (0.63), primary school (0.57), secondary school (0.60) and tertiary education (0.71) were all lower than 1, suggesting that a lower proportion of First Nations students attended these educational intuitions compared with the Victorian rates.

[11] Rate ratio was calculated by dividing rate of attendance (per 10,000) for the SEMPHN catchment area by total rate of attendance (per 10,000) for all of Victoria. If the rate ratio is 1 (or close to 1), it suggests no difference or little difference in rates (rate of attendance is the same). A rate ratio greater than 1 suggests higher rate of attendance in the LGA compared to Victoria. A rate ratio lesser than 1 suggests a lower rate in the LGA compared to Victoria.

LGA-specific rate ratios[12] were also calculated to compare the school attendance rates between First Nations and non-First Nations students. In the LGAs of Cardinia, Frankston and the Mornington Peninsula, the rate ratios were greater than 1 across all levels of educational institutions for First Nations people (Figure 4.4). This indicates that in these 3 LGAs, a higher proportion of First Nations people attended preschool, primary school, secondary school and tertiary education compared to the overall SEMPHN rates. Port Phillip also had a higher First Nations attendance rate (1.3) for tertiary education than the corresponding SEMPHN rate.

[12] Rate ratio was calculated by dividing rate of attendance (per 10,000) for each LGA by total rate of attendance (per 10,000) for all the SEMPHN catchment. If the rate ratio is 1 (or close to 1), it suggests no difference or little difference in rates (rate of attendance is the same). A rate ratio greater than 1 suggests higher rate of attendance in the LGA compared to Victoria. A rate ratio lesser than 1 suggests a lower rate in the LGA compared to Victoria.

Figure 4.4 First Nations people attending an educational institution relative to SEMPHN catchment residents by LGA, 2021

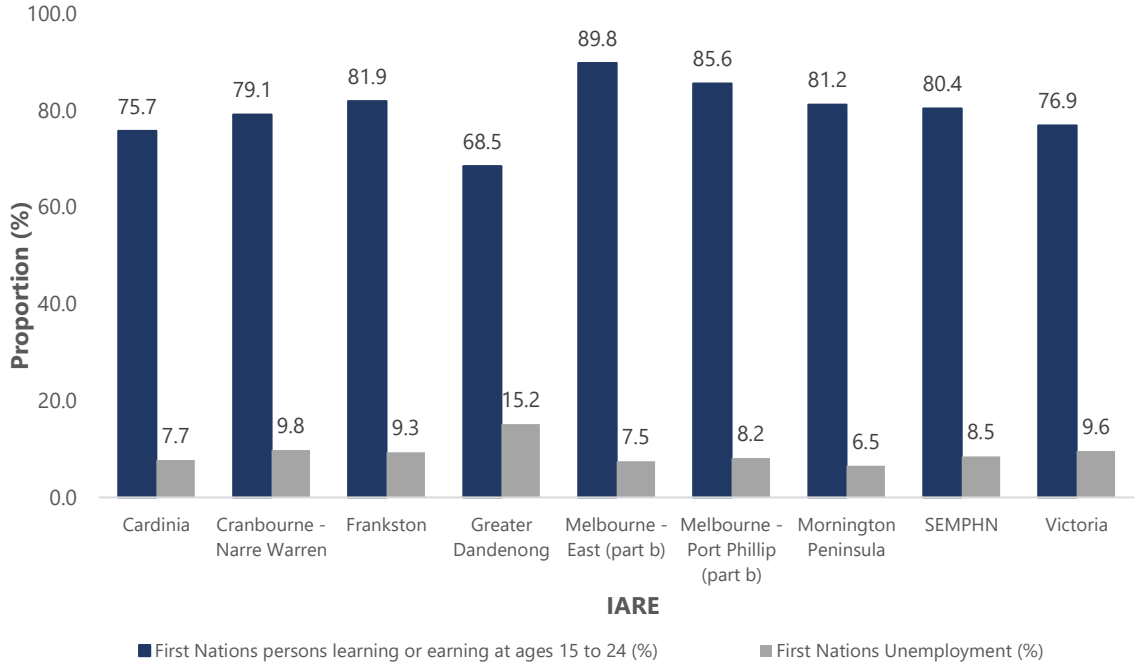


Source: 2021 Census, ABS (June 2022), TableBuilder: LGA (UR) by TYPP type of educational institution attending by INGP indigenous status. Please note Monash LGA is excluded due to the small proportion of the LGA falling within SEMPHN catchment (4%). The rate ratio was calculated by dividing rate of attendance (per 10,000) for each LGA by total rate of attendance (per 10,000) for all of the SEMPHN catchment area. If the rate ratio is 1 (or close to 1), it suggests no difference or little difference in rates (rate of attendance is the same). A rate ratio greater than 1 suggests higher rate of attendance in the LGA compared to the SEMPHN catchment. A rate ratio lesser than 1 suggests a lower rate in the LGA compared to the SEMPHN catchment.

EMPLOYMENT

In 2021, the proportion of First Nations people aged 15 to 24 years engaged in school, work or further education/training was lowest in the Greater Dandenong IARE at 68.5%, followed by Cardinia at 75.7% and Cranbourne - Narre Warren (Casey) at 79.1%. These proportions were lower than the catchment area average of 80.4%, as shown in Figure 4.5.

Figure 4.5 Education and employment status among First Nations people by IARE, 2021



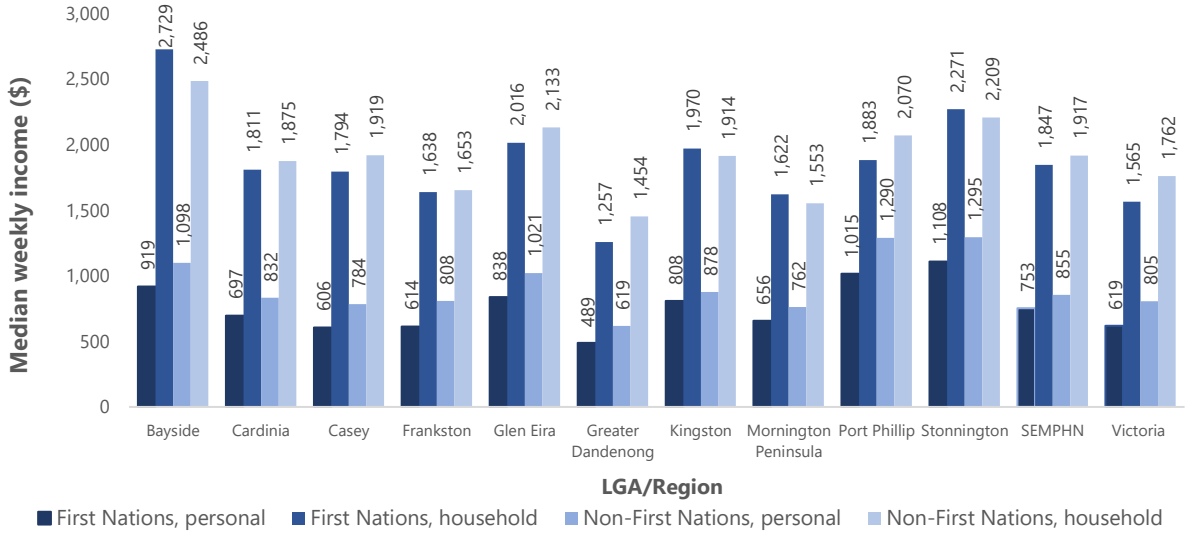
Source: PHIDU (September 2024 release), accessed on 7 October 2024, Table: Education. https://phidu.torrens.edu.au/social-health-atlases/maps/#aboriginal-torres-strait-islander-social-health-atlas-of-australia. IARE = Indigenous Area. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

INCOME

Income is closely linked to health outcomes, with numerous studies demonstrating a correlation between income and other SDOH such as educational attainment and employment. A significant income gap has been identified between First Nations adults with a median equivalised gross weekly household income of $830, and non-First Nations adults with a median equivalised gross weekly household income of $1,080 (Australian Institute of Health and Welfare 2023, 2017a).

When comparing median household income across the SEMPHN catchment, First Nations households generally had lower median personal weekly income compared with non-First Nations households in most LGAs. The excepts were Bayside where First Nations household income ($2,729) was higher than non-First Nations ($2,486), in Kingston where First Nations household income ($1,970) exceeded non-First Nations ($1,914), and in Stonnington where First Nations household income ($2,271) was higher than for non-First Nations ($2,209) (Figure 4.6).

Figure 4.6 Average weekly personal and household income of First Nations people by LGA, 2021



Source: 2021 Census, ABS (June 2022), I04 Selected medians and averages, accessed on 7 October 2024. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Housing

Housing status plays a crucial role in determining an individual's health and well-being. The concept of crowding is based on an assessment that compares the number of bedrooms in a dwelling with various household demographics, such as the number of usual residents, their relationships, ages and genders. According to data from the 2021 ABS Census, overcrowding, defined as people living in households that require 3 or more additional bedrooms, was experienced by 0.7% of First Nations Victorians compared with 0.5% of non-First Nations Victorians. Furthermore, First Nations Victorians were 3.3 times more likely to experience homelessness than their non-First Nations counterparts.

The average size for First Nations households across the SEMPHN catchment was 2.8 persons per household, compared with 2.5 persons in non-First Nations households. Casey and Cardinia reported the largest average size for First Nations households, at 3.4 persons per household, followed by Mornington Peninsula at 3.1 persons per household.

The proportion of First Nations households renting private dwellings that require extra bedrooms (based on Canadian National Occupancy Standard) (Australian Institute of Health and Welfare 2017b) was highest in Greater Dandenong at 18.0%, followed by Casey at 13.8% and Cardinia at 12.1%. This result represents the proportion of all private rented dwellings occupied by First Nations households that needed additional bedrooms based on occupancy standards.

Life expectancy and burden of disease

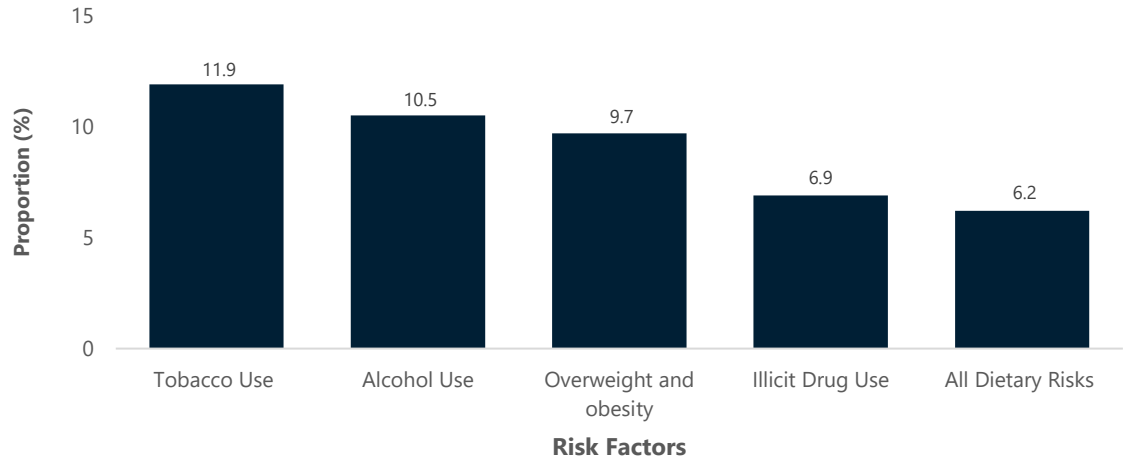
First Nations people in Australia have a lower life expectancy than non-First Nations people (Australian Bureau of Statistics 2023a). Life expectancy for First Nations females is 75.6 years, which is lower than the 83.8 years for non-First Nations females. First Nations males have a life expectancy of 71.9 years, compared with 80.2 years for non-First Nations males.

In 2018, First Nations people lost 113,445 years of life due to premature death (fatal burden), equivalent to 137 years of life lost (YLL)[13] per 1,000 people. In 2018, First Nations Australians lost 113,445 years of life due to premature death (fatal burden), equivalent to 137 YLL per 1,000 people. These lost years of life were the result of 3,619premature deaths, with 59% occurring in First Nations people aged less than 65 years. In contrast, only 17% of premature deaths in the non-First Nations population occurred before the age of 65 in the same time period (Australian Institute of Health and Welfare 2022). First Nations males (58%) were at higher risk of premature death compared with First Nations females (42%). The main disease groups causing fatal burden among First Nations people were injuries (23%), cancer (20%) and cardiovascular disease (CVD) (19%). Injuries contributed 43% of fatal burden among First Nations children and adolescents (aged 1 to 14) and 73% of the fatal burden among First Nations young adults (aged 15-24) (Australian Institute of Health and Welfare 2022, 2018).

HEALTH RISK FACTORS

In 2018, half (49.0%) of the total disease burden among First Nations people could have been avoided by eliminating exposure to certain modifiable risk factors, according to the Australian Burden of Disease Study (Australian Institute of Health and Welfare 2022). Figure 4.7 illustrates the contribution of various health risk factors to the overall disease burden among First Nations people. The figure shows that tobacco use and alcohol consumption together accounted for 22.4% of the total disease burden among First Nations people.

Figure 4.7 Health risk factors contributing to burden of disease among First Nations people, 2018



Source: Australian Burden of Disease Study: impact and causes of illness and death in Australia, 2018 (Australian Institute of Health and Welfare 2022).

TOBACCO USE

The 45 & Up Study revealed that over the past decade, smoking caused more than 10,000 deaths among First Nations people over the age of 45 (Thurber et al. 2021). Those who never smoked were approximately twice as likely to live until age 75 compared with current smokers (Thurber et al. 2021). Although smoking prevalence among First Nations people has steadily declined over time (from 53.1% in 2002 to 41.0% in 2019), the National Aboriginal and Torres Strait Islander Health Surveys for 2018-19 (Australian Bureau of Statistics 2020) estimated that 38.0% of First Nations people over the age of 15 across Australia were daily smokers. The rates were similar for both males (39.0%) and females (36.0%)

[13] Fatal burden is a measure of the YLL in the population due to dying from disease or injury, where 1 YLL is 1 year of life lost. The YLL associated with each death is based on 2 factors: the age at which death occurs and the life expectancy, which is the number of remaining years that a person would, on average, expect to live from that age.

(Greenhalgh et al. 2023). When broken down by age group, First Nations males between 25 and 44 years showed the highest prevalence of smoking (67.0%) across all cohorts. In contrast, older First Nations women aged over 65 had the lowest prevalence of current smoking (22.0%) and the highest prevalence of never smoking (50.0%) (Greenhalgh et al. 2023). In Victoria, 36.0% of First Nations peoples were daily smokers in 2018-19, which was lower than the national rate of 41.0% (Greenhalgh et al. 2023).

Smoking during pregnancy

Between 2019 and 2021, the proportion of First Nations women who smoked during pregnancy in the SEMPHN catchment (37.5%) was similar to the Victorian average (39.6%) (Public Health Information Development Unit 2024). As shown in Table 4.2, the IAREs with the highest proportion of First Nations women who smoked during pregnancy were Greater Dandenong (52.6%) and Port Phillip (43.9%). This data represents the proportion of First Nations women who reported smoking during pregnancy, out of the total number of pregnancies among First Nations women during the 2019-2021 period. This aggregated data may include women who gave birth more than once during that period.

Table 4.2 Prevalence of smoking during pregnancy among First Nations women by IARE, 2019-2021

IARE	First Nations women		
	Number who smoked during pregnancy	Number of pregnancies	Proportion who smoked during pregnancy (%)
Cardinia	18	58	31.0
Cranbourne – Narre Warren	48	140	34.3
Frankston	45	113	39.8
Greater Dandenong	20	38	52.6
Melbourne – East (part b)	7	27	25.6
Melbourne – Port Phillip	8	19	43.9
Mornington Peninsula	20	78	25.6
SEMPHN catchment	170	476	37.5
Victoria	1,285	3,244	39.6
LGAs covered in the IARE are Cardinia (Cardinia Shire), Cranbourne – Narre Warren (City of Casey), Frankston (City of Frankston, City of Kingston), Greater Dandenong (City of Greater Dandenong), Melbourne – East (part b) (City of Bayside, City of Glen Eira, City of Stonnington), Melbourne – Port Phillip (City of Port Phillip), Mornington Peninsula (Mornington Peninsula Shire).			

Source: PHIDU (September 2024 release), accessed on 4 October 2024, Table: Mothers and babies. https://phidu.torrens.edu.au/social-health-atlases/maps/#aboriginal-torres-strait-islander-social-health-atlas-of-australia. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Alcohol

Excessive alcohol consumption is associated with health and social well-being issues. Long-term excessive consumption is a major risk factor for health conditions, including liver and heart disease, stroke, diabetes, obesity, and cancer. Binge drinking, which involves consuming large quantities of alcohol in a short period, contributes to injuries, suicide, transport accidents, violence, burns and falls (Australian Institute of Health and Welfare 2017a). First Nations people in Victoria present at EDs for

alcohol-related causes at a rate 4 times higher than other Victorians (Department of Health Victoria 2020).

Physical inactivity

Physical inactivity is a risk factor linked to several disease groups. For First Nations people, it has contributed to the burden[14] of cardiovascular (13.7%), cancer (1.7%), neurological (3.9%) and endocrine diseases (21.0%) (Australian Institute of Health and Welfare 2022).

The data from the Victorian Population Health Survey 2019 emphasised the need to address the lack of physical inactivity among First Nations people. The survey found that only 43.7% of First Nations people met the recommended physical activity guidelines, compared with 51.1% of all non-First Nations adults. The disparity was more pronounced among women, with only one-third (33.7%) of First Nations women meeting the guidelines, in contrast to almost half (48.9%) of all non-First Nations adult women (Victorian Department of Health 2021)

These findings underscore the need for targeted interventions and programs to encourage and facilitate regular physical activities among First Nations peoples, particularly among women.

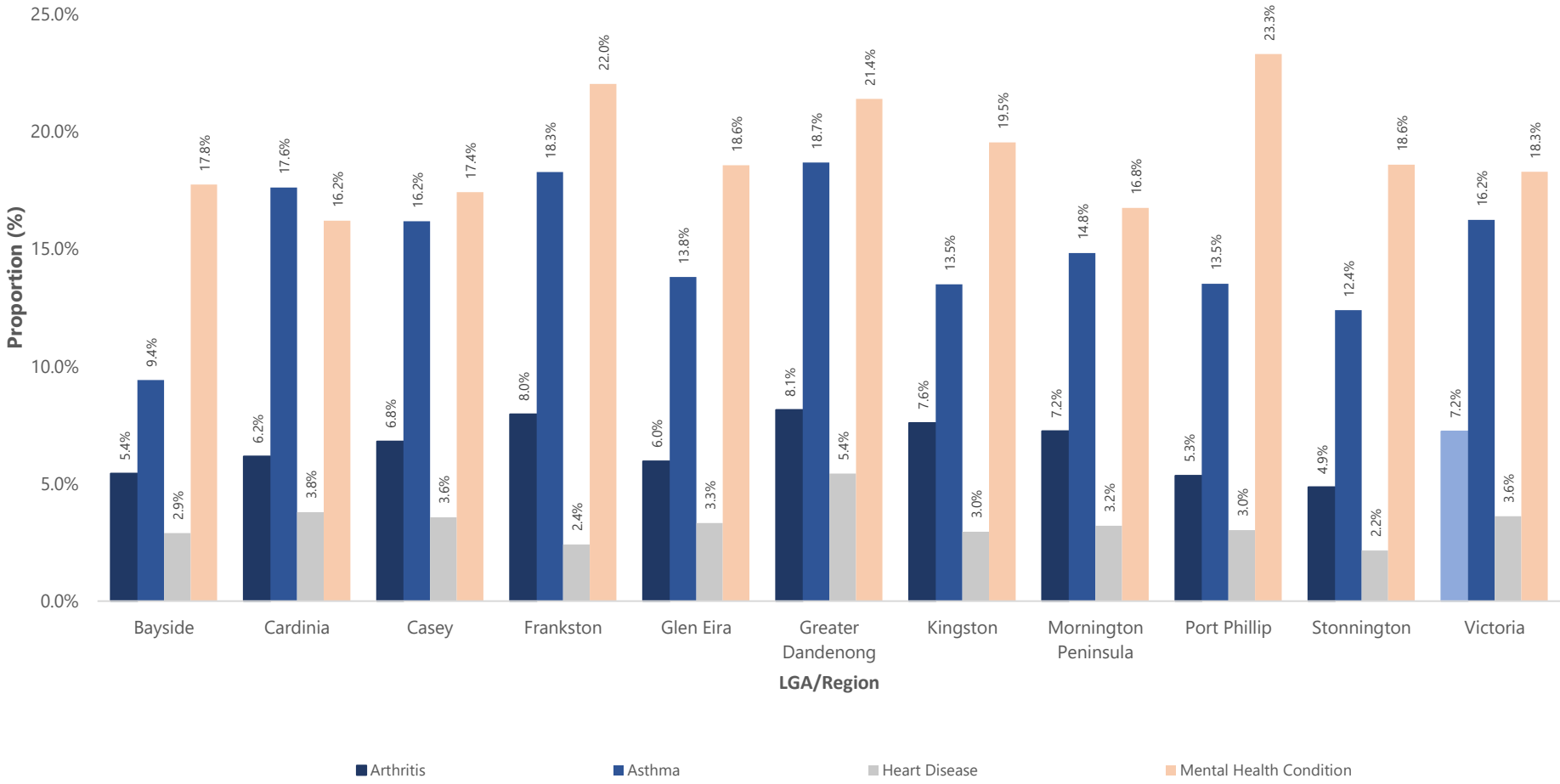
Chronic conditions

The Victorian Population Health Survey 2019 showed a disparity in chronic disease rates between First Nations people and non-First Nations adults in Victoria (Victorian Department of Health 2021). The data indicate that 43.2% of First Nations people in Victoria have been diagnosed with 2 or more chronic diseases, compared with 27.4% of all non-First Nations adults (Victorian Department of Health 2021). As shown in Figure 4.8, the 2021 Census highlighted that across most LGAs in the SEMPHN catchment, the rates of most chronic diseases in First Nations people were higher than the Victorian average (Australian Bureau of Statistics 2023a).

MH conditions are the most prevalent chronic condition among First Nations people across almost all SEMPHN LGAs and across Victoria. The highest rates of MH conditions among First Nations people were in Port Phillip (23.3%), Frankston (22.0%) and Greater Dandenong (21.4%), which were all higher than the Victorian average of 18.3%. These findings highlight the need to address chronic disease rates, particularly MH conditions, among First Nations people living within the SEMPHN catchment.

[14] Disability-adjusted life years (DALY), where 1 DALY represents one year of healthy life lost, either through premature death or from living with an illness or injury.

Figure 4.8 Prevalence of common chronic conditions among First Nations people by LGA, 2021



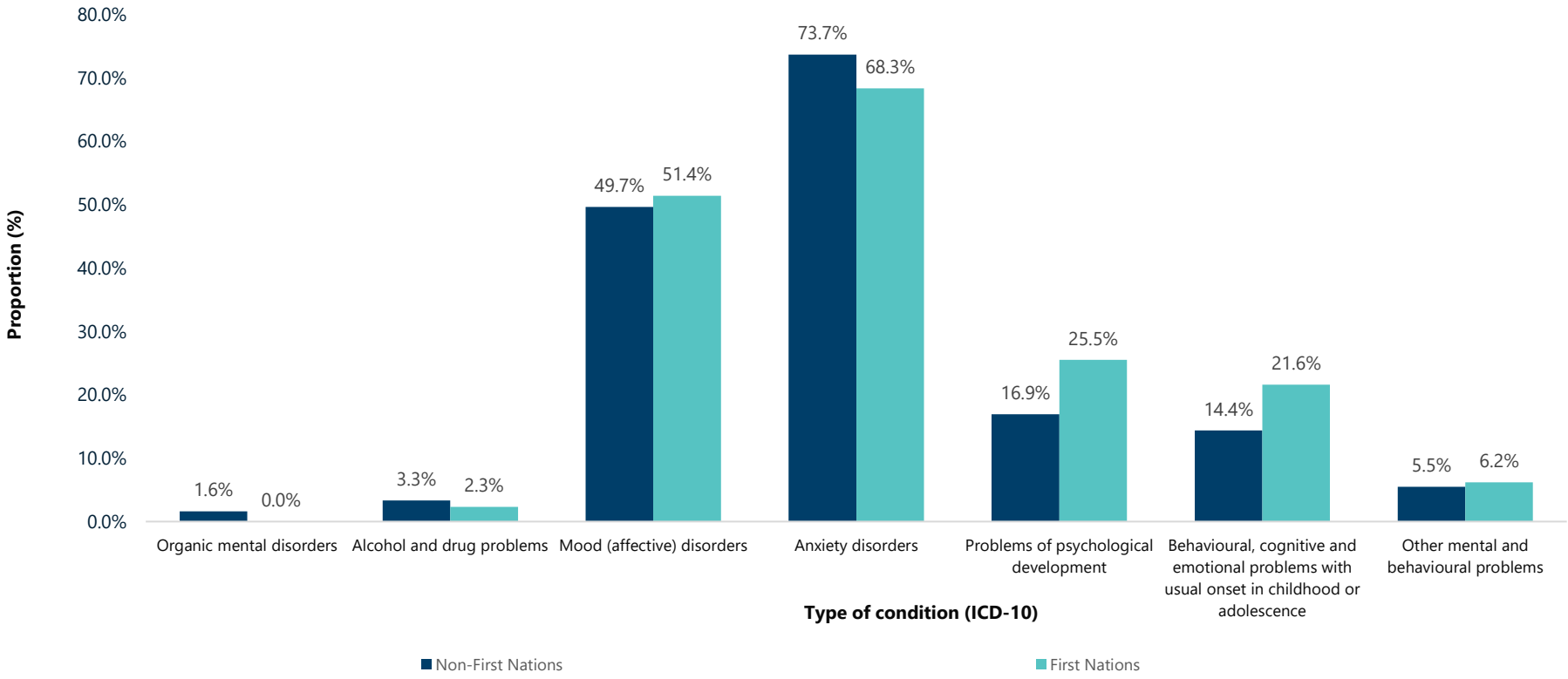
Source: 2021 Census, ABS (June 2022) TableBuilder: LGA (EN) by LTHP type of long-term health condition by INGP indigenous status, accessed on 8 October 2024. Note that Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%). Values are the proportion of chronic conditions among the First Nations people in each LGA and Victoria.

MENTAL HEALTH (MH)

According to the 2022 National Health Survey (Australian Bureau of Statistics 2022b), the prevalence of mental and behavioural disorders was broadly similar between First Nations people and non-First Nations populations. Specifically, 64.5% of First Nations people and 66.4% of non-First Nations populations reported having mental and behavioural disorders. Among those affected, anxiety and mood disorders were the most common conditions. For First Nations people, 63.8% reported anxiety disorders and 51.4% mood disorders, while 73.7% of non-First Nations populations reported anxiety disorders and 51.4% reported mood disorders.

Yet while the prevalence rates for most other mental and behavioural disorders were comparable across the 2 populations, some notable disparities were observed (Figure 4.9). For example, First Nations people were 1.5 times more likely than non-First Nations to report psychological development problems such as autism spectrum disorders, dyslexia and dyslalia (25.5% versus 16.9%, respectively). They were also 1.5 times more likely to report behavioural, cognitive and emotional problems with usual onset in childhood or adolescence (21.6% versus 14.4%, respectively), including attention deficit hyperactivity disorder (ADHD), conduct disorders and speech impairments.

Figure 4.9 Prevalence of mental and behavioural disorders among First Nations and Non-First Nations populations, 2022



Source: National Health Survey 2022, ABS (December 2023) TableBuilder: Type of condition (ABS condition item put into ICD-10 Hierarchy) by non-indigenous status, accessed on 11 October 2024.

Immunisation

In Victoria, immunisation rates for First Nations children have been comparable to the overall population at specific age milestones. The Victoran Department of Health (2024) reported that at one year of age the immunisation rate for First Nations children was 91.7%, similar to the rate of 93.4% for the entire Victorian population. At 2 years of age, the immunisation rate for First Nations children was 89.6%, while the rate for the overall population was 91.7%. At 5 years of age, the immunisation rate for First Nations children was 96.0%, which was slightly higher than the rate of 94.8% for the overall population.

When examining the immunisation data within the SEMPHN catchment, variations were evident (Public Health Information Development Unit 2024). Table 4.3 shows that in 2021, Greater Dandenong had the lowest childhood immunisation rate for First Nations children in the one-year cohort at 75.0%. Furthermore, Mornington Peninsula, Cardinia, and Frankston had the lowest immunisation rates for the 2-year cohort, with rates of 41.9%, 65.0%, and 65.6% respectively. These findings highlight the importance of analysing immunisation data at both the state and local levels to identify areas where targeted interventions may be necessary to improve immunisation coverage and address potential variations within specific communities.

Table 4.3 Full immunisation among First Nations children (1-5 years) by IARE, 2021

IARE	Fully immunised at 1 year of age		Fully immunised at 2 years of age		Fully immunised at 5 years of age	
	Number	Proportion (%)	Number	Proportion (%)	Number	Proportion (%)
Cardinia	25	96.2	13	65.0	15	100.0
Cranbourne – Narre Warren	45	95.7	44	84.6	41	97.6
Frankston	38	86.4	21	65.6	38	100.0
Greater Dandenong	6	75.0	#	..	8	100.0
Melbourne – East (part b)	16	95.8	#	..	#	..
Melbourne – Port Phillip (part b)	#	..	#	..	#	..
Mornington Peninsula	7	100.0	13	41.9	22	100.0
SEMPHN catchment	139	92.1	93	60.7	131	99.2
Victoria	1,429	94.1	1,180	77.7	1,371	97.6
LGAs covered in the IARE are Cardinia (Cardinia Shire), Cranbourne – Narre Warren (City of Casey), Frankston (City of Frankston, City of Kingston), Greater Dandenong (City of Greater Dandenong), Melbourne – East (part b) (city of Bayside, City of Glen Eira, City of Stonnington), Melbourne – Port Phillip (City of Port Phillip), Mornington Peninsula (Mornington Peninsula Shire).						

Source: PHIDU (September 2024 release), accessed on 9 October 2024, Table: Immunisation. https://phidu.torrens.edu.au/social-health-atlases/maps/#aboriginal-torres-strait-islander-social-health-atlas-of-australia. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%). #=not shown in data source;=not applicable.

Antenatal and perinatal health

In Australia, 24,388 First Nations women gave birth in 2022 (Australian Bureau of Statistics 2023b). The median age of these First Nations women was 26.7 years, approximately 5 years younger than the median age of non-First Nation mothers, which was 31.9 years (Australian Bureau of Statistics 2023b). First Nations

women were also twice as likely to give birth when they were under 30 years of age (68.9%) compared to non-First Nations women in the same age group (36.2%).

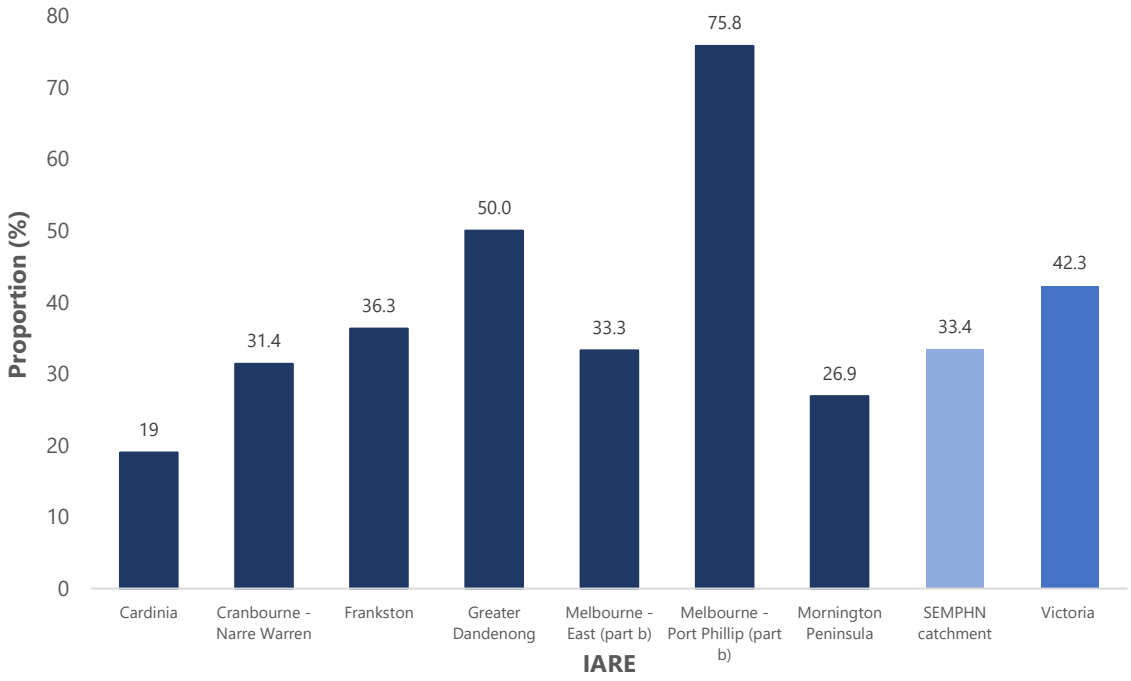
Furthermore, 57.8% of all First Nations women who gave birth in 2022 were aged between 20 and 29 years (n=13,176), and one in 10 (10.2%) were aged between 15 and 19 years (n=1,694) (Australian Bureau of Statistics 2022a). This age distribution is comparable to the statistics in Victoria, where 57.0% of all First Nations women had a maternal age between 20 and 29 years (n=332), and one in 13 (7.4%) were between 15 and 19 years (Australian Bureau of Statistics 2022a).

There are significant gaps in antenatal health when comparing First Nations against non-First Nations populations, and First Nations women and newborns face an excessive burden of inequitable perinatal outcomes (Australian Institute of Health and Welfare 2024). To redress this, numerous state and federal government (Victorian Department of Health 2012; Department of Health 2021; Council of Australian Governments (COAG) Health Council 2019) strategies recommend that maternity service providers should partner with First Nations communities to implement evidence-based, culturally appropriate models of maternity care.

Research has highlighted that the Australian maternity system does not meet the needs of First Nations people and is not culturally safe (Kildea et al. 2019). For example, First Nations women are 14 times more likely to live in remote locations than non-First Nations women (21% of birthing women compared to 1.5%, respectively), with approximately one-fifth of all First Nations women living more than one hour's drive from the nearest birthing facility.

Figure 4.10 illustrates the proportion of First Nations women who gave birth but did not receive antenatal care within the first 10 weeks of pregnancy, out of all First Nations women who gave birth between 2019 and 2021 in the SEMPHN catchment (also see Appendix Table 1.2.4). It is important to note that the data were aggregated over 3 years, and may include women who gave birth more than once during this period. The proportion of First Nations women within the SEMPHN catchment who did not attend antenatal care within the first 10 weeks was highest in Port Phillip (75.8%) and Greater Dandenong (50.0%).

Figure 4.10 First Nations women who did not attend antenatal care by IARE, 2019-2021

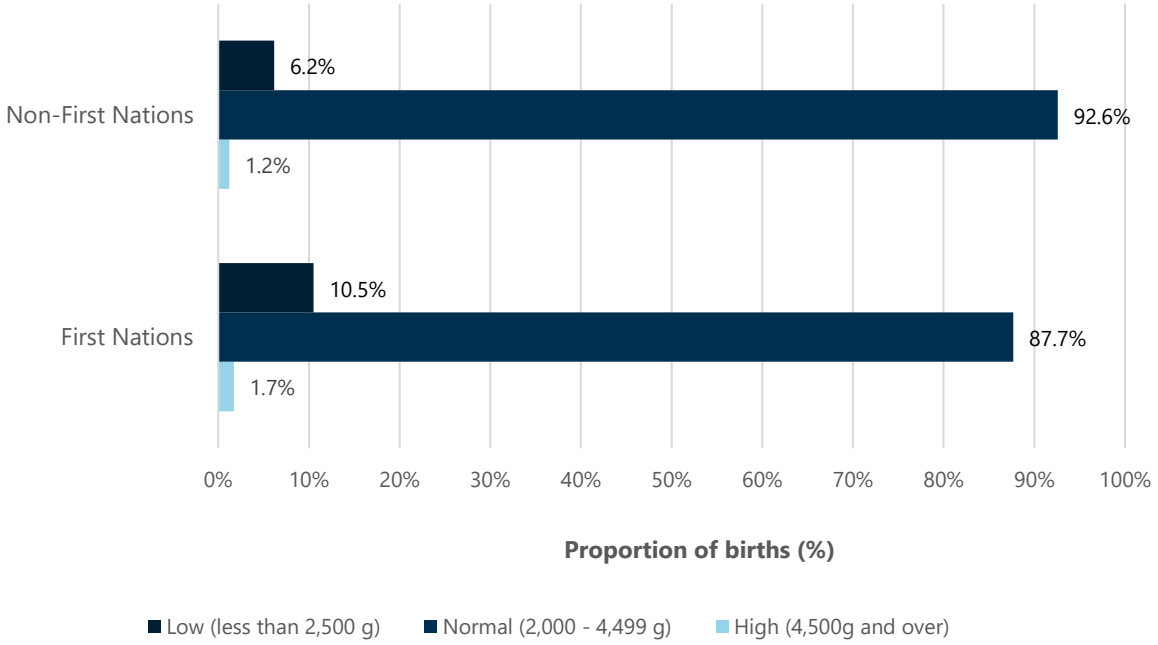


Source: PHIDU (September 2024 release), accessed on 10 October 2024, Table: Mothers and babies. https://phidu.torrens.edu.au/social-health-atlases/maps/#aboriginal-torres-strait-islander-social-health-atlas-of-australia. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Birthweight

Being born at a healthy weight gives children a good start in life, while babies with a low birthweight are more likely to experience ill health during childhood and chronic diseases as adults (AHMAC 2017). In 2022, the proportion of Victorian babies born underweight (under 2,500 grams) was higher among First Nations babies (10.5%) compared with non-First Nations babies (6.2%) (Figure 4.11).

Figure 4.11 Birthweights of First Nations newborns across Victoria, 2022

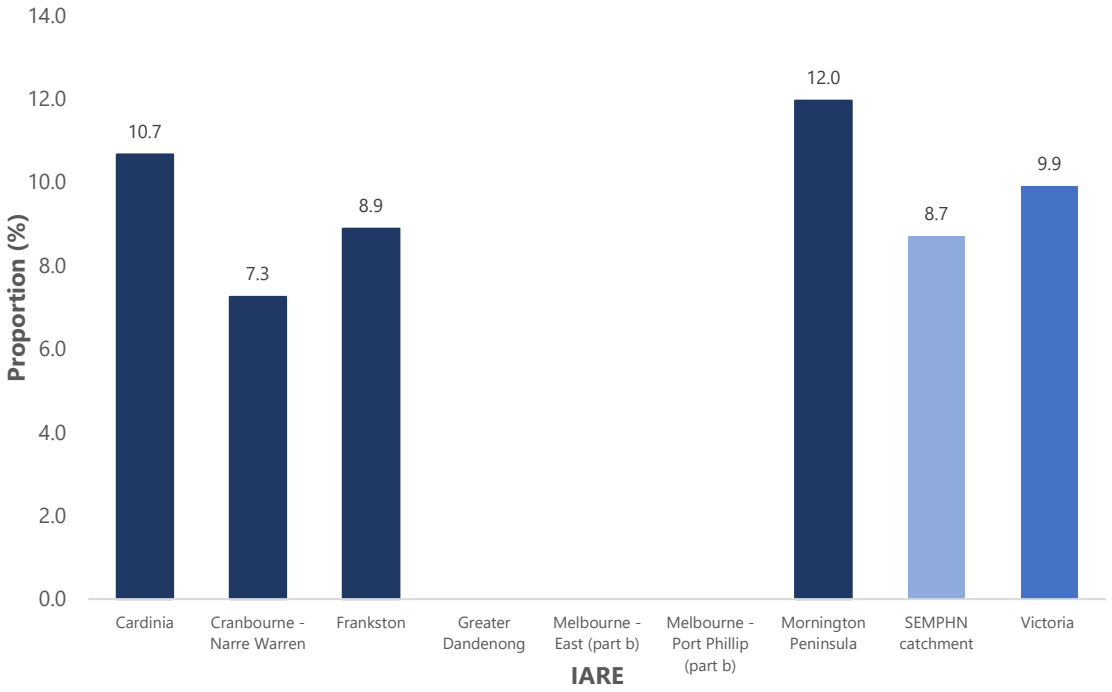


Source: AIHW analysis of National Perinatal Data Collection, 2022. Table 3.12: Live births of Aboriginal and Torres Strait Islander mothers, by birthweight and state and territory, 2022, Table 3.9: Live births, by birthweight and state and territory, 2022.

In the SEMPHN catchment between 2019 and 2021, the Mornington Peninsula and Cardinia regions had higher rates of babies born with low birthweight compared with the overall Victorian rate (Public Health Information Development Unit 2024). Specifically, the Mornington Peninsula recorded 12.0% of babies born with low birthweights, while Cardinia recorded 10.7%, both exceeding the Victorian average of 9.9% during the same period (

Figure 4.12).

Figure 4.12 Low birthweights of First Nations newborns by IARE, 2019-2021

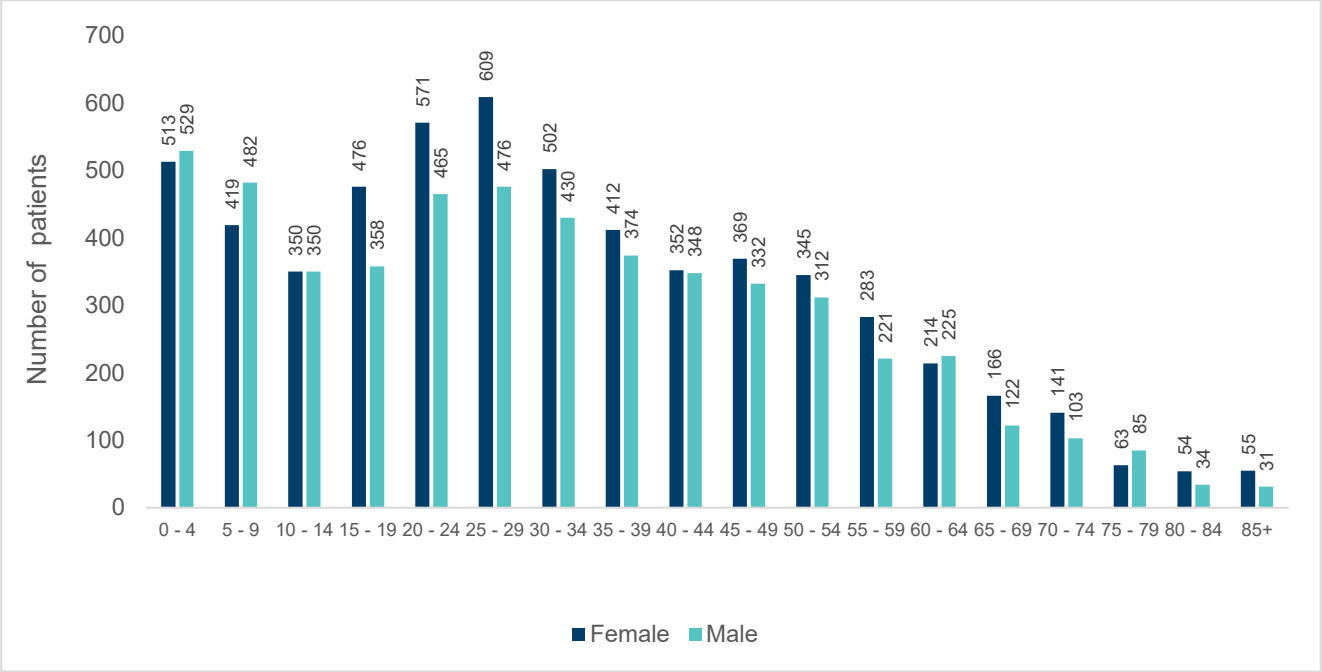


Source: PHIDU (September 2024 release), accessed on 10 October 2024, Table: Mothers and babies. https://phidu.torrens.edu.au/social-health-atlases/maps/#aboriginal-torres-strait-islander-social-health-atlas-of-australia. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%), and no data were available for Greater Dandenong, Melbourne – East (part b), and Melbourne – Port Phillip (part b).

Primary care insights

As of May 2024, there were approximately 11,200 unique active general practice patients in the past 2 years who identified as Aboriginal and/or Torres Strait Islander. Just over half of these patients (52.7%) were female. The age group with the most patients was 25-29 years (9.7%), followed by 0-4 years (9.3%) and 20-24 years (9.3%) (Figure 4.13). These findings suggest that First Nations people accessing GP services are generally younger than the general population.

Figure 4.13 First Nations general practice patients by age and gender, 2024



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Casey had the largest number of First Nations people accessing primary healthcare, with around 2,600 patients. Next was Mornington Peninsula at 1,763 patients, and then Frankston at 1,553 patients. Frankston had the highest proportion of First Nations general practice patients, making up just over 1.2% of all patients in that area (Figure 4.13).

Chronic disease diagnoses

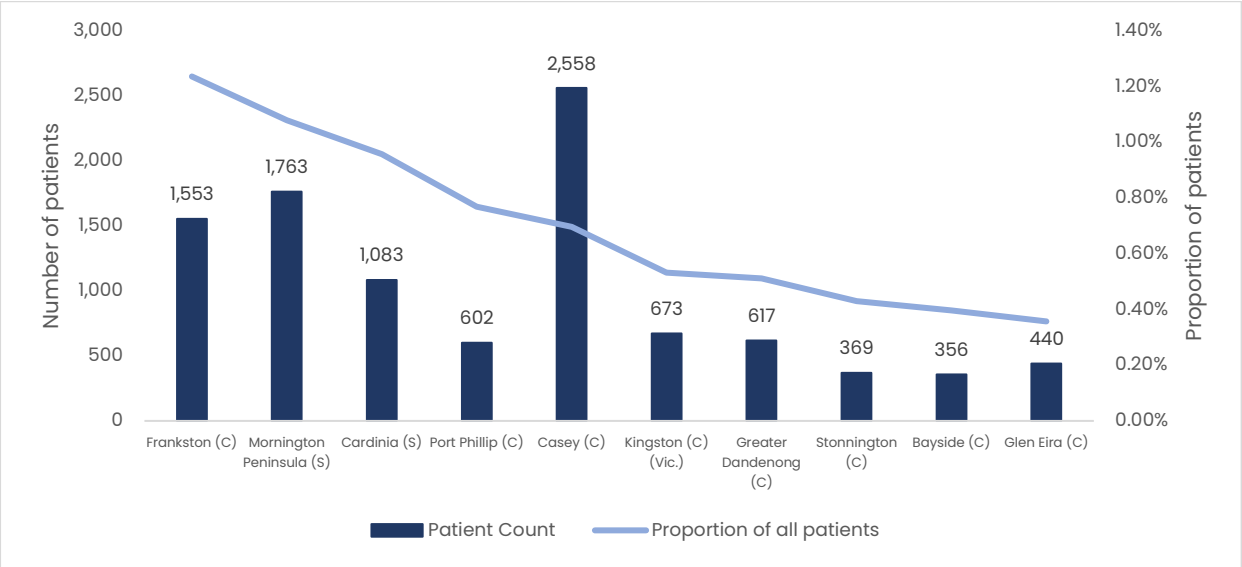
Between July 2023 and June 2024, 2,259 First Nations people received 5,869 new chronic disease-related diagnoses from GPs in the SEMPHN catchment. This represents an average of 2.6 chronic disease-related diagnoses per person within the First Nations population, which is higher than the average of 1.6 chronic disease-related diagnoses per person in the general population in the SEMPHN catchment. Among First Nations people, the most common chronic disease diagnoses were MH (16.0%, n=361), accounting for one in 6 new diagnoses. This was followed by respiratory (10.3%, n=233), cardiovascular (7.6%, n=172) and musculoskeletal (5.1%, n=166) diagnoses (Figure 4.14).

Of all MH diagnoses in the SEMPHN catchment, the most common were anxiety (26.9%, n=97), mixed anxiety and depressive disorder (24.4%, n=88), and attention deficit and hyperactivity disorder (22.2%, n=80). Asthma (81.5%, n=190), obstructive sleep apnoea (7.7%, n=18) and chronic obstructive pulmonary disease (COPD) (7.3%, n=17) accounted for almost all respiratory diagnoses. Of all cardiovascular diagnoses, the most common were hypertensive disorder (44.2%, n=76), hypercholesterolemia (27.3%, n=47) and hyperlipidaemia (14.5%, n=25). Half of all musculoskeletal diagnoses comprised backache (31.9% n=37) and osteoporosis (15.2%, n=18).

Figure 4.14 Chronic disease diagnoses for First Nations people, 2023-24

Source: SEMPHN Primary Care Diagnosis Data (POLAR), July 2023 – June 2024. AOD=alcohol and other drugs; COPD=chronic obstructive pulmonary disease. Each main diagosis category is represented by a different colour. The size of the square corresponds to the proportion of diagnoses within that category, with larger squares indicating a higher proportion of diagnoses.

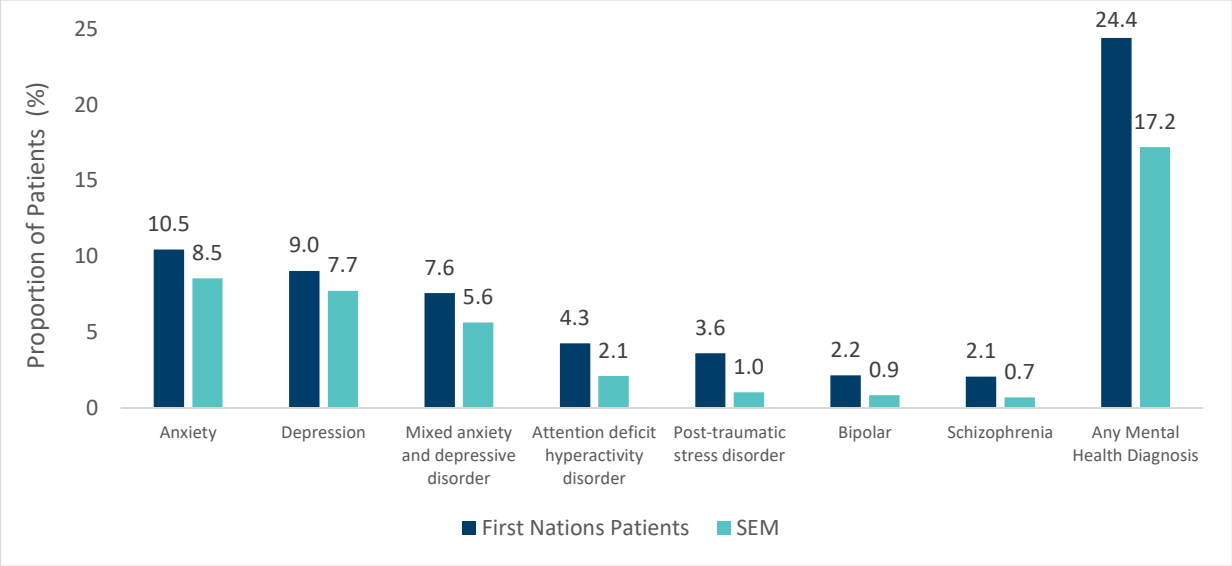
Figure 4.15 First Nations GP patients by LGA, 2024



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Over 4 in 5 (85.7%) First Nations patients had at least one active diagnosis from a GP, and one in 4 (24.4%) had at least one active MH diagnosis recorded. In many cases, there were multiple comorbid MH diagnoses (e.g. anxiety and depression). Anxiety was the most common MH diagnosis (10.5%), followed by depression (9.0%), mixed anxiety and depressive disorder (7.6%), and ADHD (4.3%). The prevalence of more severe and complex MH issues such as post-traumatic stress disorder (PTSD) at 3.6%, bipolar disorder (BPD) at 2.2% and schizophrenia 2.1% ranged from 2-4% respectively, which is a higher than for the wider south east Melbourne population (Figure 4.16).

Figure 4.16 Prevalence of MH-related diagnoses for First Nations patients, 2022-2024



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

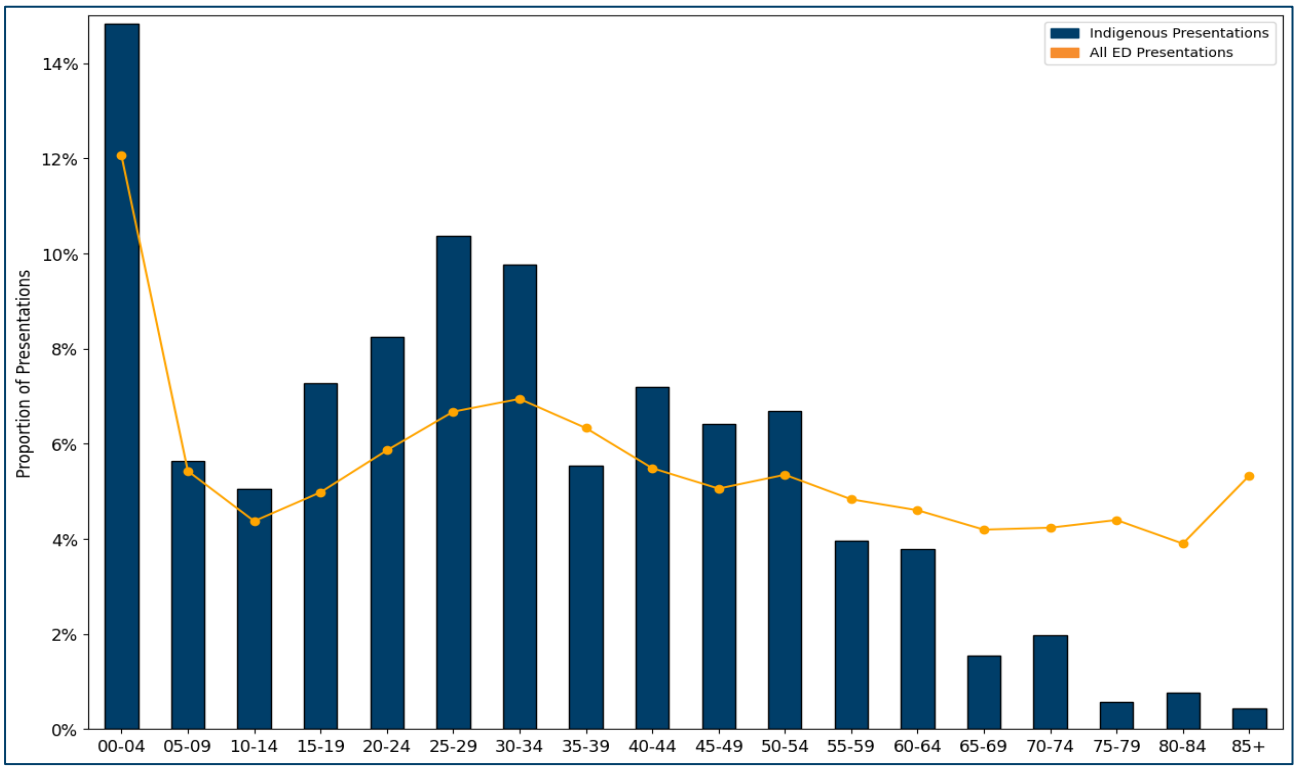
Tertiary care insights

ED PRESENTATIONS

ED presentations among First Nations people across south east Melbourne increased by 33.1% (n=1,478) between the 2019-20 and 2022-23 FYs, representing an annual growth rate of approximately 8.3%. Throughout the 2022-23 FY, there were 5,941 ED presentations by First Nations people residing in south east Melbourne. Of these, 54.0% were female, 45.3% were male and 0.7% were intersex. People aged 0-4 years were overrepresented, accounting for 14.7% of all First Nations ED presentations, which was slightly higher than the proportion for all ED presentations in south east Melbourne (12.1%).

Conversely, the least represented age group in First Nations ED presentations was 85 years and above, making up only 0.4% compared with 5.3% across all ED presentations in south east Melbourne. This discrepancy likely reflects the younger average age of First Nations residents in the south east Melbourne region (Figure 4.17).

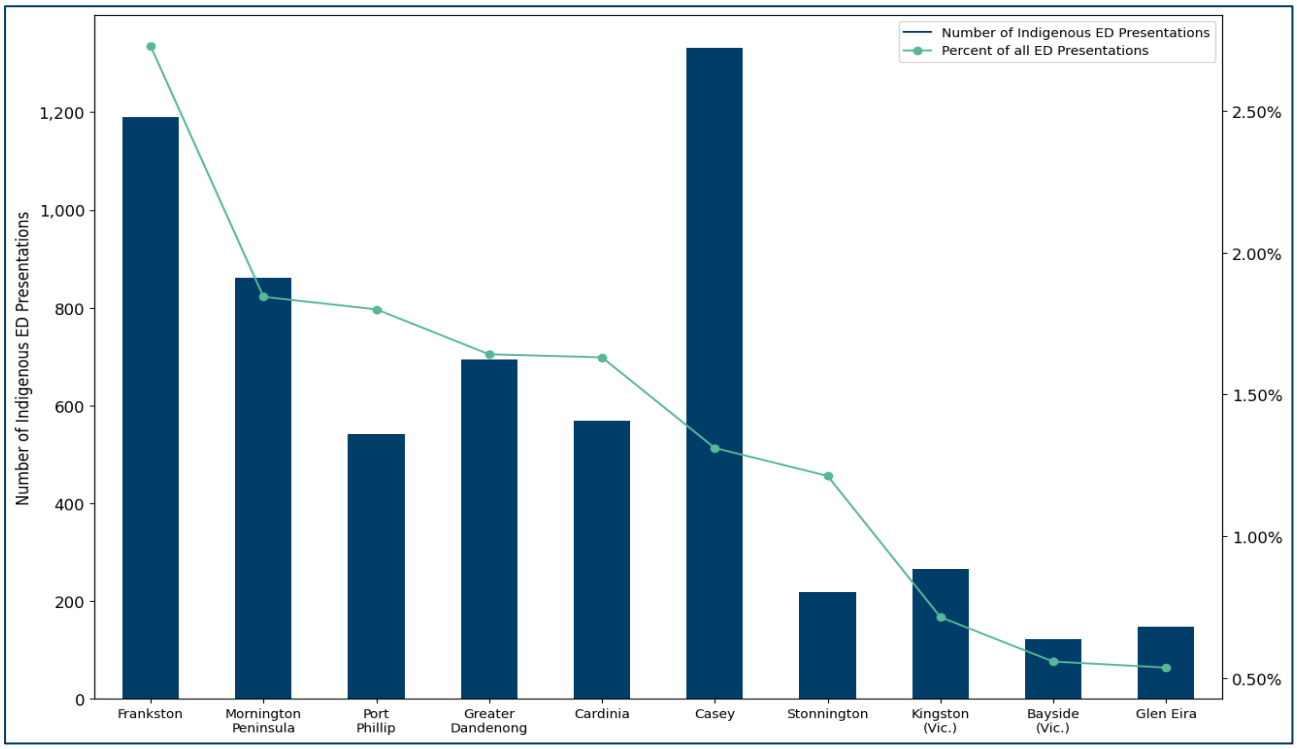
Figure 4.17 First Nations ED presentations by age, FY2022-23



Source: VEMD, Department of Health – Victoria, 2022-23.

In the 2022-23 FY, there were just over 5,900 ED presentations by people identifying as First Nations in the SEMPHN region. The Casey LGA had the largest amount of ED presentations by First Nations people (n=1,332), representing 22.4% of all First Nations ED presentations in south east Melbourne. This was followed by Frankston (n=1,190, 20.0%) and the Mornington Peninsula (n=861, 14.5%). Although proportionately First Nations ED presentations were highest in Frankston, accounting for 2.7% of all ED presentations in that LGA, followed by the Mornington Peninsula (1.8%) and Port Phillip (1.8%) (Figure 4.18).

Figure 4.18 First Nations ED presentations by LGA, FY2022-23



Source: VEMD, Department of Health - Victoria, 2022-23.

Table 4.4 First Nations ED presentations by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Number of ED presentations	Percentage of ED presentations
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1,661	28.0
Injury, poisoning and certain other consequences of external causes	1,193	20.0
No recorded diagnosis	604	10.2
Mental and behavioural disorders	382	6.4
Diseases of the respiratory system	370	6.2
Certain infectious and parasitic diseases	271	4.6
Diseases of the musculoskeletal system and connective tissue	237	4.0
Diseases of the digestive system	226	3.8
Factors influencing health status and contact with health services	174	2.9
Diseases of the genitourinary system	162	2.7

Source: VEMD, Department of Health – Victoria, 2022/23.

Excluding the broad ICD-10 category groupings of 'factors influencing health status and contact with health services', and 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified', the 5 most common primary broad category diagnoses for ED presentations from First Nations patients across SEMPHN were (Table 4.4):

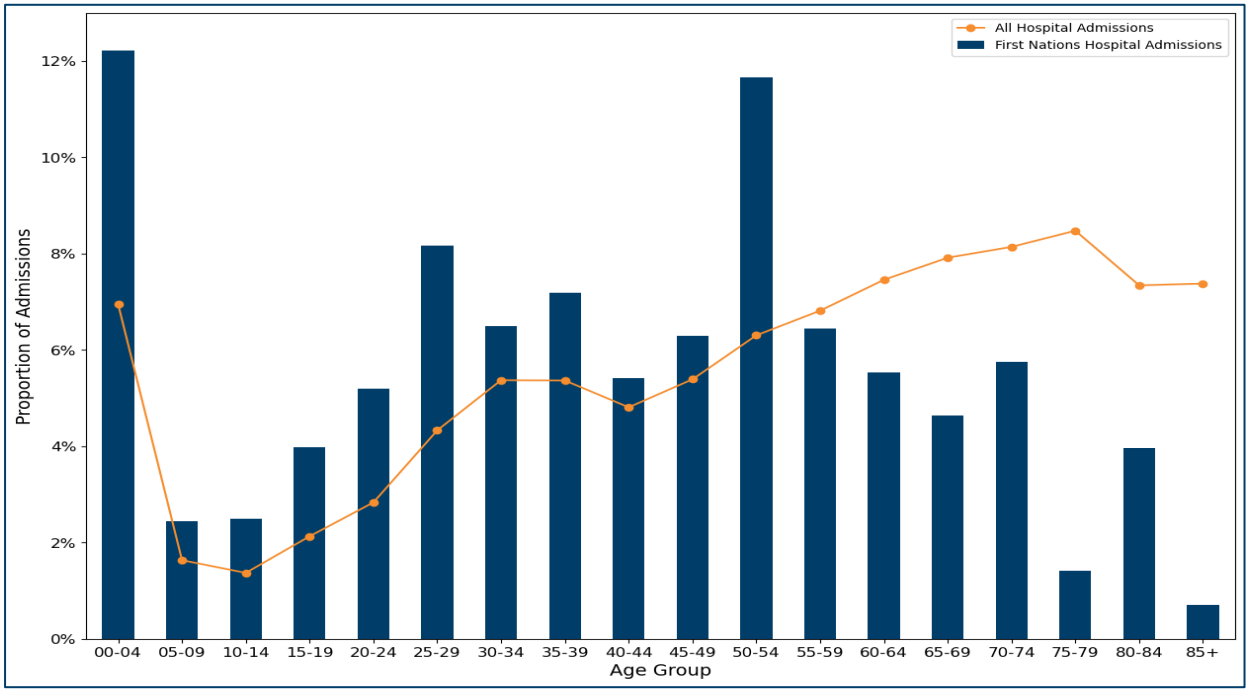
- injury, poisoning, and certain other consequences of external causes
- mental and behavioural disorders
- diseases of the respiratory system
- certain infectious and parasitic diseases
- diseases of the musculoskeletal system and connective tissue.

The average wait time to treatment for First Nations ED presentations was 35.4 minutes, exactly the same as that observed for all SEMPHN presentations. Just under 70% of these ED presentations were categorised as resuscitation, emergency or urgent, and the remaining 30% as semi-urgent or non-urgent cases, comparable with all SEMPHN presentations.

Hospital Admissions

In the 2022-23 FY, there were just over 4,700 hospital admissions by First Nations residents from south east Melbourne. Of these, 59.1% were female, 40.2% were male and 0.6% were intersex/other. A larger proportion of hospital admissions were for those aged under 5 years (12.2%) and those aged 50-54 years (11.6%) when compared with all admissions across south east Melbourne (Figure 4.19).

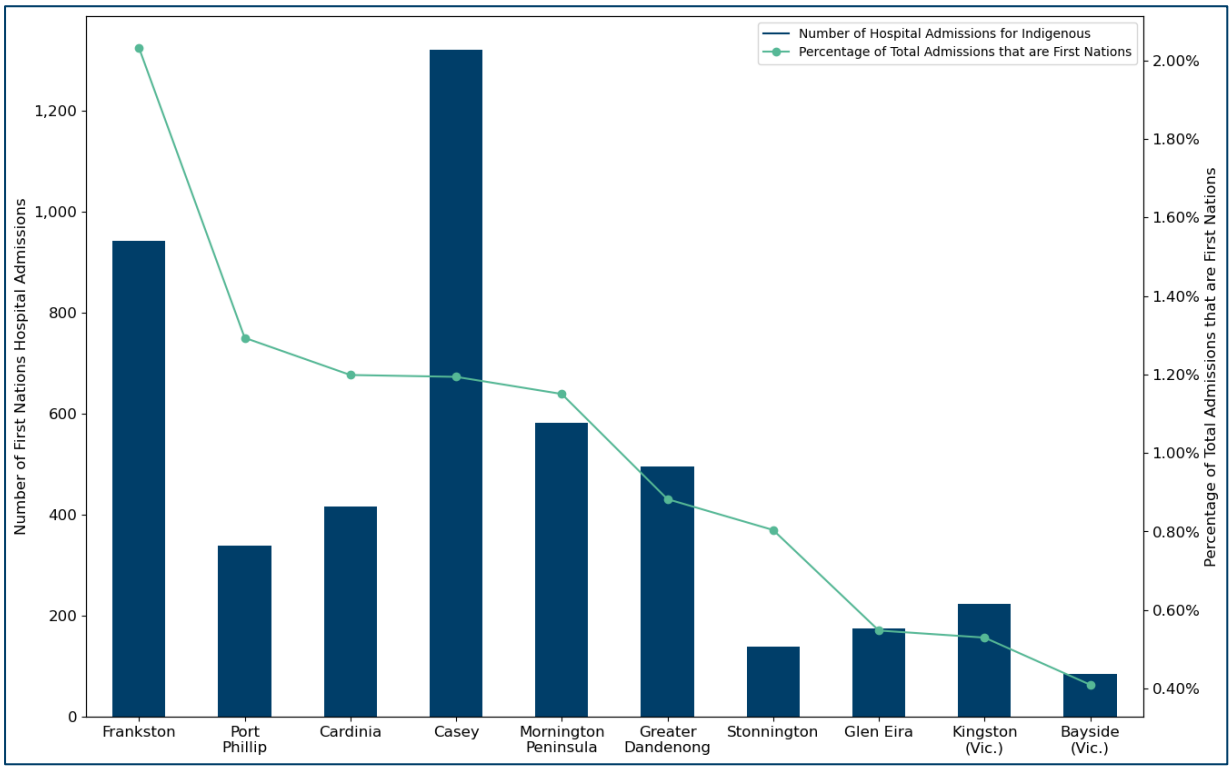
Figure 4.19 First Nations hospital admissions by age, FY2022-23



Source: VAED, Department of Health – Victoria, 2022/23.

Casey recorded the highest number of First Nations hospital admissions in south east Melbourne, with just over 1,300 admissions, representing over one-quarter (27.6%) of all First Nations admissions in the region. This was followed by Frankston and the Mornington Peninsula. Frankston had the highest proportion of total admissions that were First Nations at approximately 2.0%, followed by Port Phillip and Cardinia (Figure 4.20).

Figure 4.20 First Nations hospital admissions by LGA, FY2022-23



Source: VAED, Department of Health – Victoria, 2022/23.

Table 4.5 First Nations hospital admissions by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Number of hospital admissions	Percentage of hospital admissions
Factors influencing health status and contact with health services	989	21.0
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	573	12.2
Injury, poisoning and certain other consequences of external causes	471	10.0
Diseases of the digestive system	335	7.1
Mental and behavioural disorders	328	7.0
Diseases of the respiratory system	296	6.3
Pregnancy, childbirth and the puerperium	240	5.1
Diseases of the nervous system	194	4.1
Diseases of the circulatory system	169	3.6
Diseases of the musculoskeletal system and connective tissue	149	3.2

Excluding the ICD-10 broad category groupings of 'factors influencing health status and contact with health services' and 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified', the 5 most frequent diagnoses for First Nations hospital admissions across the SEMPHN region were (Table 4.5):

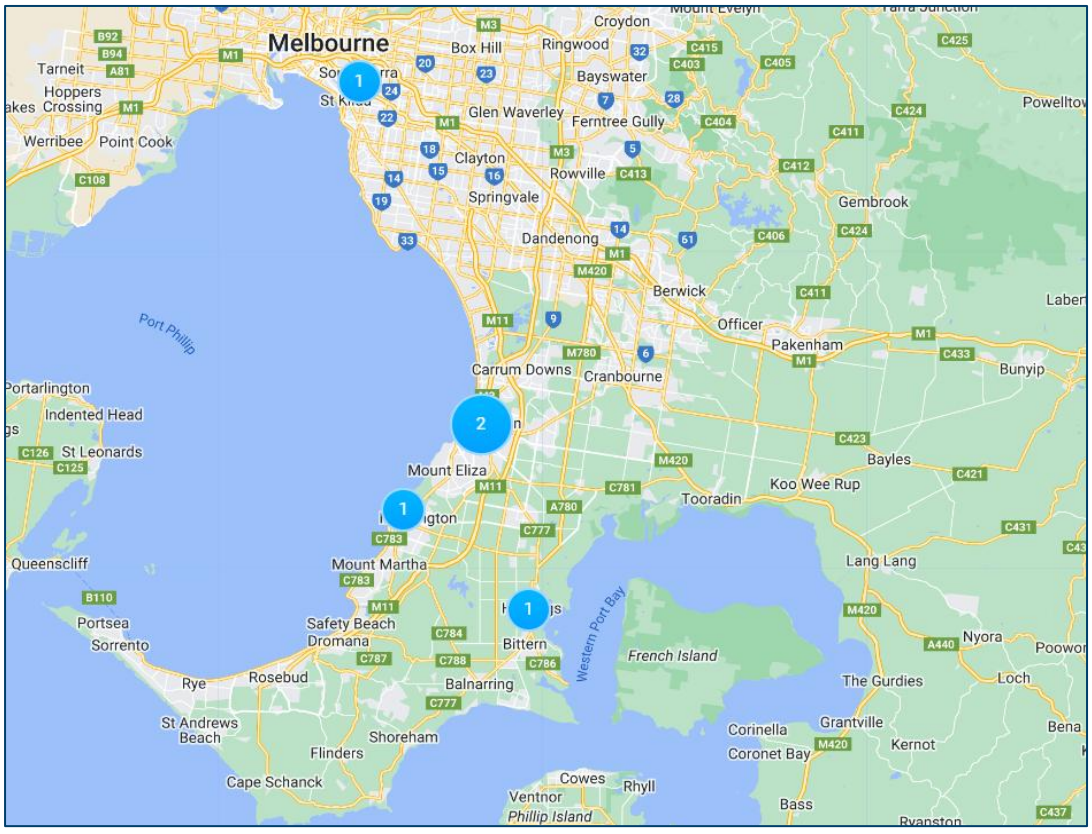
- injury, poisoning and certain other consequences of external causes
- diseases of the digestive system
- mental and behavioural disorders
- diseases of the respiratory system
- pregnancy, childbirth and the puerperium.

A higher proportion of First Nations hospital admissions related to mental and behavioural disorders when compared with all hospital admissions across SEMPHN. The average length of stay for First Nations hospitalisations was 3.08 days, which was marginally longer than the overall average of 2.98 days for all SEMPHN hospital admissions. Over half (52%) of hospital admissions were same-day stays, 19% were overnight stays and 28% were multi-day stays.

First Nations health services

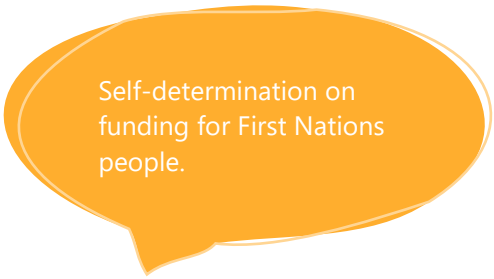
As of June 2023, the National Health Services Directory (NHDS) had records for at least 5 Aboriginal and Torres Strait Islander health services (or clinics that offered the same services) in the south east Melbourne region. These services were primarily distributed in the north western (inner-city) portion of the region, located in the LGAs of Port Phillip, Stonnington, Bayside and Dandenong. A notable absence of services was identified in Casey (South) and Cardinia (Figure 4.21).

Figure 4.21 Map of community care First Nations health services, 2023



Source: Health Direct – Health Map, NHSD, June 2024.


Design models that can work at a local level, ensuring we are designing for what people want. Co-design is so important.


Self-determination on funding for First Nations people.

References

Australian Bureau of Statistics (2020) *National Aboriginal and Torres Strait Islander Health Survey*, Australian Bureau of Statistics,, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release.

——— (2021) *Census of Population and Housing: Core activity need for assistance*, https://www.abs.gov.au/census/guide-census-data/census-dictionary/2021/variables-topic/disability-and-carers/core-activity-need-assistance-assnp.

——— (2022a) *Aboriginal and Torres Strait Islander fertility, by age, by state [Data Explorer]* [data set], https://explore.data.abs.gov.au/vis?tm=births&pg=0&df[ds]=ABS_ABS_TOPICS&df[id]=ATSI_FERTILITY&df[ag]=ABS&df[vs]=1.0.0&hc[Measure]=Births&pd=2022%2C2022&dq=1.IM..AUS%2B2.A&ly[rw]=AGE&ly[cl]=REGION, accessed 10 October 2024.

——— (2022b) *National Health Survey* [data set], https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/latest-release.

——— (2023a) *2021 Census - counting dwellings, place of enumeration [Census TableBuilder]*, https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder, accessed 9 October 2024.

——— (2023b) *Births, Australia*, Australian Bureau of Statistics, https://www.abs.gov.au/statistics/people/population/births-australia/latest-release#aboriginal-and-torres-strait-islander-people, accessed 10 October 2024.

——— (2023c) *Estimates of Aboriginal and Torres Strait Islander Australians* [data set], https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples.

Australian Institute of Health and Welfare (2017a) *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, Australian Institute of Health and Welfare,.

——— (2017b) *Canadian National Occupancy Standard*, https://meteor.aihw.gov.au/content/386254.

——— (2018) Australian Burden of Disease Study: Impact and causes of illness and death in Australia

——— (2022) Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018, 2024, Australian Burden of Disease Study, AIHW.

——— (2023) *Income and finance of First Nations people*, AIHW, https://www.aihw.gov.au/reports/australias-welfare/indigenous-income-and-finance, accessed 7 October 2024.

——— (2024) Australia's mothers and babies. Cat no. PER 101, Canberra.

Council of Australian Governments (COAG) Health Council (2019) Woman-centred care: Strategic directions for Australian maternity services.

Department of Health (2021) National Aboriginal and Torres Strait Islander Health Plan 2021–2031, Commonwealth of Australia, Canberra.

Department of Health Victoria (2020) *Aboriginal and Torres Strait Islander Victorians*, Department of Health, Victoria,, https://www2.health.vic.gov.au/public-health/chief-health-officer/cho-publications/your-health-report-2018/health-inequalities/aboriginal-torres-strait-islander-victorians

Greenhalgh EM, Maddox R, van der Sterren A, Jenkins S, Knoche D and Winstanley MH (2023) '8.3 Prevalence of tobacco use among Aboriginal and Torres Strait Islander peoples', in Greenhalgh EM, Scollo MM, andWinstanley MH (eds), *Tobacco in Australia: Facts and issues*, Cancer Council Victoria, Melbourne.

Hart MB, Moore MJ and Laverty M (2017) 'Improving Indigenous health through education', *Medical Journal of Australia*, 207(1):11-2.

Kildea S, Hickey S, Barclay L, Kruske S, Nelson C, Sherwood J, Allen J, Gao Y, Blackman R and Roe YL (2019) 'Implementing birthing on country services for Aboriginal and Torres Strait Islander families: RISE framework', *Women and Birth*, 32(5):466-75.

Public Health Information Development Unit (2024) *Aboriginal & Torres Strait Islander data by Primary Health Network* [data set], https://phidu.torrens.edu.au/current/data/atsi-sha/phidu_atsi_data_phn_aust.xls.

The Australian Institute of Aboriginal and Torres Strait Islander Studies (2022) *Map of Indigenous Australia,* , https://aiatsis.gov.au/explore/map-indigenous-australia.

The Nepean Historical Society (2022) *The Bunurong People*, https://nepeanhistoricalsociety.asn.au/history/pre-history/.

Thurber KA, Banks E, Joshy G, Soga K, Marmor A, Benton G, White SL, Eades S, Maddox R and Calma T (2021) 'Tobacco smoking and mortality among Aboriginal and Torres Strait Islander adults in Australia', *International journal of epidemiology*, 50(3):942-54.

Victoran Department of Health (2024) *Vaccination coverage rates for Victoria*, Department of Health, Victoria, https://www.health.vic.gov.au/immunisation/vaccination-coverage-rates-for-victoria, accessed 10 October 2024.

Victorian Department of Health (2012) Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022, Melbourne.

——— (2021) *Victorian Population Health Survey*, Victoria Department of Health,, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey.

Chapter 5 Older people (65+)

- **Incidence:** 16.2% of residents are 65+ years and 2.1% are 85+years, mostly in Mornington Peninsula, Bayside, and Kingston; projected 29.7% growth by 2030, especially in Cardinia, Port Phillip, and Casey.
- **First Nations:** Largest population of First Nations persons over 50 years in Mornington Peninsula, Casey, and Frankston.
- **CALD:** 37.4% of residents 65+ are born overseas (country of birth varies across LGAs), with only a third from English-speaking countries.
- **Mortality:** median age at death is 81.3 years (males) and 85.9 years (females); leading causes are Alzheimer's disease (women) and coronary heart disease (men).
- **Hospitalisation:** 76.7% due to injuries.
- **At Risk:** highest proportion in need of low-income assistance, living alone or with disabilities: Kingston (15.3%), Mornington Peninsula (14.8%), and Glen Eira (14.6%).
- **Chronic Conditions:** most common are heart disease, MH conditions (anxiety, depression), and lung diseases (COPD, emphysema). High rates of chronic disease comorbidity evident: cardiovascular, followed by musculoskeletal, MH and diabetes diagnoses.

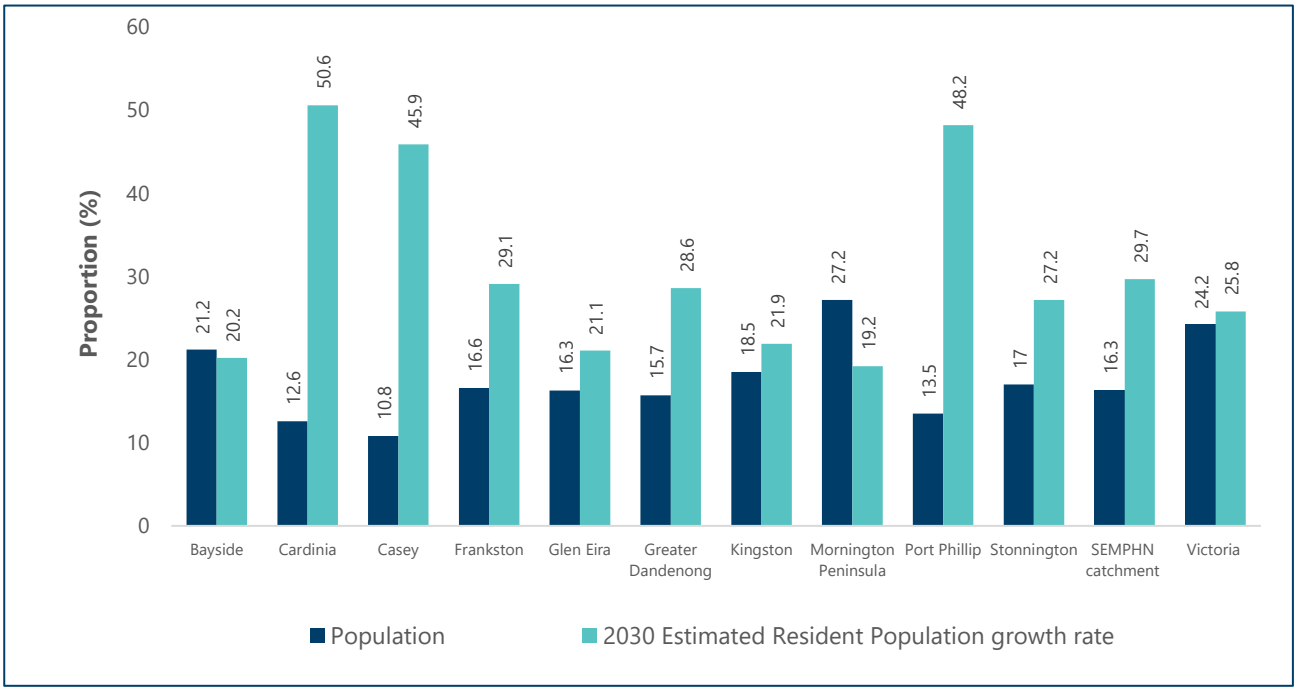
Population

The global population of individuals aged 65 years and older is growing faster than any other age group (Abud et al. 2022). In Victoria, one in 6 residents (16.8% or 1,092,833 people) were aged 65 or older[15] as of 30 June 2021. As Australians age, they become increasingly exposed to a range of vulnerabilities, including increasing frailty and poorer MH including loneliness (Victoran Department of Health 2024). Most older Australians have multiple chronic conditions, with 8 in 10 (80%) having at least one chronic condition, and 3 in 10 (28%) having 3 or more chronic conditions (Australian Institute of Health and Welfare 2024d). This makes them more likely to use the healthcare system, accounting for 1 in 5 (22%) ED presentations nationally. Older persons who are CALD, First Nations, LGBTIQA+ or living with disability may face additional challenges of social and cultural isolation as well as structural barriers to accessing care (Australian Institute of Health and Welfare 2024d).

In the 2021 ABS Census (Australian Bureau of Statistics 2023b), one in 6 (16.2%, n=255,020) residents in the SEMPHN region were aged 65 years and older, and 2.1% (n=34,166) were aged 85 years and older. Mornington Peninsula had the largest population of people aged 65 years or over (27.2%), followed by Bayside (21.2%) and Kingston (18.5%). Cardinia had the smallest older population (12.5%); yet this was still more than one in 10 people in the LGA. Mornington Peninsula (n=6,029), Kingston (n=4,401), Casey (n=4,207) and Glen Eira (n=3,979) had the largest population of people aged 85 years and older. Population projections (Figure 5.1) indicate that the older population in the SEMPHN region is expected to grow by 29.7% (n=330,719) by 2030. The largest growth is expected in Cardinia (50.6% growth, n=22,350), followed by Port Phillip (48.2% increase, n=20,448) and Casey (45.9% increase, n=57,762).

[15] First Nations older people are aged 50 years and older.

Figure 5.1 Population aged 65 and over by LGA, 2021

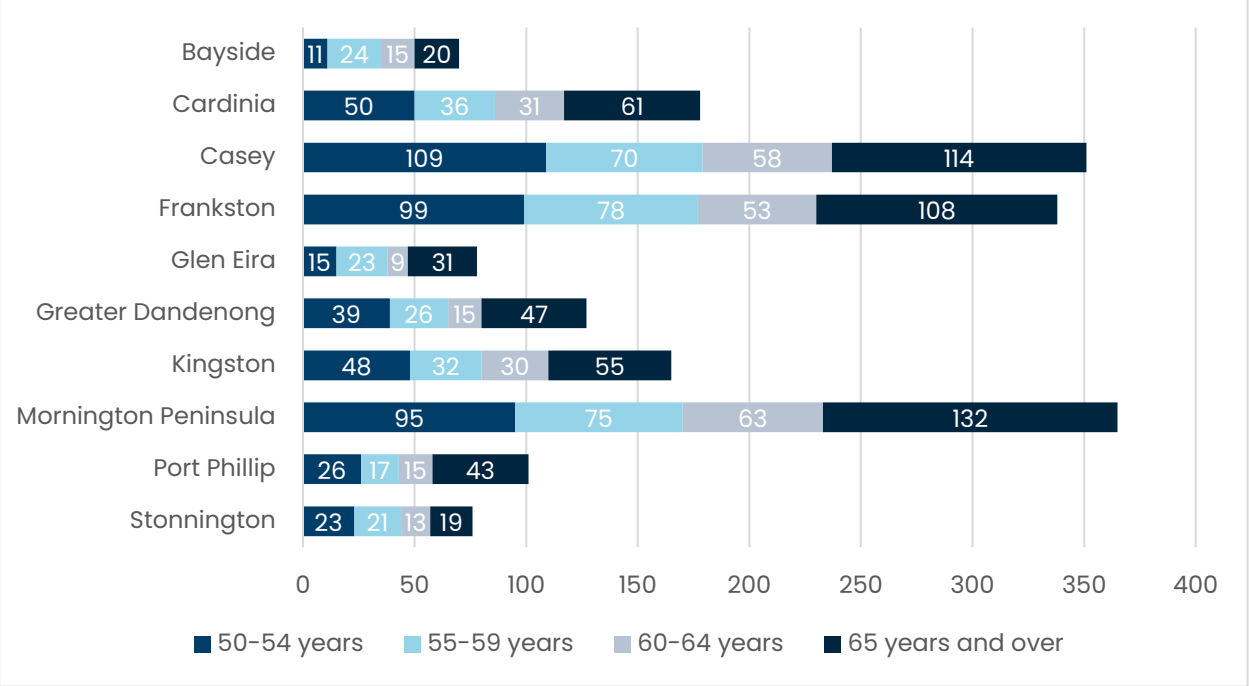


Source: 2021 Census, ABS (June 2022).

First Nations

According to the ABS 2021 Census, 9,970 residents within the SEMPHN catchment identified as First Nations people. Approximately one in 5 of these First Nations people (1,847 individuals) were aged 50 years or older. The Mornington Peninsula had the largest population of First Nations people over 50 years of age at 365 individuals, followed by Casey with 351 individuals and Frankston with 338 individuals (Figure 5.2).

Figure 5.2 First Nations older population by age and LGA, 2021



Source: 2021 Census, ABS. Please note Monash LGA is excluded as it was not possible to distinguish which proportion of the Monash LGA was within the SEMPHN catchment.

Culturally and linguistically diverse (CALD)

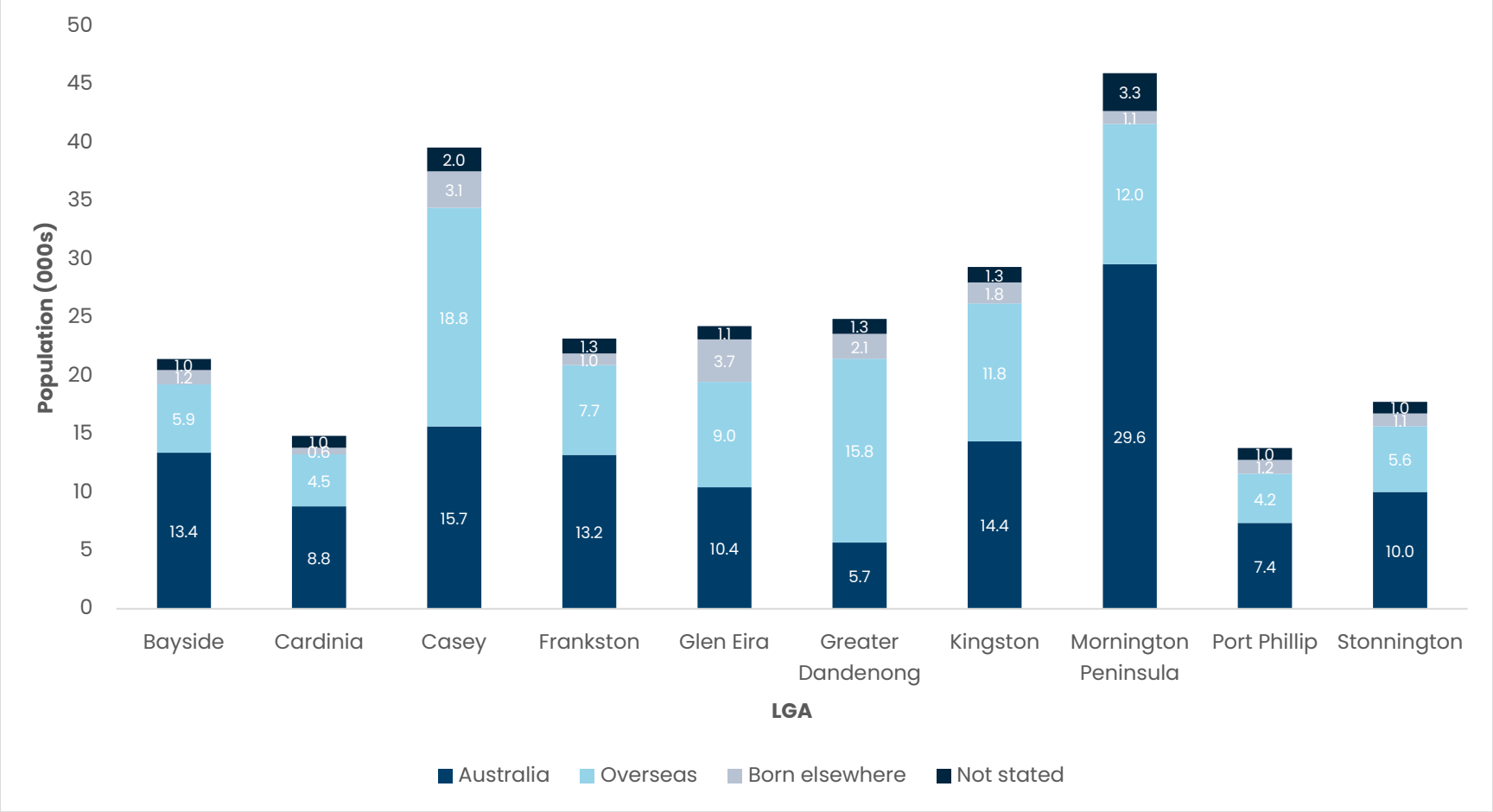
In the ABS 2021 Census, several observations were made concerning the population aged 65 and over in the SEMPHN region. One-third (37.4%, n=95,350) of SEMPHN residents aged 65 and over were born overseas, while half (50.4%, n=128,429) were born in Australia (Figure 5.3, Appendix Table 1.3.1). Of those born overseas, one-third (33%) were born in primarily English-speaking countries such as England, New Zealand and Canada (Figure 5.4). Another one-third (31%) were born in other European countries where English is not the main language, including Greece, Italy and the Netherlands, with this proportion varying across LGAs from 24% in Frankston to 43% in Glen Eira.

There were large Greek-born populations in Kingston (n=2,078), Glen Eira (n=1,572), Stonnington (n=1,253) and Greater Dandenong (n=1,222), with Greater Dandenong also having a large Italian-born population (n=1,210). The largest populations of older people born in non-European countries such as India, Sri Lanka and China resided in Greater Dandenong (n=10,108), Casey (n=9,530) and Kingston (n=4,462). Greater Dandenong and Casey can be considered especially diverse, with other non-European countries making up 64% and 51% of their overseas-born populations, respectively. For example, Greater Dandenong had large Vietnamese-born (n=2,561), Sri Lankan-born (n=1,231) and Cambodian-born populations (n=1,225), while Casey had large Indian-born (n=1,878) and Sri Lankan-born (n=1,668) populations.

In all LGAs, a significant number of people aged 65 and over were categorised as 'born elsewhere' in the ABS 2021 Census. This category includes individuals whose countries of birth were not identified individually, inadequately described or reported as 'at sea'. As a result, these individuals were not assigned to a specific country of birth, making it challenging to determine their precise birth origins and potential barriers to accessing healthcare services in the region. The LGAs with highest amounts of older persons 'born elsewhere' were Glen Eira (n=3,657), Casey (n=3,119) and Greater Dandenong (n=2,134). In Glen Eira, those classified as 'born elsewhere' made up a substantial 75% of the non-Australian-born population aged 65 and over. This significant proportion with an unknown country of birth indicate potential barriers to accessing healthcare in LGAs like Glen Eira, even though their country of origin cannot be determined based on available census data. Most older residents with low proficiency in English[16] resided in Greater Dandenong (n=7,183), Casey (n=4,791), Kingston (n=2,895) and Glen Eira (n=2,355).

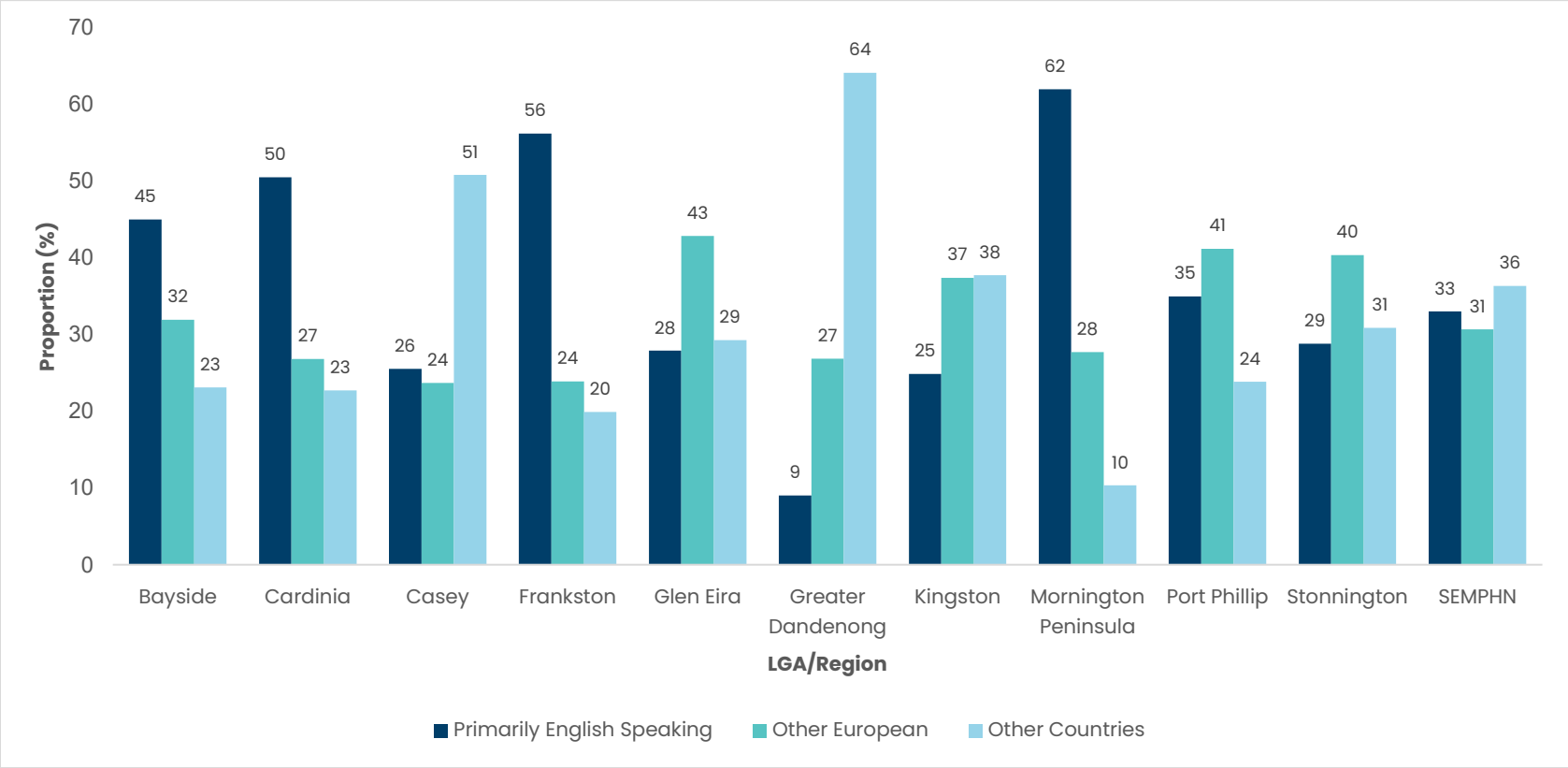
[16] Low proficiency in English is defined as when a person either does not speak English well or does not speak English at all.

Figure 5.3 Older persons by country of birth and LGA, 2021



Source: ABS 2021 Census, ABS (June 2022 release) Table G09: Country of birth of person by age by sex, Victoria, accessed on 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

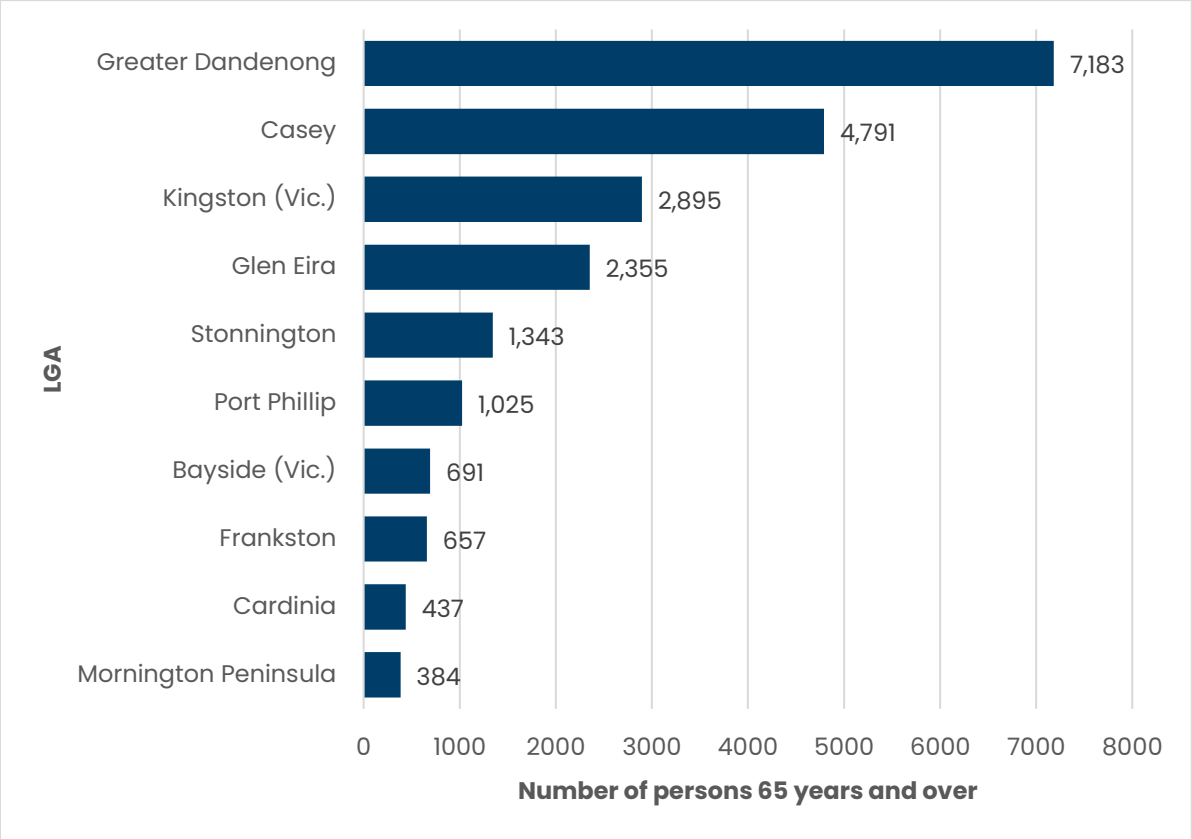
Figure 5.4 Older persons born overseas by language spoken in country of birth and LGA, 2021



Source: ABS 2021 Census, ABS (June 2022 release) Table G09: Country of birth of person by age by sex, Victoria, accessed on 20 October 2024. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Focus group consultations held in July and August 2022 highlighted the need for service planning to include the needs of older CALD people in the SEMPHN region. They suggested that the CALD community bring strengths to the catchment, yet services are often inaccessible due to cultural and language barriers. This is consistent with the ABS 2021 Census data for older persons with low proficiency in English (Figure 5.5).

Figure 5.5 Older persons with low proficiency in English by LGA, 2021

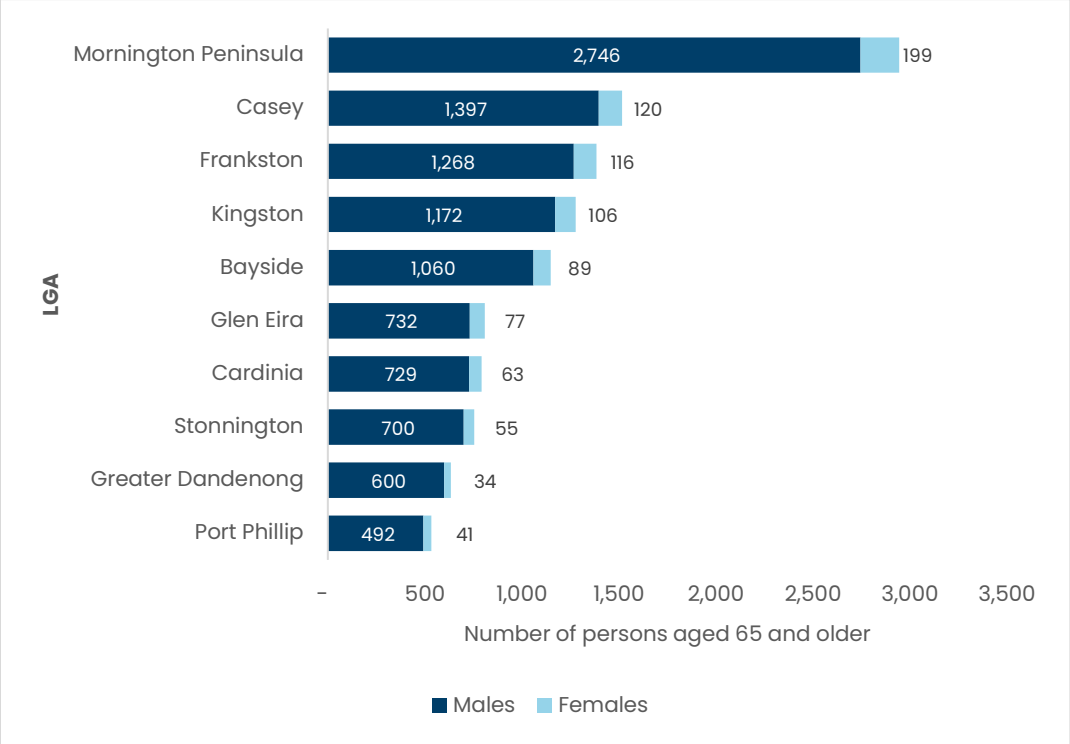


Source: ABS 2021 Census, ABS (June 2022 release) Table G11: Proficiency in spoken English by year of arrival in Australia by age, Victoria, accessed on 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Veterans

The largest group of veterans in Australia are now aged 65-74 years. Data for 2022 indicates that there were approximately 54,000 Department of Veterans Affairs (DVA) pensioners and treatment cardholders in Victoria (Department of Veterans' Affairs 2022). Figure 5.6 highlights that the largest number of older veterans lived in Mornington Peninsula (25.0%, n=2,945).

Figure 5.6 Older veterans by LGA, 2021



Source: 2021 Census, ABS (June 2022 release) Table G22: Australian Defence Force Service by age, by sex, Victoria, accessed on 16 October 2024. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%). The numbers outside the bars refer to the number of older female veterans.

Mortality and causes of death

In the SEMPHN region, the median age at death in 2022 was 81.3 years for males and 85.9 years for females. This aligns with the Victorian median age at death of 80.3 years for males and 85.5 years for females in the same year (Australian Institute of Health and Welfare 2024c). Table 5.1 presents the median age at death across the SEMPHN catchment. It shows that Glen Eira had the highest median age at death at 87.9 years, while Cardinia had the lowest median age of death at 81.7 years.

Table 5.1 Median age at death by LGA, 2022

LGA	Median age at death (years)
Bayside	86.8
Cardinia	81.7
Casey	82.7
Frankston	85.2
Glen Eira	87.9
Greater Dandenong	84.7
Kingston	86.2
Mornington Peninsula	86.3
Port Phillip	82.2
Stonnington	87.6
SEMPHN catchment	83.4
Victoria	82.9

Source: Mortality over regions and time (MORT) books (2018-2022), AIHW, accessed on 23 October 2024. Note that Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Between 2018 and 2022, the leading causes of death in the SEMPHN region were Alzheimer's disease for women, accounting for 12.4% of all causes, and coronary heart disease for men, accounting for 11.8% of all causes (Australian Institute of Health and Welfare 2024c). The age-standardised mortality rate (ASMR) in the region (505.2 per 100,000) was lower than the Victorian estimate (541.4 per 100,000) in 2022.

The 2022 ASMR in the region (505.2 per 100,000) was lower than the Victorian estimate (541.4 per 100,000). However, the Greater Dandenong (554.2 per 100,000) and Frankston (612.0 per 100,000) LGAs had higher death rates than the Victorian estimate (Australian Institute of Health and Welfare 2024c).

At a national level, chronic and progressive illnesses were the leading causes of death among older Australians in 2023 (Australian Bureau of Statistics 2023a). Table 5.2 shows that for individuals aged between 65 and 74 years, lung cancer and ischaemic heart disease were the leading causes of death. For individuals aged 75 years and over, the leading causes of mortality were dementia including Alzheimer's and ischaemic heart diseases.

Table 5.2 Leading causes of death in Australians aged 65 years and above by age, 2023

Age group (years)	Rank	Cause of death	ASMR per 100,000
65–74	1	Lung cancers	108.6
	2	Ischaemic heart diseases	105.5
	3	Chronic lower respiratory diseases	64.3
	4	Lymphoid and haemopoietic cancers	49.7
	5	Colorectal cancers	44.0
75–84	1	Dementia including Alzheimer's disease	292.4
	2	Ischaemic heart diseases	284.2
	3	Lung cancers	202.6
	4	Chronic lower respiratory diseases	192.1
	5	Cerebrovascular diseases	178.7
85-94	1	Dementia including Alzheimer's disease	1,699.3
	2	Ischaemic heart diseases	1,336.9
	3	Cerebrovascular diseases	732.2
	4	Chronic lower respiratory diseases	458.1
	5	COVID-19	414.9
95+	1	Dementia including Alzheimer's disease	5,136.2
	2	Ischaemic heart diseases	3,426.0
	3	Cerebrovascular disease	2,063.4
	4	Heart failure and complications and ill-defined heart	1,396.2
	5	Diseases of the urinary system	1,250.4

*Numbers reported are ASMR (per 100,000). Source: ABS Causes of Death, Australia, 2023; Table 1.3, ABS (accessed on 23 October 2023).

Falls are the leading cause of hospitalisation for injuries and injury-related deaths in older Australians (Australian Institute of Health and Welfare 2024b). In 2022-23, falls were responsible for 70% of all injury-related deaths among individuals aged 65 and above.

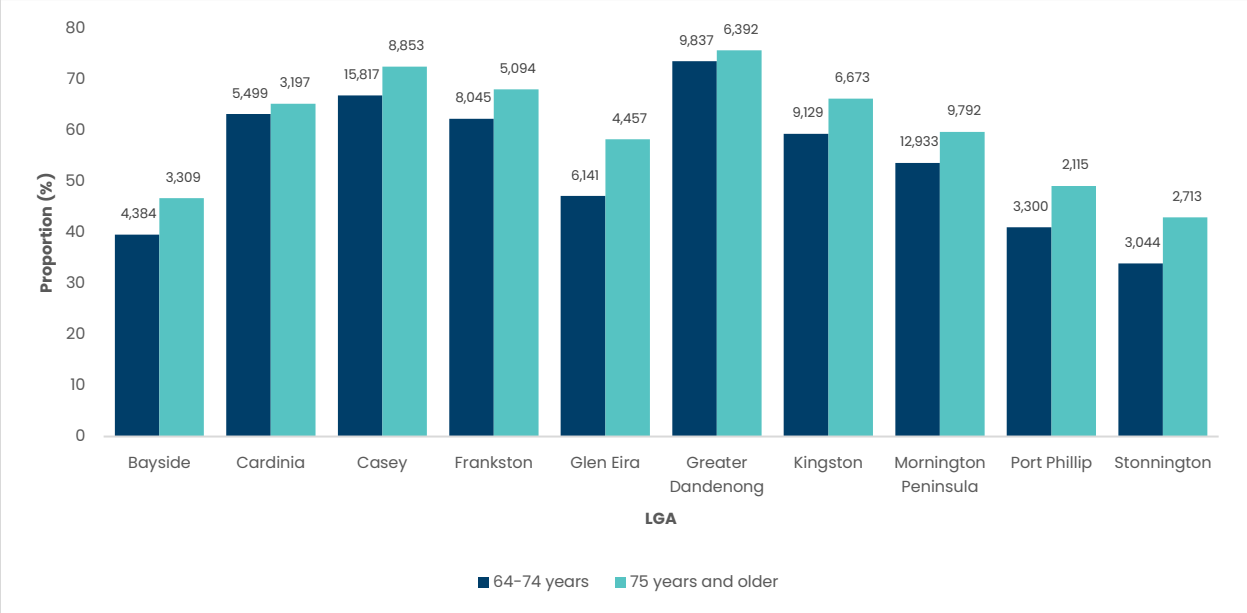
Across all Australian PHN regions, the SEMPHN region ranked fourth in terms of the highest national rate of deaths caused by accidental falls, with an overall ASMR of 14.9 per 100,000 population between 2018 and 2022. Furthermore, the SEMPHN region had the second-highest national rate of deaths due to accidental falls among males at 18.0 per 100,000, and the sixth-highest national rate among females at 12.5 per 100,000.

For individuals aged 65 years and over, 76.7% (n=144,635) of hospitalisations were due to injuries. The rates of hospitalisation caused by injury were 2,618.8 per 100,000 males and 3,742.3 per 100,000 females in this age group (Australian Institute of Health and Welfare 2024b).

Low income

The Australian Taxation Office (ATO) grants the maximum low-income tax offset to persons whose annual income is below $37,500, equating to a weekly income of $721.15 (Thurber et al. 2021). Based on the ABS 2021 Census, low-income persons are those earning less than $650 per week (i.e. under the ATO's low-income tax offset limit). According to self-reported data, the majority of residents aged 65 years and older residing within the SEMPHN catchment that needed assistance with daily activities OR tax offset assistance were from the LGAs of Casey, Greater Dandenong, Mornington Peninsula and Kingston (Figure 5.7). Among those aged 75 years and older, most requiring assistance were concentrated in Casey and Greater Dandenong.

Figure 5.7 Older persons earning less than $650 per week by LGA, 2021

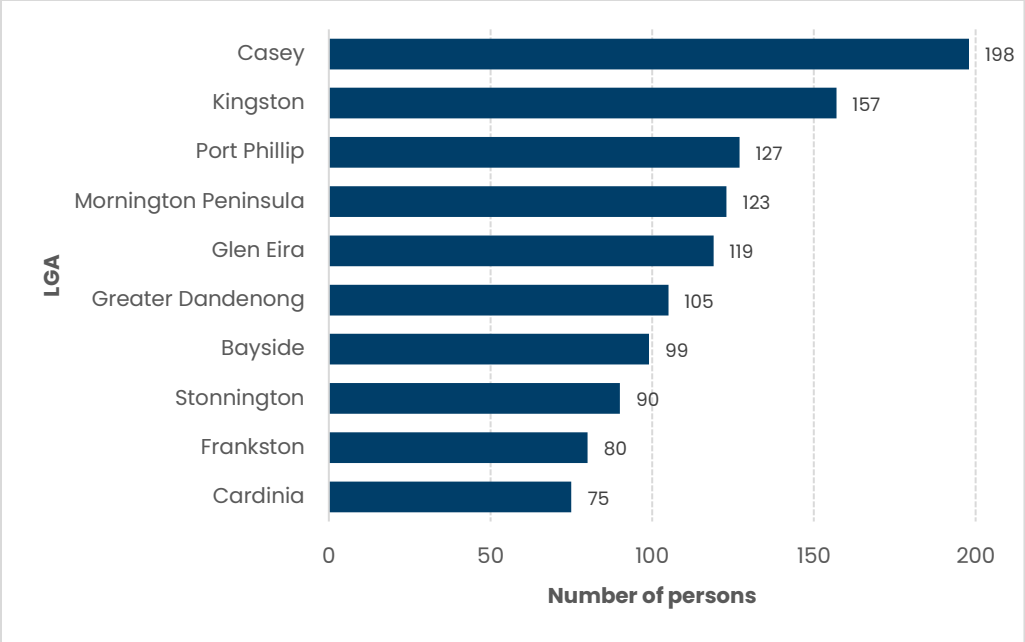


Source: 2021 Census, ABS (June 2022 release) Table G17: Total personal income (weekly) by age by sex, Victoria, accessed on 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Unemployment

In 2021, Casey recorded the highest unemployment rate among residents aged 65 and above, with 16.9% (n=198) actively seeking part- or full-time employment (Figure 5.8). These figures exclude those who were underemployed or jobless but had stopped job searching.

Figure 5.8 Older persons unemployed and looking for work by LGA, 2021

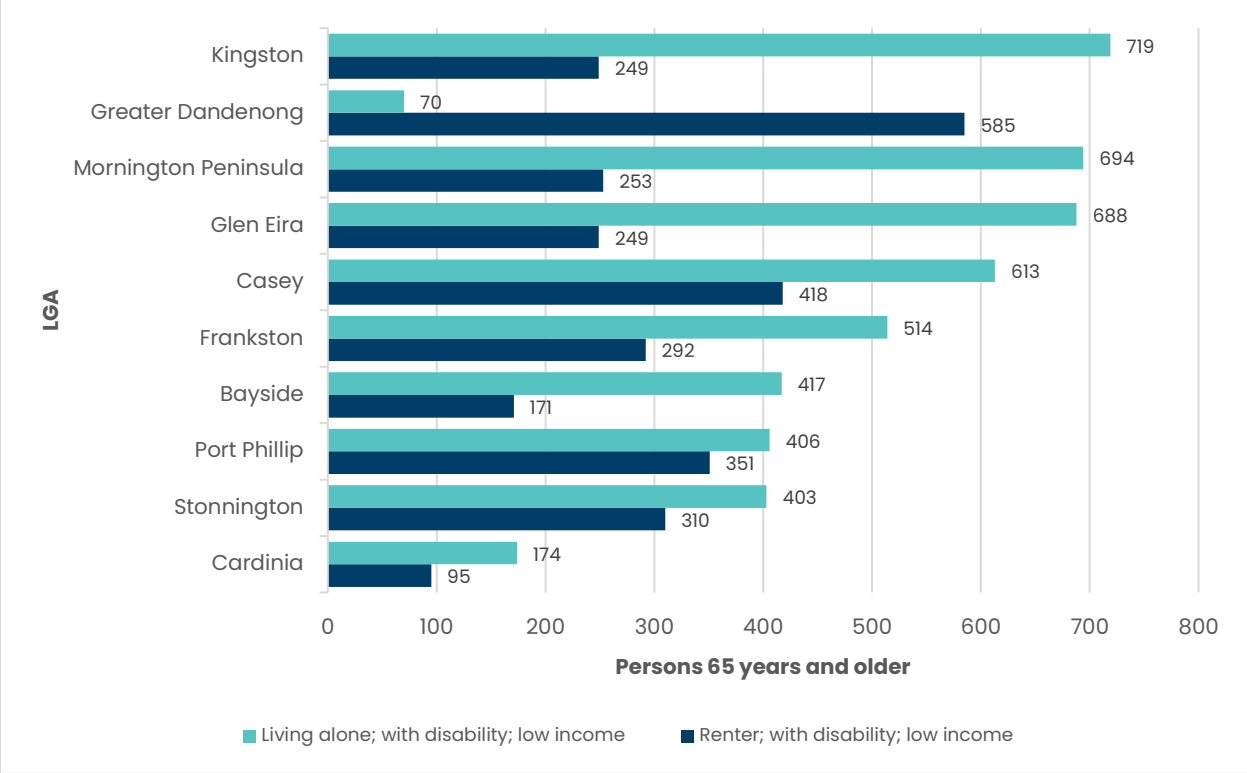


Source: 2021 Census, ABS (June 2022 release) Table G46: Labour force status by age by sex, Victoria, accessed on 24 October 2024. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Vulnerable older population

Figure 5.9 shows that Dandenong, Casey, Mornington Peninsula, Kingston and Glen Eira had the highest proportion of older persons living alone, with disability and/or on low income in the SEMPHN region. This combination of socioeconomic and physical factors could potentially increase the risk of poor health outcomes for the older population residing in these LGAs.

Figure 5.9 Older persons living alone, on low income and with disability by LGA, 2016



Source: Social Health Atlas of Older People in Australia Data by PHN (published June 2021). Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Homelessness

People experiencing homelessness may have to manage a range of complex issues related to not having physical shelter, that when not dealt with can further exacerbate this experience. The ABS uses 6 groups to estimate the number of people experiencing homelessness on Census night. These are people living in improvised dwellings, tents or sleeping out, people living in supported accommodation for the homeless, people staying temporarily with other households, people living in boarding houses, people in other temporary lodgings, and people living in 'severely' crowded dwellings (Australian Bureau of Statistics 2021).

Table 5.3 highlights in 2021, there were 986 homeless older persons in the SEMPHN catchment, representing a rate of 3.9 homeless older persons per 1,000 older SEMPHN residents. Several LGAs had higher rates of older people experiencing homelessness compared with the Victorian rate of 2.8 per 1,000.

These LGAs were Port Phillip (12.7 per 1,000), Greater Dandenong (9.6 per 1,000), Casey (4.9 per 1,000), Frankston (4.1 per 1,000) and Cardinia (2.8 per 1,000).

Table 5.3 Older persons experiencing homelessness and rates per 1,000 older residents by LGA, 2021

LGA	Number	ERP 2021	Rate per 1,000
Bayside	15	20,771	0.7
Cardinia	40	14,367	2.8
Casey	192	38,928	4.9
Frankston	93	22,913	4.1
Glen Eira	24	23,808	1.0
Greater Dandenong	237	24,763	9.6
Kingston	69	28,781	2.4
Mornington Peninsula	96	44,150	2.2
Port Phillip	169	13,302	12.7
Stonnington	33	17,403	1.9
SEMPHN	968	249,186	3.9
Victoria	2,961	1,069,770	2.8

Source: 2021 Census, ABS (June 2022) TableBuilder: LGA (ERP) by LFSP labour force status, generated on 25 October 2024. ERP=estimated resident population. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

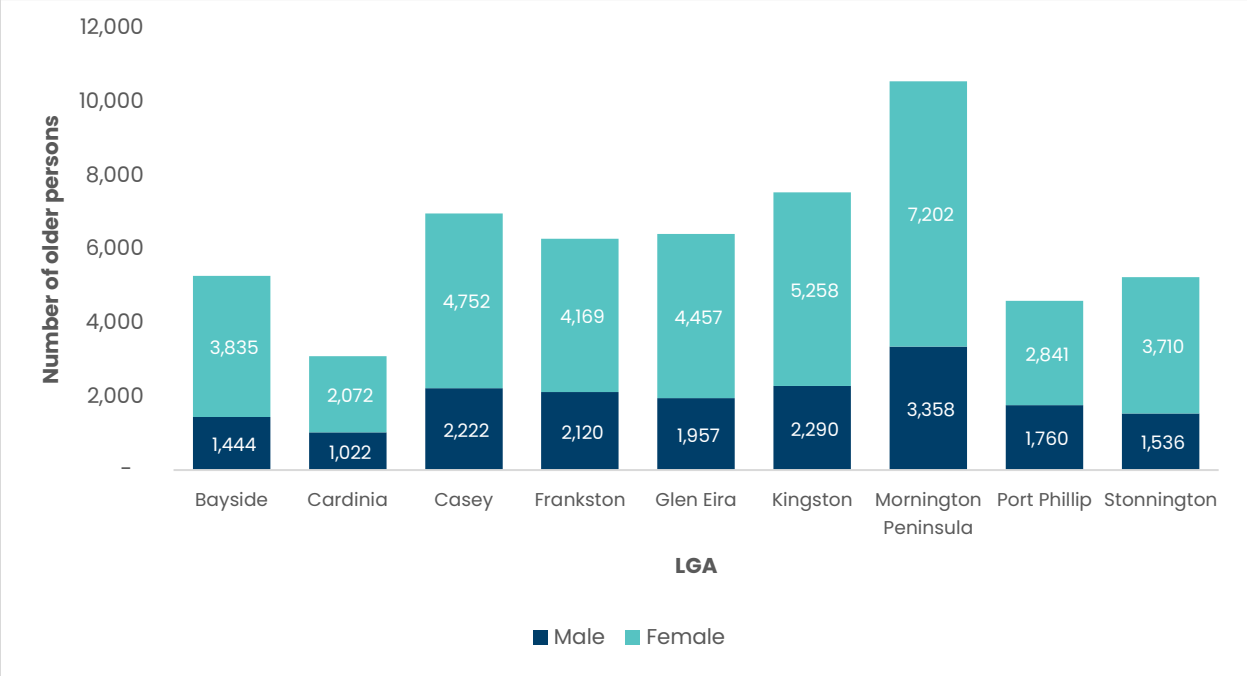
Social support

Living alone can be a determinant of social isolation and loneliness, especially among the older population. According to the ABS 2021 Census, the Mornington Peninsula (n=10,560), Kingston (n=7,548) and Casey (n=6,974) had the largest number of persons aged 65 years and older living alone within the SEMPHN region (

Figure 5.10). Proportionally, the Mornington Peninsula had the highest number of older people living alone (18.9%), followed by Kingston (13.5%) and Casey (12.5%).

Other studies have reported that multiple factors including social, financial, health and sociodemographic significantly impacted the psychological condition of older people during the COVID-19 pandemic. This was due to social isolation and fear of infection during public health order lockdowns (Richter and Heidinger 2021).

Figure 5.10 Older persons aged 65+ years who lived alone by LGA and gender, 2021



Source: ABS Census 2021, ABS (June 2022 release) Table G27: Family composition, Victoria, accessed on 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

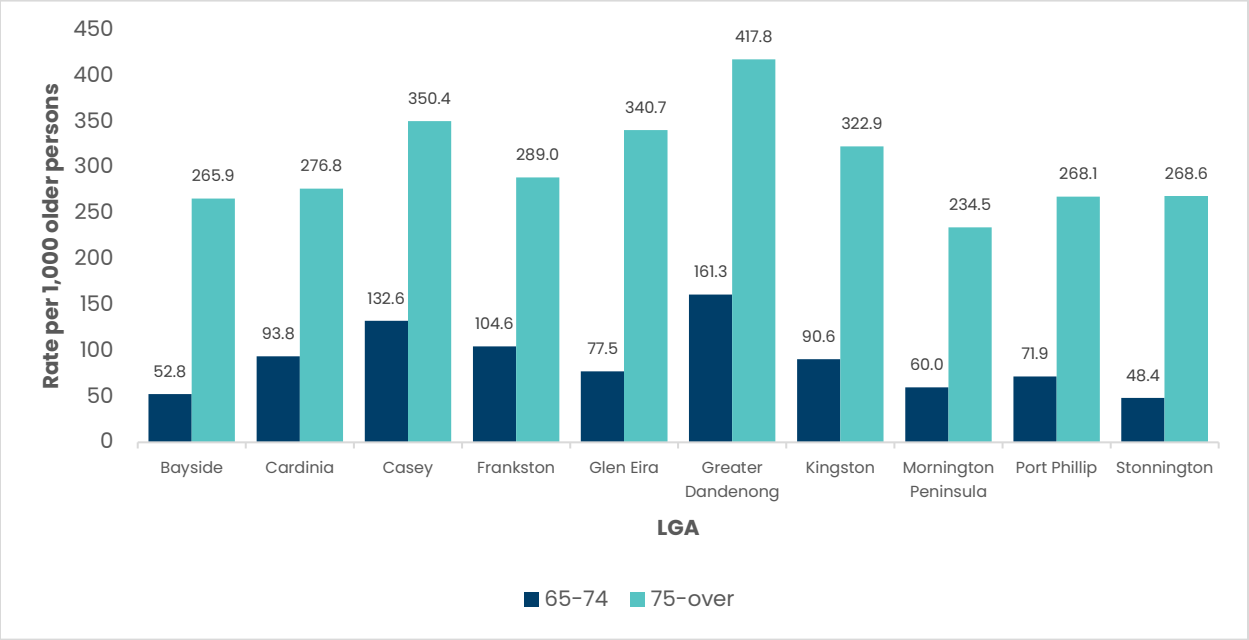
Physical health

The physical health status of an individual can be estimated based on self-reported chronic conditions, self-rated health and if one needs assistance for daily living activities.

People requiring assistance

Figure 5.11 shows that among the population aged 65 and above within the SEMPHN region, the highest number requiring assistance with core daily activities were residing in the Casey, Greater Dandenong and Cardinia LGAs. When considering the older subset of this population (those aged 75 and above), the LGAs with the highest rate of residents needing assistance were Casey, Greater Dandenong and Glen Eira.

Figure 5.11 Older persons who needed daily assistance by LGA, 2021



Source: 2021 Census, ABS (June 2022 release) Table G18: Core activity need for assistance by age by sex, Victoria, accessed on 20 August 2022. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Chronic conditions

Chronic conditions significantly impact the quality of life and are a leading cause of mortality among Australians. These conditions substantially contribute to the nation's burden of disease, resulting in death, disability and diminished quality of life, and accounting for a significant proportion of healthcare costs (Department of Health and Human Services 2019). While chronic conditions can affect individuals of any age group, their prevalence increases with older age, and their development, progression and effects are wide-ranging.

As people age, the number of chronic conditions they may have also tends to increase (Department of Health and Human Services 2019). For many older individuals, coping with multiple chronic conditions presents a challenge. That is, learning to manage various treatments while maintaining an acceptable

quality of life can be problematic. Chronic conditions are a significant health concern, and their impact on the ageing population is a crucial consideration for healthcare providers and policymakers.

Table 5.4 presents the rate of chronic conditions among those aged 65 years and above within the SEMPHN catchment (see Appendix Table 1.3.2 for further detail). Across the catchment, heart disease had the highest prevalence rates among the older population. This was followed by MH conditions including anxiety and depression, and lung conditions such as COPD and emphysema.

Table 5.4 Rate of chronic conditions per 1,000 older persons by LGA, 2021

	Dementia	Heart diseases	Kidney diseases	Lung conditions	MH	Stroke
Bayside	46.0	152.7	24.0	46.1	70.3	31.9
Cardinia	35.1	165.4	36.7	72.4	88.1	40.5
Casey	39.6	164.2	37.2	60.7	86.4	43.1
Frankston	43.9	170.0	40.6	78.0	98.4	44.1
Glen Eira	43.3	156.2	33.2	42.9	80.3	33.1
Greater Dandenong	50.3	143.0	36.5	48.9	90.8	43.2
Kingston	41.6	159.8	32.6	54.8	82.9	37.8
Mornington Peninsula	38.7	163.6	28.5	59.0	83.4	38.2
Port Phillip	24.4	134.0	25.7	45.3	77.6	30.4
Stonnington	36.8	139.4	24.8	39.7	65.1	30.0
Victoria	26.9	106.9	22.2	40.1	57.6	26.3

Source: ABS Census 2021, ABS (June 2022 release) Table G19: Type of long-term health condition by age by sex, Victoria, accessed on 24 October 2024. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Mental health (MH)

As people age, dementia, depression and anxiety often contribute to a decline in mental well-being. Physical health challenges including chronic pain and frailty can also adversely impact psychological well-being (World Health Organization 2017). According to the ABS 2021 Census, there were 21,212 persons 65 years and older in the SEMPHN catchment who reported having a MH condition (including anxiety and depression). Mornington Peninsula (18.1%) and Casey (16.1%) had the largest number of older persons with a reported MH condition. Within the older subset of 75 years and above, Kingston and Greater Dandenong featured more prominently, which may be due to the delayed service access among CALD communities in Kingston and Greater Dandenong, given the diversity of their populations.

During focus group consultations, MH and dementia were the most frequently cited health conditions. Both were identified as major health concerns in the older cohort across the region and contributors to vulnerability. Although those focus groups did not provide specific insights into the relative needs across the different LGAs. Mental well-being and cognitive health are crucial aspects of ageing, and addressing the associated challenges requires a comprehensive understanding of the needs and vulnerabilities within each local community.

In the 2023-24 FY, mixed anxiety and depression was the most prevalent diagnosis (34.9%) for individuals aged 65 years and over who accessed SEMPHN-commissioned primary MH services (South Eastern Melbourne Primary Health Network 2024). Depression (20.6%%) and anxiety (7.8%) were the second and third most common diagnoses, respectively, for this older age group[17]. There was a substantial decrease (6.3%) in mixed anxiety and depression diagnoses among those aged 65 and above, dropping from 34.9% in the 2022-23 FY to 28.1% in the 2023-24 FY.

A recent report by COTA Australia (2023) indicated that one-third of older individuals aged 75 years and over reported their MH being adversely affected by COVID-19 and the associated lockdown measures. Most of these respondents did not receive support from MH professionals or services. Some were unaware of suitable MH support options tailored for older adults, while others found such services inaccessible due to factors like cost, location or the challenges posed by the transition to online delivery. Many older Australians relied heavily on primary care, with GPs serving as their preferred initial point of contact when seeking care or support for their MH needs.

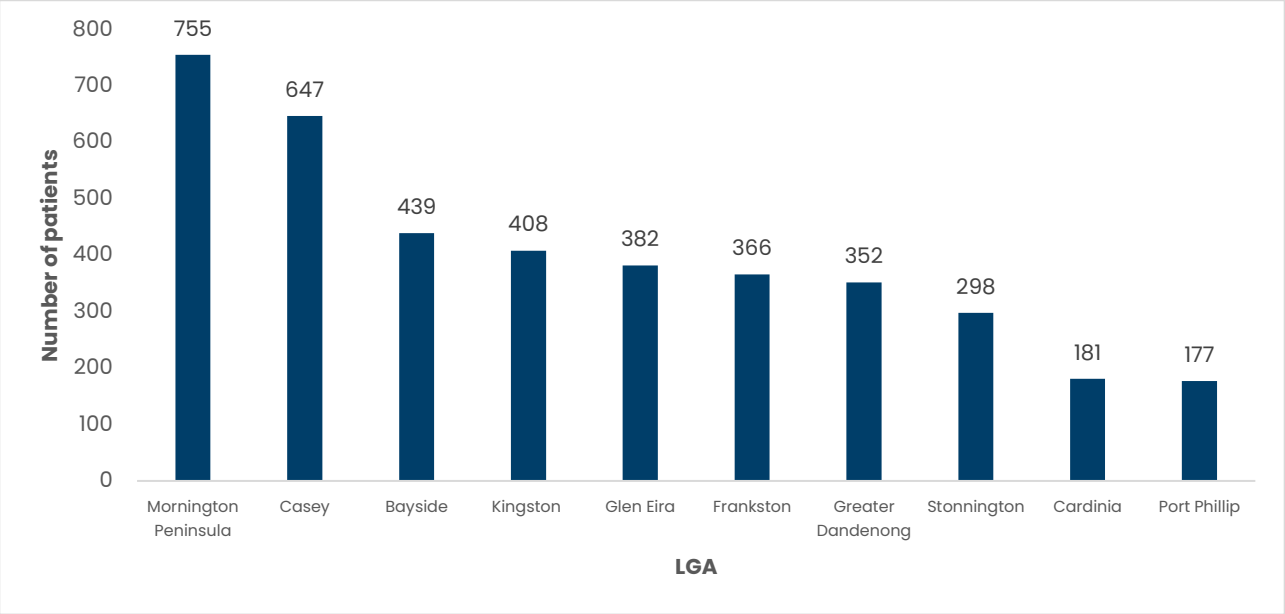
Dementia

Dementia is a progressive disease without a cure, impacting close to half a million Australians; and almost 1.6 million Australians are involved in the care of people with dementia. The number of people living with dementia is estimated to double in the next 25 years (Dementia Australia 2022). While people with dementia do not always die of dementia, it is the second leading cause of death in Australia since 2018 (Dementia Australia 2022).

In the ABS 2021 Census, there were 10,388 persons 65 years and older in the SEMPHN catchment who reported living with dementia. Mornington Peninsula (17.1%) and Casey (15.1%) had the largest number of residents with dementia (Figure 5.12). According to general practice data accessed via POLAR, as of 30 October 2024 there were 7,293 persons with a dementia or Alzheimer's disease diagnosis who accessed primary care within the SEMPHN catchment. The majority were female, accounting for 4,366 patients or 60% of the total.

[17] Note: 11.3% and 13.1% of diagnosis data were missing from the Primary Mental Healthcare Minimum Dataset (PMHC-MDS) (South Eastern Melbourne Primary Health Network 2024) for residents aged 65 years and over for FY2022-23 and FY2023-24, respectively.

Figure 5.12 Older patients with dementia accessing primary care by LGA, 2024



Source: SEMPHN POLAR general practice data, accessed on 30 October 2024. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Palliative care

Palliative care services in Australia are considered among the best globally. The Economist Intelligence Unit's Quality of Death Index assessed 80 countries using 20 indicators across 5 categories: the palliative and healthcare environment, human resources, the affordability of care, the quality of care, and the level of community engagement (The Economist 2015). Australia ranked second worldwide and first in the Asia-Pacific region for quality of death in 2015.

In Australia, most deaths occurred in hospitals and residential aged care facilities (Australian Institute of Health and Welfare 2021). In 2019, admitted patients in a hospital/medical service accounted for half of all deaths in Victoria (50.0%, n=21,916). Nearly one-third occurred in residential aged care (29.9%, n=13,137) and around one-fifth in home care (18.2%, n=7,990). The remaining deaths occurred in other settings or were not specified (1.6% n=794).

While most Australians understand the importance of discussing end-of-life wishes and planning, only half have had had such conversations or made plans (Palliative Care Australia, 2021). Other studies have suggested that improving community attitudes and perceptions about end-of-life care and dying is not solely the responsibility of health services but also requires a social perspective for improved awareness (Grindrod et al. 2019). Some have recommended having advanced care planning discussions when patients are medically stable, in a comfortable environment with a familiar healthcare professional they have an existing relationship with (Franklin et al. 2020).

Research is ongoing to better understand the amount of palliative care being undertaken by GPs, and the experiences and challenges faced by GPs providing palliative care in Australia (Herrmann et al. 2019). Palliative care is complex and involves communication and interactions between GPs and patients and their families, and other service providers both in the community and acute setting.

It is worth noting that while not all terminally ill patients require support through a specialist palliative care (SPC) service, most terminally ill patients are engaged with their GP. The need for better health service integration is acknowledged across the health system, and there is a growing sense of shared responsibility for this by many different practitioners and services (Coulton and Boekel 2019).

The need for palliative care support, as assessed by Palliative Care South East (Table 5.5), has identified high demand for service utilisation among clients living in Pakenham (n=121) and Berwick (n=104). Other suburbs they identified in terms of high volume of clients were Springvale, Noble Park, Dandenong North, Endeavour Hills, Narre Warren and Cranbourne, with 51-100 clients across each suburb requiring support[18].

Table 5.5 Palliative care providers in SEMPHN catchment by LGA, October 2024

LGA	Community palliative care (CPC)	Local health network/SPC (LHN/SPC)
Bayside	Cavalry Healthcare Bethlehem Cabrini (Private CPC)	The Alfred Cabrini (Private SPC)
Casey	Palliative Care South East	Monash Health
Cardinia	Palliative Care South East	Monash Health
Frankston	Peninsula Home Hospice	Peninsula Health
Glen Eira	Cavalry Healthcare Bethlehem Cabrini (Private CPC)	The Alfred Cabrini (Private SPC)
Greater Dandenong	Palliative Care South East	Monash Health
Kingston (Parts of Kingston)	Peninsula Home Hospice Palliative Care South East Cavalry Healthcare Bethlehem Cabrini (Private CPC)	Peninsula Health Monash Health The Alfred Cabrini (Private SPC)
Mornington Peninsula	Peninsula Home Hospice	Peninsula Health
Port Phillip	Cavalry Healthcare Bethlehem Cabrini (Private CPC)	The Alfred Cabrini (Private SPC)
Stonnington	Cavalry Healthcare Bethlehem Cabrini (Private CPC)	The Alfred Cabrini (Private SPC)

To gain insights into local GP perspectives on palliative care delivery, including collaboration with palliative care services within the SEMPHN region, 29 GPs in the catchment completed a short survey (South Eastern Melbourne Primary Health Network 2022). The survey showed that 21 out of the 29 GPs (72.4%) conducted home and/or aged care facility visits for palliative care patients, with one GP offering telehealth consultations via video. When asked about referring patients to community palliative care (CPC) services, 96.4% of the GPs expressed confidence (n=16) or some level of confidence (n=11) in doing so.

Most GPs referred about 5 patients per year to CPC services, and those GPs with patients in residential and aged care facilities generally made more referrals. There were several common challenges when GPs made referrals to local CPC services, including delays or lack of discharge summaries, communication issues with referrals and patient deaths, long wait times, and a shortage of hospital beds. When asked about potential improvements, GPs identified a few areas. These included better triage, timely discharge summaries and results, improved support for patients with mental illness, access to MH workers in general practice, and streamlined processes for anticipatory medications.

[18] Palliative Care South East does not cover all SEMPHN LGAs, including Mornington Peninsula or Bayside.

Residential aged care

As of 30 June 2023, the SEMPHN catchment had 155 residential care services, 129 home care services and 143 home support services (Australian Institute of Health and Welfare 2024a). On the same date, the occupancy rate for residents in residential aged care facilities across the catchment was 83.9%, similar to what was observed in 2021 (84.3%). In 2022-23, approximately half (48.4%) of the residents using the Commonwealth Home Support Programme (CHSP) in the SEMPHN catchment were born outside of Australia, and one in 4 (26.5%) had a disability.

Utilisation of residential aged care facilities

As of 30 June 2023, there were 11,571 residents aged 65 years and over in permanent residential aged care, representing 42.3 per 1,000 of this age group in the SEMPHN catchment (Australian Institute of Health and Welfare 2024a). During the 2022-23 FY the most used home support services in the catchment were domestic assistance (n=21,012) and allied health and therapy services (n=16,520). Individuals aged 80 to 90 years represented the largest age group entering permanent residential care, comprising 48.8% of men and 43.7% of women. Furthermore, 51.1% of those in permanent residential aged care had a diagnosis of dementia.

Table 5.6 describes length of stay and movement of residents in residential aged care facilities during 2022-23 FY. The median length of stay for residents in permanent residential aged care facilities until death was approximately 2 years (23.2 months).

Table 5.6 Length of stay (days) and number exiting permanent residential aged care in SEMPHN catchment, by discharge reason, 2022-23

	Death	Return to community	To hospital	Other	To other residential care
Mean length of stay (days)	33.3	11.3	19.3	19.8	29.1
Median length of stay (days)	23.2	5.0	4.3	9.6	17.3
Range of length of stay (days)	0.0–349.8	0.0–153.5	0.0–155.5	0.0–145.1	0.2–259.4
Total exits (n)	3,683	195	53	247	327

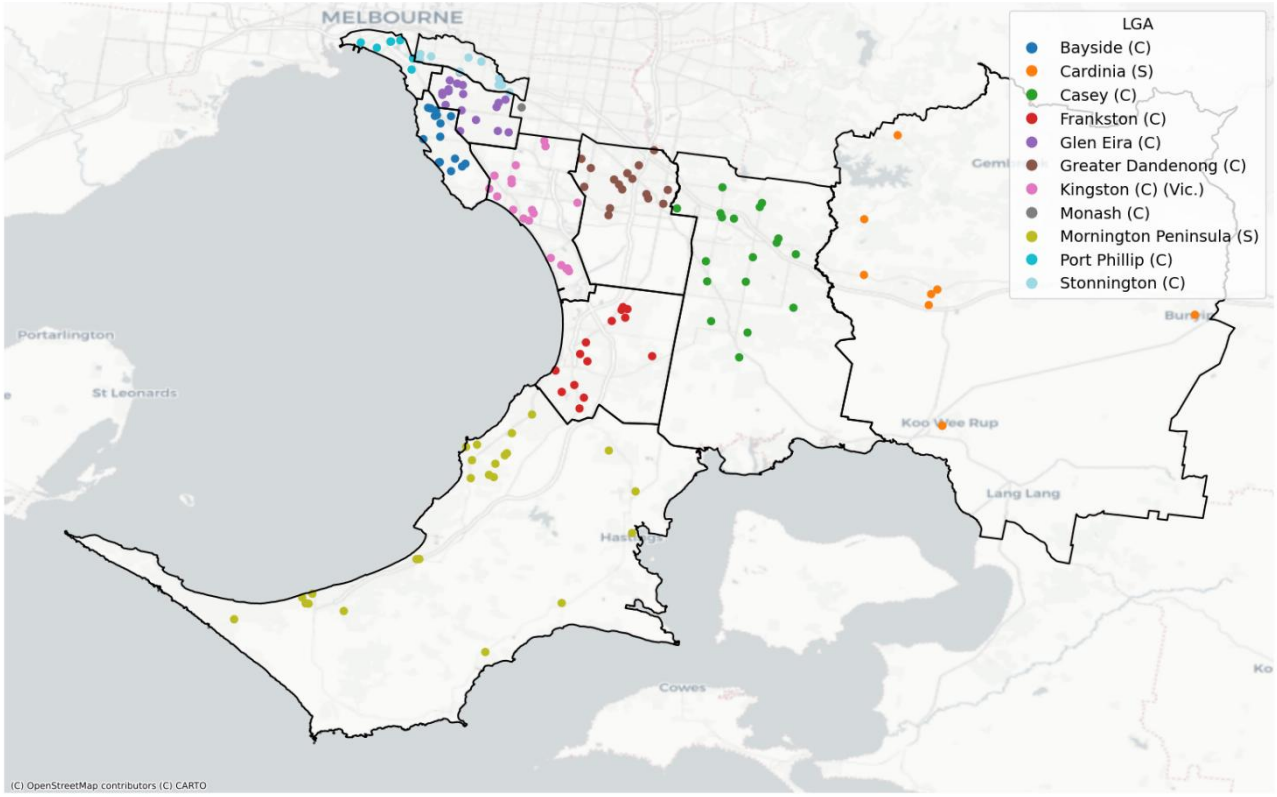
Source: GEN aged care data, AIHW 2024, Dashboard: My aged care region (PHN), Table 3.2: Length of stay and exits from permanent residential care, by discharge reason, by PHN, 2022-23. Accessed 30 October 2024.

While data on unmet nursing and community care needs is limited, focus groups[19] with key stakeholders including service providers (SEMPHN, 2022) emphasised issues related to workforce and access to home and carer support. These issues stem from a lack of resources, especially for home care or residential aged care. According to the focus group participants, the most significant health needs of the aged population were home care, carer support and care coordination.

[19] Qualitative input was taken from 3 focus groups (n=29) conducted with aged care service providers from across the SEMPHN catchment in August 2022.

Figure 5.13 provides a map of the residential aged care facilities across the SEMPHN catchment as of 31 July 2022.

Figure 5.13 Map of residential aged care facilities in SEMPHN catchment, June 2024



Source: GEN aged care data, AIHW 2024, Dashboard: Aged care service list – VIC – as at 30 June 2024, accessed 25 October 2024.

Aged care services

In 2022, SEMPHN conducted a survey of aged care-related organisations within its catchment area to assess the locations, nature and extent of services provided (South Eastern Melbourne Primary Health Network 2022). When asked to describe the barriers to meeting service demand, the most common responses were related to:

- workforce (lack of skilled workforce available)
- shortage of funding or funding packages
- staff retention issues
- complexity of clients.

The survey respondents unanimously acknowledged a shortage of workforce in personal care and nursing roles. Many also believed there was an undersupply of workforce in health and specialised support service areas. These organisations were surveyed about the types of services they offered (as defined by services regularly provided/funded under the CHSP), and their availability within each of the SEMPHN LGAs to identify service gaps.

SEMPHN plays a critical role in facilitating and supporting connections between primary care providers and residential aged care facilities. The current model of integration predominantly relies on existing grassroot connections between GPs and residential aged care facilities within the SEMPHN catchment. SEMPHN supports engagement between residential aged care facilities and residents' GPs using their own communication channels. SEMPHN recently commissioned several initiatives to increase and improve integration between primary care providers and GPs. These include MH services delivered through the residential aged care facilities, the COVID response across residential aged care facilities, and COVID vaccination programs conducted through partnerships between practice managers and GPs.

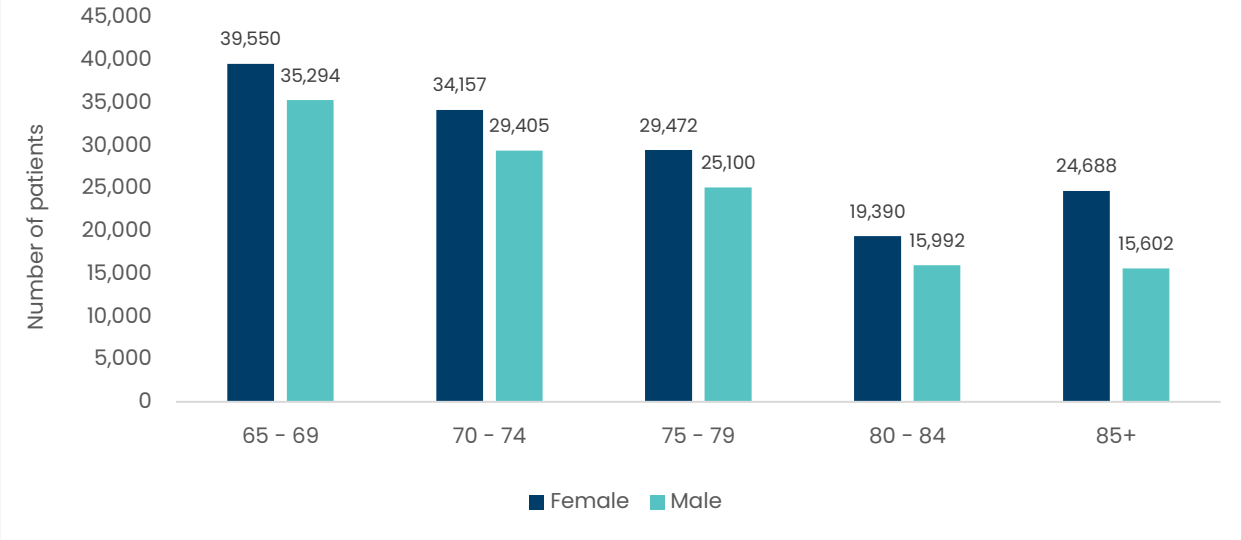
One example of a SEMPHN-commissioned initiative is the Vulnerable Vaccination Program, which targets vulnerable groups who may be homebound and unable to visit a healthcare clinic to receive their COVID-19 vaccination. Such groups include older persons, people living with a disability and those with a MH condition that prevents them from leaving their home.

SEMPHN is also currently a member of the Better at Home Initiative, which is a collaboration with the Health Service Partnership. Other SEMPHN initiatives include the Allied Health Services in Residential Aged Care Facilities Program, which aims to enhance mobility in older persons and reduce the effects of social isolation during the COVID-19 pandemic. Such initiatives provide a foundation to improve integration of primary care and residential aged care services.

Primary care insights

As of May 2024, there were approximately 270,000 unique active patients aged 65 years or older who had at least one recorded general practice consultation within the previous 2 calendar years (May 2022 – May 2024). This patient cohort typically represents the permanent patient population for a given region or practice. Of these patients, 54.8% were female and 45.2% were male. The higher proportion of female patients may reflect their marginally increased rate of service utilisation and higher life expectancy compared to males (Figure 5.14).

Figure 5.14 General practice patients (65+) by age and gender in SEMPHN catchment, 2024



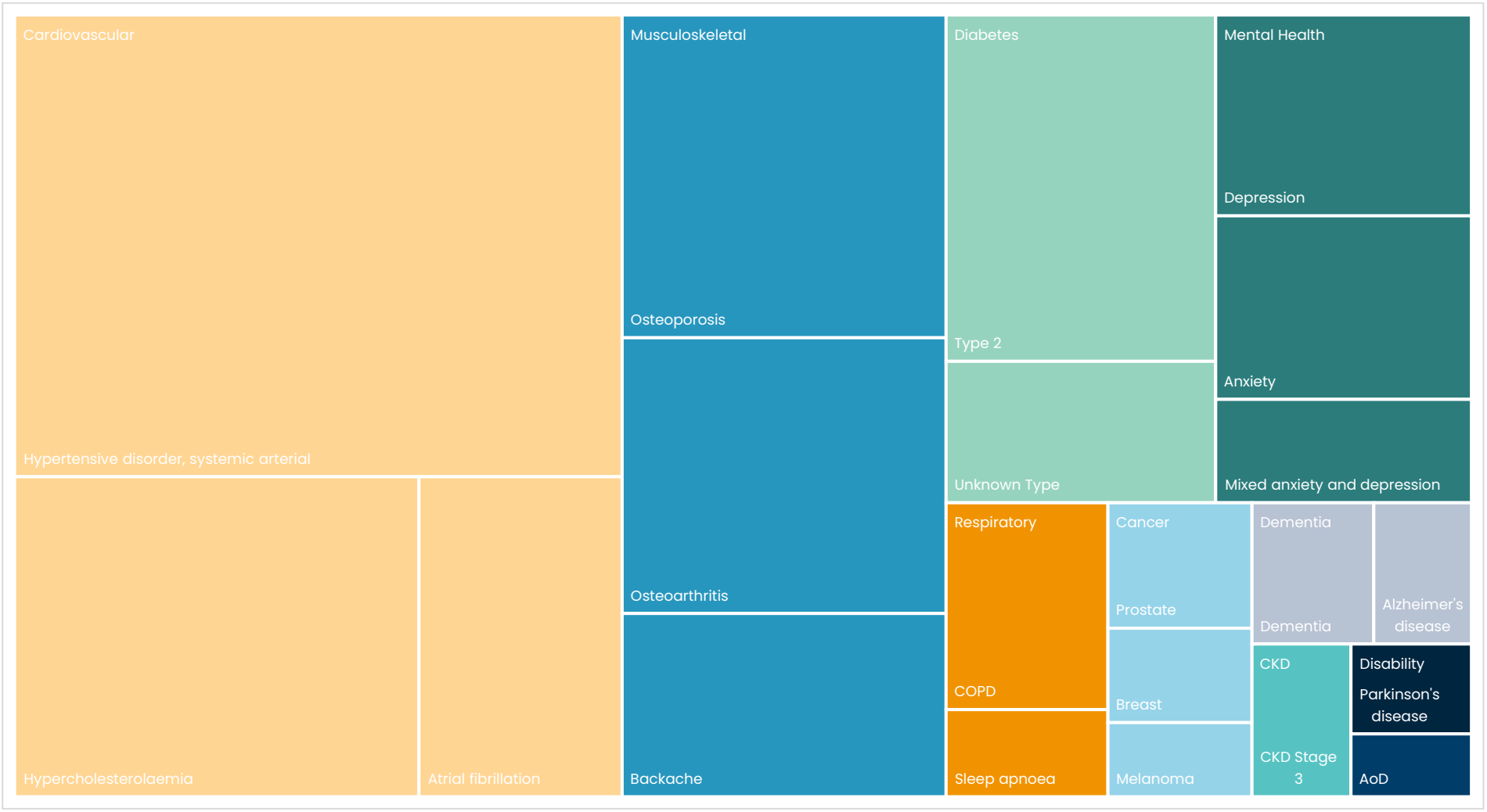
Source: SEMPHN primary care utilisation data (POLAR), May 2022 – May 2024.

Chronic disease diagnoses 2023-2024

Between July 2023 and June 2024, 59,799 patients aged 65 years and older received 109,381 new chronic disease-related diagnoses from GPs in the SEMPHN catchment. One average, each of these older persons had 2 (1.89) new diagnoses related to chronic diseases. This highlights the high rates of chronic disease comorbidity within this older population. The most common diagnoses were cardiovascular (29.2%, n=31,914), accounting for over a quarter of new diagnoses. This was followed by musculoskeletal (19.6%, n=21,392), MH (7.1%, n=7,721) and diabetes (7.0%, n=7,684) diagnoses (Figure 5.15).

Of all cardiovascular diagnoses, the most common were hypertensive disorder (52.5%, n=16,757), hypercholesterolemia (24.2%, n=8,171) and atrial fibrillation (12.2%, n=4,260). Osteoporosis (29.2%, n=6,921) and osteoarthritis (24.9%, n=6,014) represented over half of all musculoskeletal diagnoses in patients aged 65 years and older. Depression (39.7%, n=3,444), anxiety (36.3%, n=3,286), and mixed anxiety and depressive disorder (20.4%, n=1,782) accounted for almost all MH diagnoses. Most diabetes diagnoses comprised diabetes mellitus type 2 (72.6%, n=6,740), while the diabetes mellitus type was unknown for 26.6% (n=2,190) of patients.

Figure 5.15 New chronic disease diagnoses for patients aged 65 or older, 2023-2024



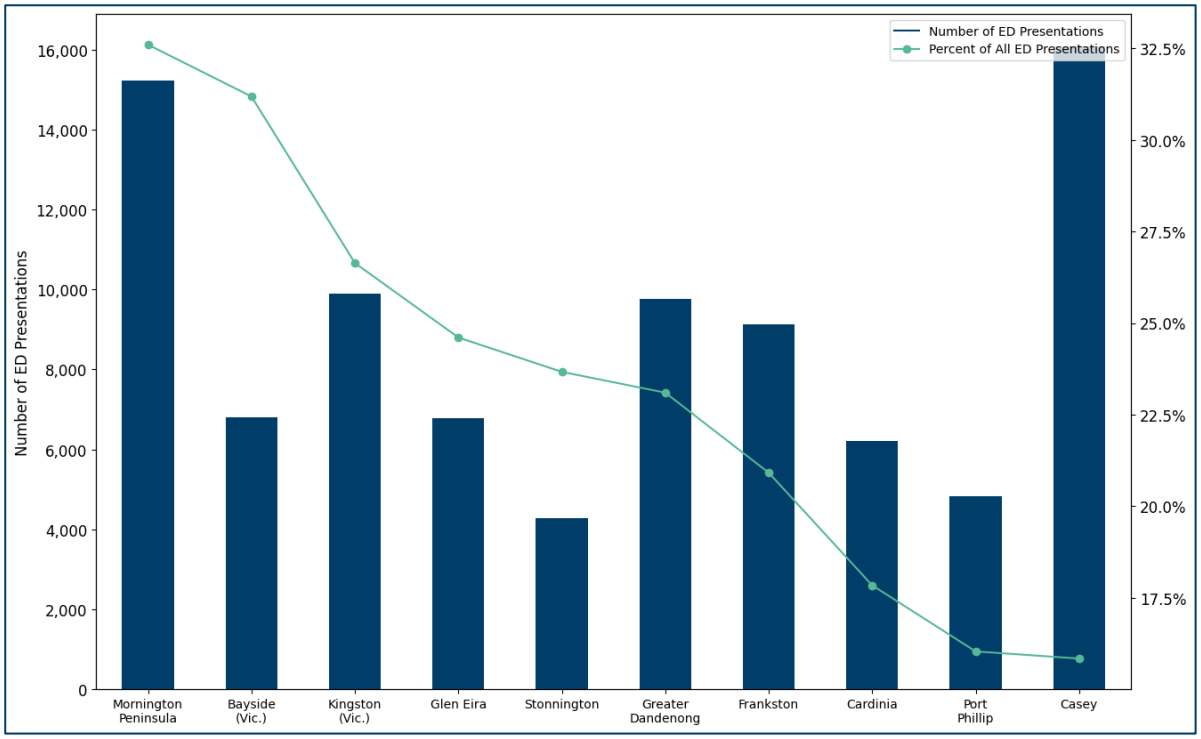
Source: SEMPHN primary care diagnosis data (POLAR), July 2023 – June 2024. AOD=alcohol and other drugs; CKD=chronic kidney disease; and COPD=chronic obstructive pulmonary disease.

Tertiary care insights

ED Presentations

In the 2022-23 FY, there were approximately 89,000 ED presentations by patients aged 65 and older across south east Melbourne. Of these presentations, 51.5% were made by females and 48.5% by males. Casey and Mornington Peninsula accounted for one-third of all ED presentations from residents aged 65 and over. Almost a third (32.6%) of ED presentations from the Mornington Peninsula were individuals aged 65 and older, which was the highest in south east Melbourne. This was followed by Bayside (31.2%) and Kingston (27.0%). In contrast, Casey had the lowest proportion of ED presentations from residents aged 65 and over, at 15.8%. This lower proportion is relatively consistent with the age distribution of these LGAs as recorded in the ABS 2021 Census (Figure 5.16).

Figure 5.16 ED presentations by residents aged 65 and older by LGA, FY2022-23



Source: VEMD, Department of Health - Victoria, 2022/23.

Table 5.7 ED presentations by residents aged 65 or older by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Number of ED presentations	Percentage of ED presentations
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	31,014	34.9%
Injury, poisoning and certain other consequences of external causes	13,527	15.2%
Diseases of the circulatory system	8,625	9.7%
Diseases of the respiratory system	5,153	5.8%

Category (by principal diagnosis)	Number of ED presentations	Percentage of ED presentations
Diseases of the musculoskeletal system and connective tissue	4,704	5.3%
Diseases of the digestive system	4,322	4.9%
Diseases of the genitourinary system	2,926	3.3%
No recorded diagnosis	2,410	2.7%
Certain infectious and parasitic diseases	2,325	2.6%
Diseases of the skin and subcutaneous tissue	2,250	2.3%

Excluding the broad ICD-10 categories of 'factors influencing health status and contact with health services' and 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified', the 5 most common diagnoses for ED presentations from patients aged over 65 across SEMPHN were (Table 5.7):

- injury, poisoning and certain other consequences of external causes
- diseases of the circulatory system
- diseases of the respiratory system
- diseases of the musculoskeletal system and connective tissue
- diseases of the digestive system.

The average wait time to treatment for ED presentations by those aged 65 or older was 31.8 minutes, shorter than the overall average of 35.4 minutes for all SEMPHN ED presentations. Over 70% of presentations were categorised as resuscitation, emergency or urgent, which was a higher proportion of priority ED presentations compared with the SEMPHN average (65%).

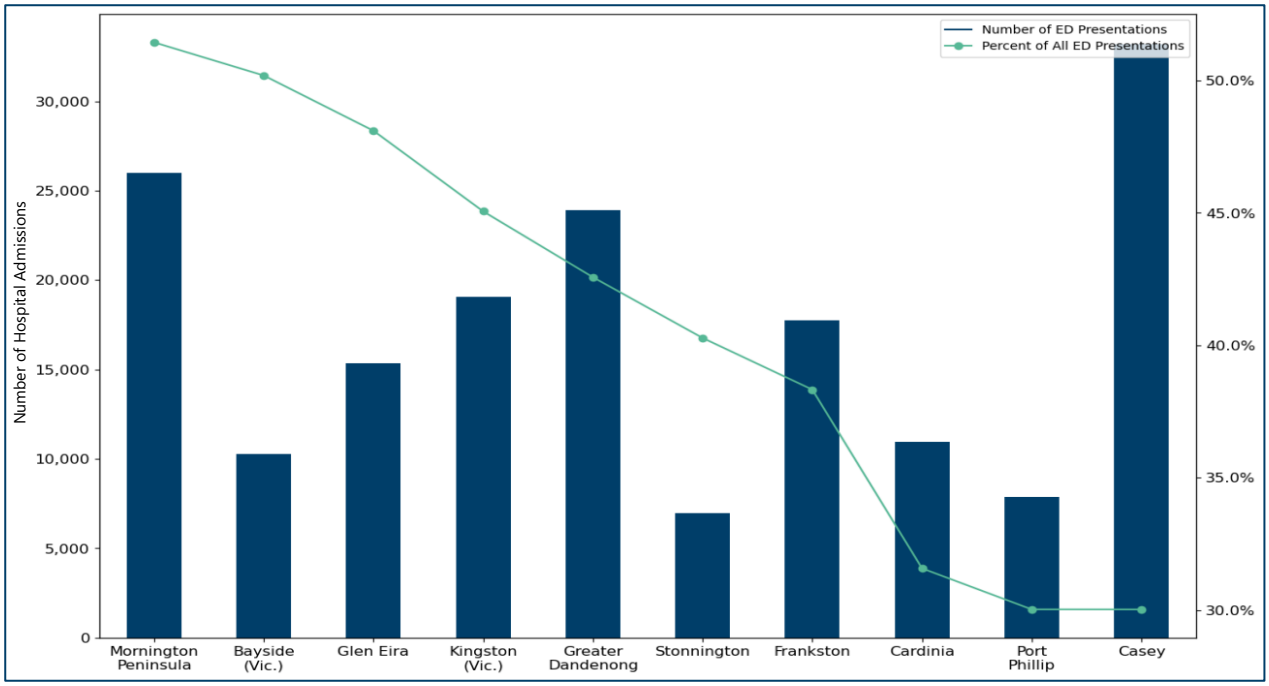
Hospital Admissions

In the 2022-23 FY there were just over 170,000 hospital admissions of south east Melbourne residents aged 65 or older. Of these, approximately 43.8% were female and 56.2% male. The proportion of males was higher compared to the gender distribution of all hospital admissions in south east Melbourne (50%/50%).

Casey reported the highest amount of hospital admissions by residents aged 65 or older at over 33,000, representing approximately 19.4% of all admissions by 65 or older residents in south east Melbourne. This was followed by the Mornington Peninsula and Greater Dandenong. As a proportion of all presentations within a region, the Mornington Peninsula had the highest proportion of presentations by residents aged 65 or older, at over one-in-2 presentation (51.4%), followed by Bayside (50.2%) and Glen Eira (48.1%) (

Figure 5.17).

Figure 5.17 Hospital admissions by residents aged 65+ by LGA, FY2022-23



Source: VAED, Department of Health – Victoria, 2022/23.

Table 5.8 Hospital admissions among residents aged 65 or older by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Number of hospital admissions	Percentage of hospital admissions
Factors influencing health status and contact with health services	61.646	36.1
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	16,192	9.5
Injury, poisoning and certain other consequences of external causes	14,722	8.6
Diseases of the circulatory system	13,090	7.7
Neoplasms (cancer)	10,984	6.4
Diseases of the digestive system	8,533	5.0
Disease of the respiratory system	7,083	4,1
Disease of the musculoskeletal system and connective tissue	5,848	3.4
Diseases of the genitourinary system	5,160	3.0
Diseases of the eye and adnexa	5,140	3.0

Source: VAED, Department of Health – Victoria, 2022/23.

Excluding the broad ICD-10 categories of 'factors influencing health status and contact with health services', and 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified', the 5 most frequent diagnoses among residents aged 65 or older across the SEMPHN region were (Table 5.8):

- injury, poisoning and certain other consequences of external causes
- diseases of the circulatory system
- neoplasms (cancer)
- diseases of the digestive system
- diseases of the respiratory system.

A higher proportion of admissions among those aged 65 or older related to diseases of the circulatory system and neoplasms (cancer) compared with all hospital admissions across the SEMPHN catchment. The average length of stay for 65+ hospitalisations was 3.56 days, longer than the overall average of 2.98 days for all SEMPHN hospital admissions. Approximately 62% of admissions were same-day stays, 11% were overnight stays and 27% were multi-day stays.

References

Abud T, Kounidas G, Martin KR, Werth M, Cooper K and Myint PK (2022) 'Determinants of healthy ageing: a systematic review of contemporary literature', *Aging clinical and experimental research*:1-9.

Australian Bureau of Statistics (2021) *Estimating Homelessness: Census.* [data set], https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release, accessed 24 October 2024.

——— (2023a) *Causes of Death, Australia*, ABS, https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release, accessed 23 October 2024.

——— (2023b) Data by region 2011-2023, by ASGS main structure (ASGS Edition 3 (2021 – 2026)) [data set].

Australian Institute of Health and Welfare (2021) *Deaths web report*, https://www.abs.gov.au/statistics/research/classifying-place-death-australian-mortality-statistics/3303.0.55.005%20Classifying%20Place%20of%20Death%20in%20Australian%20Mortality%20Statistics%2C%202019.xlsx.

——— (2024a) *GEN data: Dashboard supplementary tables* [data set], https://www.gen-agedcaredata.gov.au/resources/access-data/2024/august/gen-data-dashboard-supplementary-tables.

——— (2024b) *Injury in Australia* [data set], https://www.aihw.gov.au/reports/injury/injury-in-australia/data.

——— (2024c) *Mortality Over Regions and Time (MORT) books* [data set], https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/contents/mort-books, accessed 23 October 2024.

——— (2024d) *Older Australians*, AIHW, Canberra.

COTA Australia (2023) Mental health and well-being during the COVID-19 Pandemic: The lived experience of Australians aged 75 and over, Barton, ACT.

Coulton C and Boekel C (2019) Research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice. 2017.

Dementia Australia (2022) *Dementia Action Week*, https://www.dementia.org.au/dementia-action-week.

Department of Health and Human Services (2019) *Care for people with chronic conditions: Guidelines for the Community Health Program*, https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/c/care-for-people-with-chronic-conditions-guide-for-community-health-program.docx.

Department of Veterans' Affairs (2022) *Statistics about the veteran population*, https://www.dva.gov.au/about-us/overview/research/statistics-about-veteran-population.

Franklin AE, Rhee J, Raymond B and Clayton JM (2020) 'Incorporating an advance care planning screening tool into routine health assessments with older people.', *Australian Journal of Primary Health*, 26(3):240-8.

Grindrod A, Boyd J, Trabsky M and Rumbold B (2019) *Public Health Public Health (PHPC) Quality End of Life (QEL) Indicators Project*, La Trobe University Public Health Palliative Care Unit, Melbourne, Australia.

Herrmann A, Carey ML, Zucca AC, Boyd LAP and Roberts BJ (2019) 'Australian GPs' perceptions of barriers and enablers to best practice palliative care: a qualitative study', *BMC Palliative Care*, 18:90.

Richter L and Heidinger T (2021) 'Hitting close to home: the effect of COVID-19 illness in the social environment on psychological burden in older adults', *Frontiers in Psychology*:4160.

South Eastern Melbourne Primary Health Network (2022) *GPs and Palliative Care - Survey results (unpublished)*.

——— (2024) Primary Mental Health Care Minimum Data Set FY23-24 [data set].

The Economist (2015) The 2015 Quality of Death Index: Ranking palliative care across the world

Thurber KA, Banks E, Joshy G, Soga K, Marmor A, Benton G, White SL, Eades S, Maddox R and Calma T (2021) 'Tobacco smoking and mortality among Aboriginal and Torres Strait Islander adults in Australia', *International journal of epidemiology*, 50(3):942-54.

Victoran Department of Health (2024) *Frailty*, https://www.health.vic.gov.au/older-people-in-hospital/frailty.

World Health Organization (2017) *Mental health of older adults*, https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults.

Chapter 6 Homelessness

- **Incidence:** significantly higher homelessness rates in Greater Dandenong (149.5 per 10,000 people) and Port Phillip (104.7 per 10,000 people) compared to overall rates for south east Melbourne (54.6 per 10,000 people)
- **Specialist homelessness service (SHS) utilisation:** 2.5% decrease in clients (2014-15 to 2022-23), with significant LGA variation: 43.9% decrease in Stonnington (418 fewer clients), 55.4% increase in Casey (1,454 more clients), and 48.8% increase in Cardinia (383 more clients).
- **High demand SHS locations:** Dandenong North, Frankston City Centre, and St Kilda Central; 59% of the 18,091 clients; most were female.
- **ED Presentations:** 17.7% increase (2019-20 and 2022-23), with the highest numbers in Greater Dandenong, Frankston and Port Phillip. Majority were male and 25-54 years old.
- **ED diagnoses:** 22.5% MH-related (markedly higher than the 3.5% across the general population), including schizophrenia, schizotypal, delusional disorders, psychoactive substance use, and mood disorders.

DEFINING HOMELESSNESS

A person is experiencing homelessness if they are living in supported accommodation for the homeless, boarding houses, temporary lodgings, severely crowded dwellings, or staying temporarily with other households (Australian Bureau of Statistics 2021a).

Population

On the night of the ABS 2021 Census, about 8,500 people (0.05%) in south east Melbourne reported they were at risk or experiencing homelessness (Australian Bureau of Statistics 2021b). The rates of homelessness in Greater Dandenong (149.5 per 10,000 people) and Port Phillip (104.7 per 10,000 people) were significantly higher than the overall rates for south east Melbourne (54.6 per 10,000 people) and Victoria (47.1 per 10,000 people). While Casey had the second-highest overall amount of homeless people, this represented a much smaller proportion of Casey's total population compared with Greater Dandenong, Port Phillip and Frankston (Table 6.1).

Table 6.1 People experiencing homelessness, ABS 2016 and 2021

LGA	People at risk or experiencing homelessness			
	N (ABS 2016)	ASR per 10,000 (ABS 2016)	N (ABS 2021)	ASR per 10,000 (ABS 2021)
Bayside	212	18.7	147	14
Cardinia	144	23.1	337	28
Casey	931	41.2	1,852	50
Frankston	465	41.2	785	56

LGA	People at risk or experiencing homelessness			
	N (ABS 2016)	ASR per 10,000 (ABS 2016)	N (ABS 2021)	ASR per 10,000 (ABS 2021)
Glen Eira	382	34.9	561	37
Greater Dandenong	1,515	121.9	2,366	148
Kingston	352	<0.1	544	34
Mornington Peninsula	272	21.7	421	25
Port Phillip	1,461	101.2	1,067	103
Stonnington	523	35.1	463	44
South east Melbourne	6,257	39.1	8,543	55
Victoria	24,825	41.9	30,605	47

Source: 2021 Census, ABS (June 2022).

Specialist Homelessness Service Utilisation

The Australian Institute of Health and Welfare (2024) released current and historical numbers of clients referred to specialist homelessness services (SHS) across Australia by location. The data spans from the 2014-15 FY to the 2022-23 FY. During this time period, substantial changes were observed in the utilisation of SHS services across the SEMPHN region.

Overall, the number of clients accessing SHS in south east Melbourne decreased by 2.5% between the 2014-15 and 2022-23 FYs (Table 6.2). Yet there were variations among different LGAs. For example, Stonnington experienced a decrease of 43.9% (418 fewer clients), while Casey and Cardinia saw increases of 55.4% (1,454 more clients) and 48.8% (383 more clients), respectively. These changes demonstrate the increasing number of people at risk of or experiencing homelessness in Casey, Cardinia and Greater Dandenong, and highlight the need to strategically provide and locate services to support those more vulnerable populations. Table 6.2 shows the total number of SHS clients recorded in the 2014-15 and 2022-23 FYs, as well as the change between these 2 FYs, for each SEMPHN LGA, as well as the south east Melbourne region and Victoria as a whole.

Table 6.2 Number of SHS clients by LGA, FY2014-15 to FY2022-23

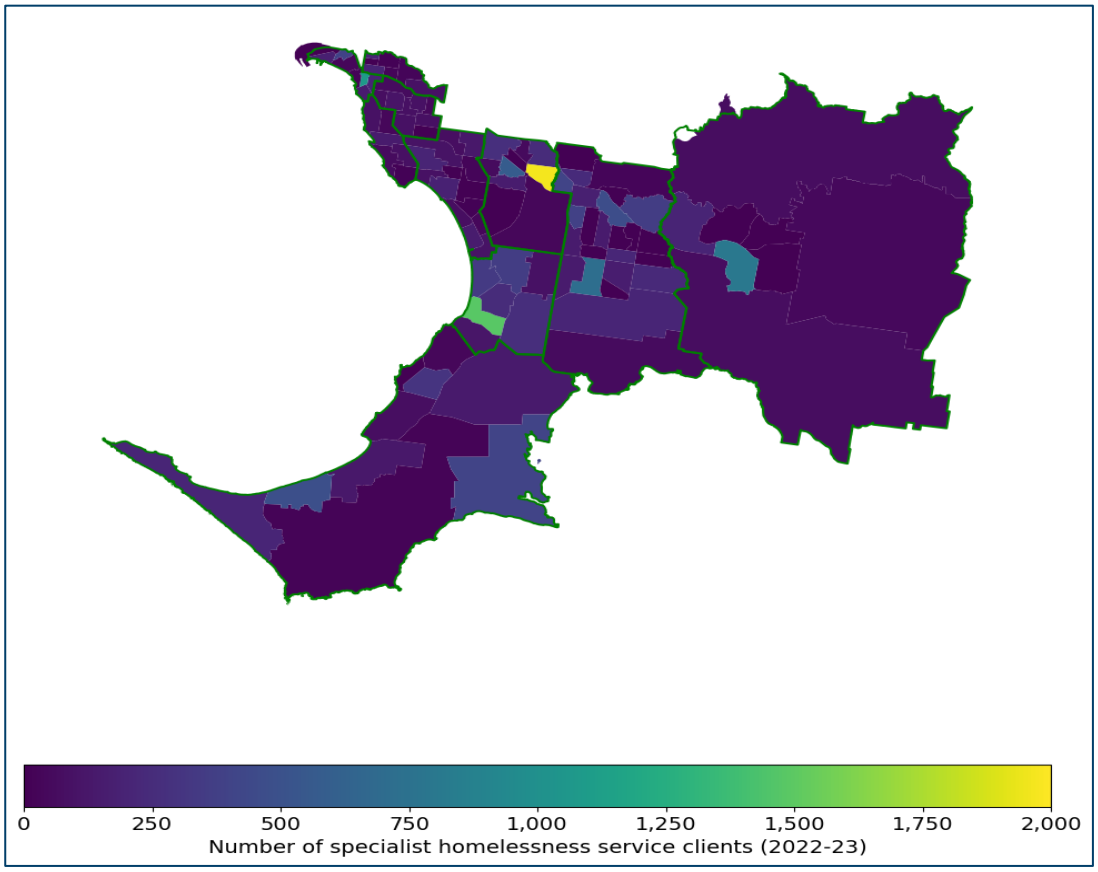
LGA	Number of SHS clients (FY2014–15)	Number of SHS clients (FY2022-23)	Change (%)
Bayside	713	433	-39.27%
Cardinia	784	1,167	48.85%
Casey	2,624	4,078	55.41%
Frankston	2,681	2,876	7.27%
Glen Eira		628	-41.91%

LGA	Number of SHS clients (FY2014–15)	Number of SHS clients (FY2022-23)	Change (%)
Greater Dandenong	2,764	3,357	21.45%
Kingston	1,596	1,177	-26.25%
Mornington Peninsula	2,121	1,784	-15.89%
Port Phillip	3,246	2,057	-36.63%
Stonnington	952	534	-43.91%
South east Melbourne	18,562	18,091	-2.54%
Victoria	90,029	88,755	-1.42%

Source: AIHW, 2024.

Figure 6.1 depicts the number of SHS clients by SA2 across SEMPHN in the 2022-23 FY, and highlights localities (SA2s) with particularly high numbers of residents accessing SHS. The 3 SA2s with the largest number of people accessing SHS were Dandenong – North (n=1,966), Frankston [City Centre] (n=1,479) and St Kilda – Central (n=1,081). Of the 18,091 SHS clients in south east Melbourne during FY2022-23, over half (59%) were female and 41% were male.

Figure 6.1 Number of SHS clients in south east Melbourne region by SA2, FY2022-23



Source: 2021 Census, ABS (June 2022). Note SA2 = Statistical Area Level 2 (population between 3,000 and 25,000).

Tertiary care insights

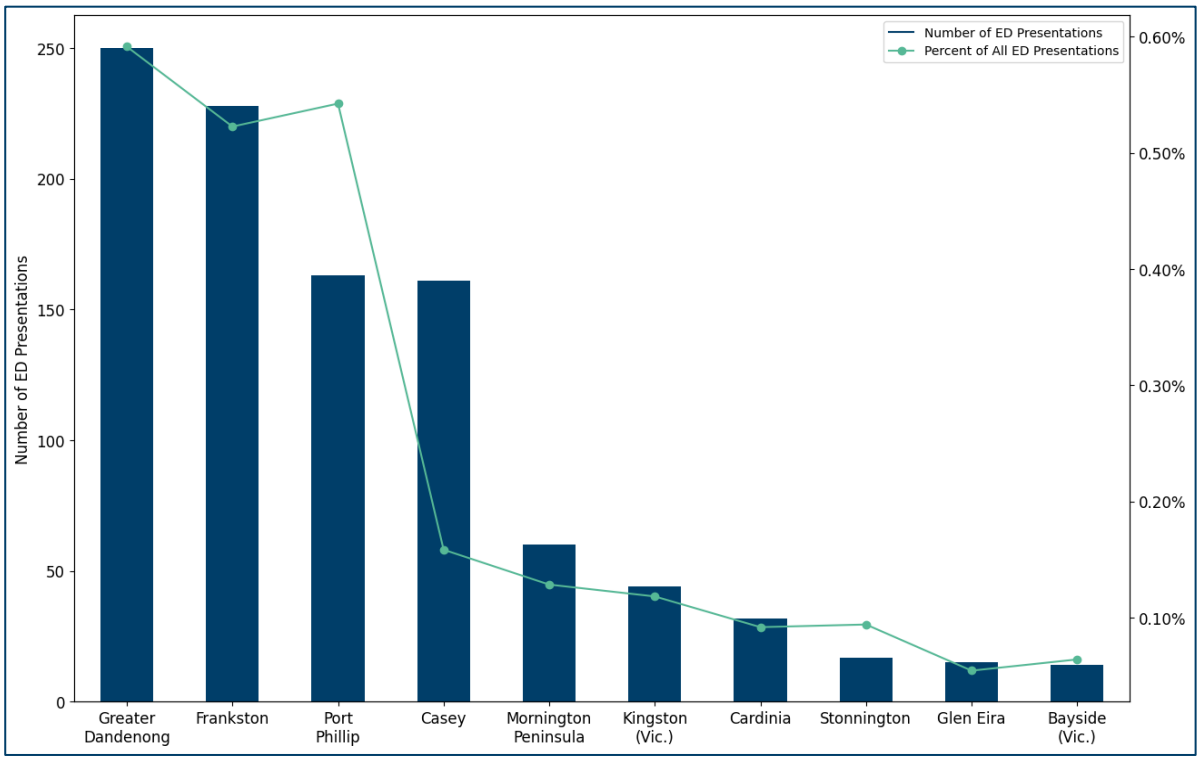
ED PRESENTATIONS

The VEMD collects information about the type of usual accommodation cited by those who present at public EDs across Victoria (Victorian State Government 2024). The 2 categories of 'homeless persons' shelter' and 'public place (homeless)' primarily represent the number of people currently experiencing homelessness and their need for tertiary healthcare. Although it should be noted that this data does not capture all people experiencing or at risk of homelessness in south east Melbourne.

Between the 2019-20 and 2022-23 FYs, ED presentations by individuals whose usual accommodation was listed as a homeless shelter or public place increased by 17.7% (148 more presentations) across south east Melbourne. This represents an approximate annual increase of 4.4%, with a small decrease observed in 2020-21 FY, likely due to the COVID-19 lockdown period.

In the 2022-23 FY, there was a total of 984 ED presentations by individuals who stated their usual accommodation was a homeless shelter or public place. Greater Dandenong had the highest number (n=250) and proportion (0.59%) of all ED presentations from these individuals, followed by Frankston (n=228, 0.52%) and Port Phillip (n=163, 0.54%). These findings were consistent with previously reported data from the ABS and the AIHW regarding the population of people at risk of or experiencing homelessness in these regions (Figure 6.2).

Figure 6.2 ED presentations by individuals experiencing homelessness by LGA, FY2022-23

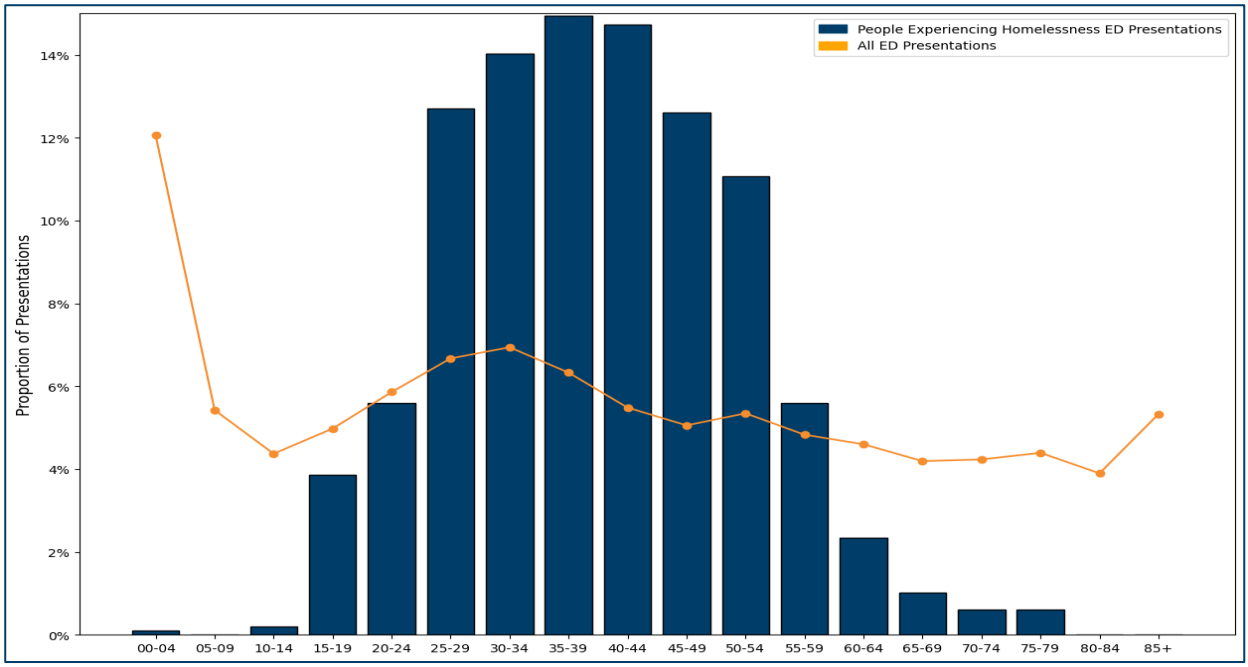


Source: VEMD, Department of Health – Victoria, 2022/23.

Among the ED presentations by individuals currently experiencing homelessness, the majority (72.1%) were male. Approximately 80% of these presentations were by individuals aged 25-54 years old. In contrast, this age group (25-54 years) represented only 35.8% of all ED presentations across the overall population of SEMPHN residents (

Figure 6.3).

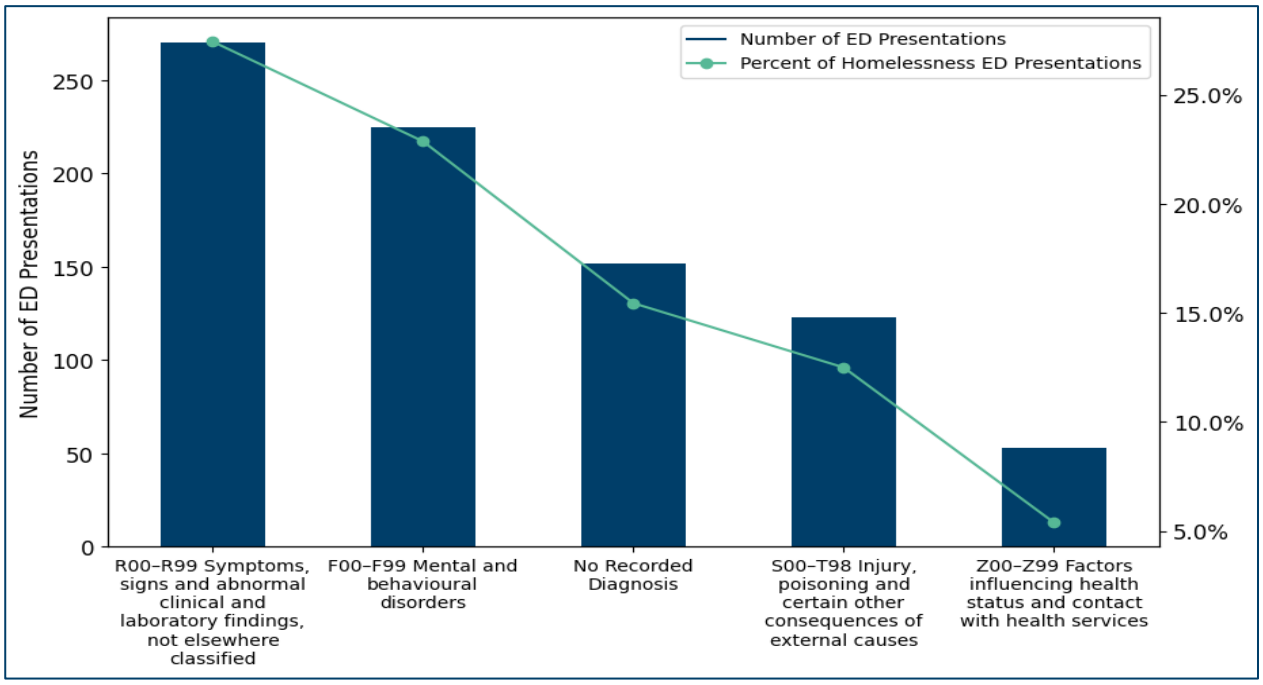
Figure 6.3 ED presentations by individuals experiencing homelessness by age, FY22-23



Source: VEMD, Department of Health – Victoria, 2022/23.

Approximately one in 5 (22.5%) ED presentations by people experiencing homelessness were for MH-related reasons. This proportion was markedly higher than the 3.5% of all ED presentations that were MH-related cross the general population in the SEMPHN region. While MH-related ED presentations were the 10th most common diagnostic category across all south east Melbourne presentations, it was second highest for those experiencing homelessness (Figure 6.3). This indicates a substantially higher MH burden or unmet MH need in this priority population.

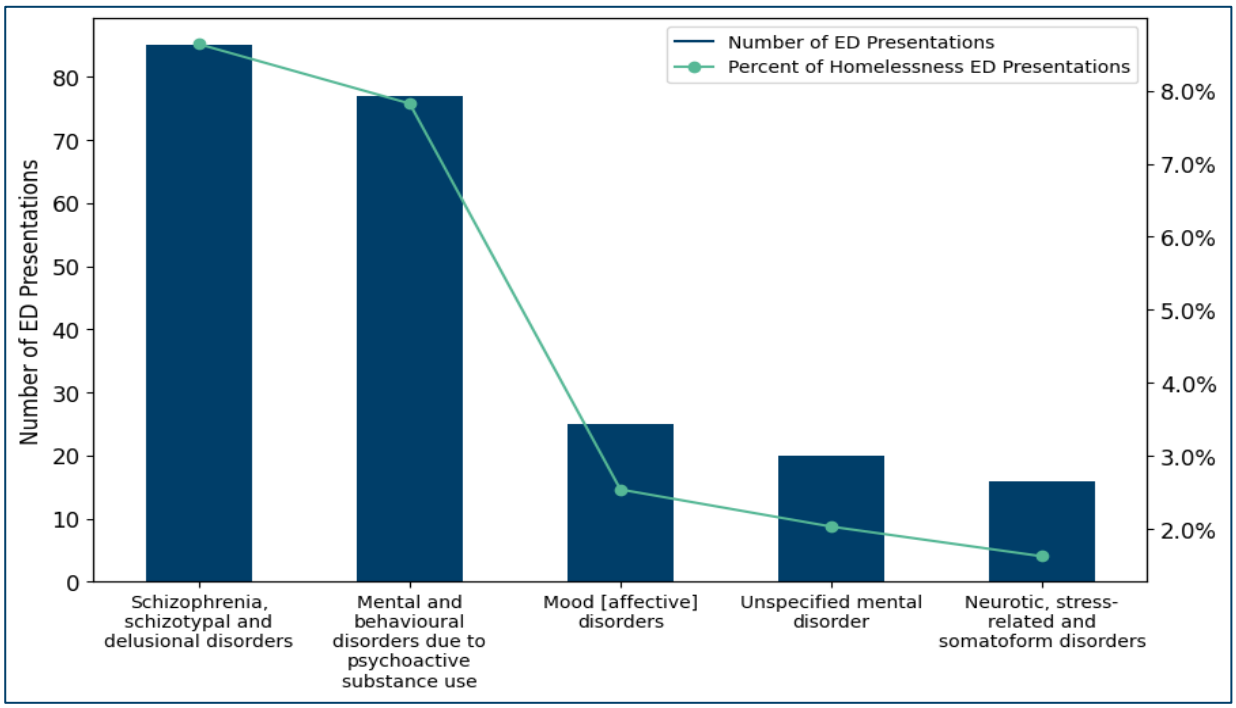
Figure 6.4 ED presentations by individuals experiencing homelessness by broad diagnosis category, FY2022-23



Source: VEMD, Department of Health - Victoria, 2022/23.

Among the MH-related ED presentations by individuals experiencing homelessness, the most common MH diagnoses were schizophrenia, schizotypal and delusional disorders (Figure 6.5). This was followed by mental and behavioural disorders due to psychoactive substance use, and mood disorders. ED presentations relating to schizophrenia represented more than 8% of all ED presentations by homeless individuals, whereas they comprised less than 1% of ED presentations in the overall population of SEMPHN residents.

Figure 6.5 ED presentations by individuals experiencing homelessness by specific MH diagnosis category, FY2022-23



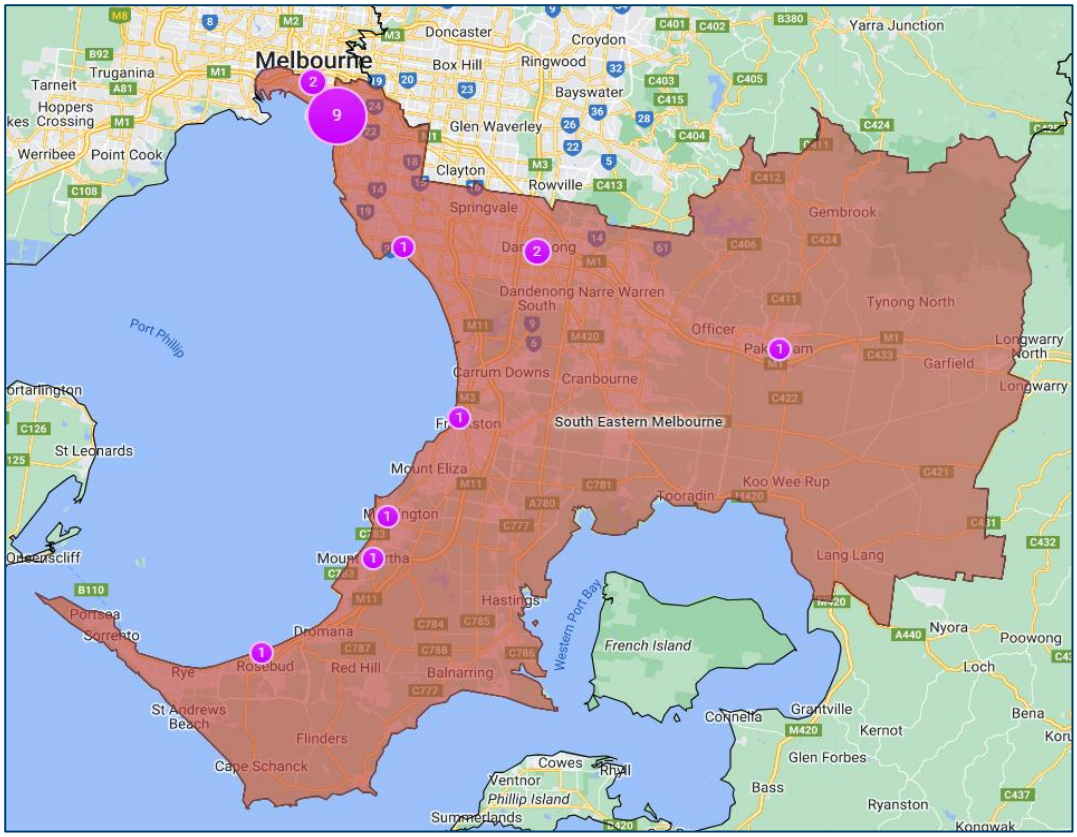
Source: VEMD, Department of Health - Victoria, 2022/23.

HOMELESSNESS SUPPORT SERVICES

As of June 2023, the NHDS had records for at least 19 homelessness support services in the south east Melbourne region. Services were primarily distributed in the north western (inner-city) portion of the region, located in the LGAs of Port Phillip, Stonnington, Bayside and Dandenong. A notable absence of services was observed in Casey (south) and Cardinia (

Figure 6.6).

Figure 6.6 Map of community care – homelessness support services (SHS), 2023



Source: Health Direct – Health Map, NHSD, June 2023.

For people at risk of homelessness, they can be people hoarding, living in squalor, financially disadvantaged, or with mental health conditions.

They're very transitional and like a lot of mental health attached to it, so unfortunately, they got banned from services.

References

Australian Bureau of Statistics (2021a) *Estimating Homelessness: Census methodology*, ABS, https://www.abs.gov.au/methodologies/estimating-homelessness-census-methodology/2021.

——— (2021b) *Estimating Homelessness: Census.* [data set], https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release, accessed 24 October 2024.

Australian Institute of Health and Welfare (2024) *Homelessness and homelessness services*, AIHW, Australian Government, https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services, accessed 2 October 2024.

Victorian State Government (2024) *Victorian Emergency Minimum Dataset (VEMD) manual 2024-25*, Melbourne, Australia.

Chapter 7 Mental health (MH)

- **Geographic Variation**: Frankston had the highest rate of MH conditions (116.1 per 1,000 residents), while Port Phillip reported the lowest rate of life satisfaction (27.8%) and highest rate of psychological distress (27.3%) in the region.
- **MH Diagnoses**: highest in Casey (22.4%), followed by Mornington Peninsula (14.4%) and Frankston (11.5%), particularly among 25-54 year olds.
- **GP Consultations**: Residents with a MH condition consulted a GP once every 3 months, while those without a MH diagnosis consulted a GP once every 4 months.
- **Diagnoses Prevalence**: anxiety (8.5%) and depression (7.7%) most common.
- **Chronic Disease Comorbidities**: most common are musculoskeletal issues (back ache, osteoarthritis, and lower back pain) at one in 4 residents, followed by cardiovascular and respiratory conditions at one in 6 residents.
- **Headspace:** 9 centres, with an 8.6-day average wait time to intake/access across all centres, peaking in July and August 2022 at 10.7 and 10.6 days, respectively.

MH and suicide prevention

MH is a state of well-being in which every individual realises their own potential, can cope with the normal stressors of life, can work productively and fruitfully, and is able to make a contribution to their community (World Health Organization 2022). This includes a person's emotional, psychological and social well-being, which can significantly affect a person's quality of life.

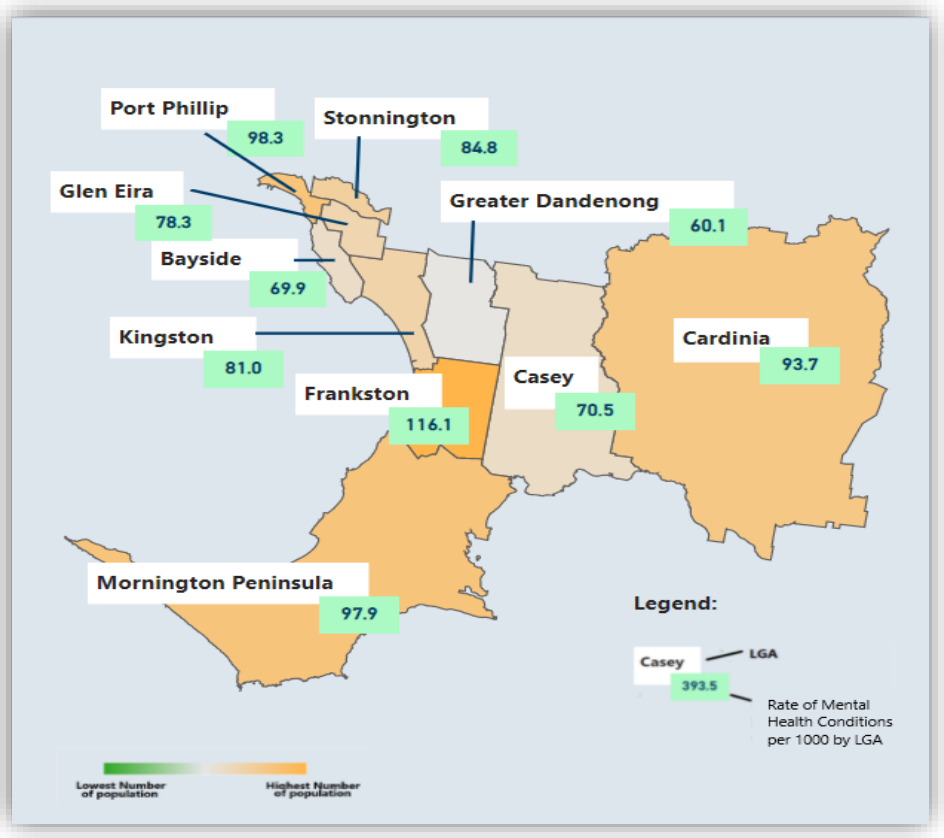
Mental illness has been defined as 'a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities' (National Mental Health Commission 2018). Mental illness covers a range of conditions, including anxiety disorders, affective disorders, psychotic disorders and substance use disorders (Australian Institute of Health and Welfare 2021a). In the 12 months prior to the 2020-21 National Study of Mental Health and Well-being Survey, one in 5 Australians (21.4%) experienced a MH disorder (Australian Institute of Health and Welfare 2022c), and in 2020-21, one in 6 Australians (16.8%) experienced an anxiety disorder (Beyond Blue 2022). Different populations and age groups are more likely to experience MH issues during their lifetime (Australian Institute of Health and Welfare 2022b). These include people living in regional and remote areas, First Nations people, CALD communities and the LGBTIQA+ community (Mental Health Australia 2022).

MH CONDITIONS

According to the ABS 2021 Census, approximately 130,000 people (ASR: 82.7 per 1,000) in south east Melbourne were living with a MH condition (including depression or anxiety). This rate was lower than for Victoria (n=571,149; 87.8 per 1,000) and Australia (n=2,231,546, 87.7 per 1000). Local MH hotspots included Frankston (116.1 per 1,000 people), Port Phillip (98.3 per 1,000) and Mornington Peninsula (97.9 per 1,000) (

Figure 7.1). Age and gender profiles in south east Melbourne indicate that females between 25-34 years (n=15,724, ASR: 121.6 per 1,000), and men aged 25-34 years (n=8,459, 65.4 per 1,000) and 35-44 years (n=8,429, ASR: 65.2 per 1,000) had higher rates of MH conditions.

Figure 7.1 Map for MH conditions per 1,000 people by LGA, 2021



Source: 2021 Census, ABS (June 2022).

LIFE SATISFACTION

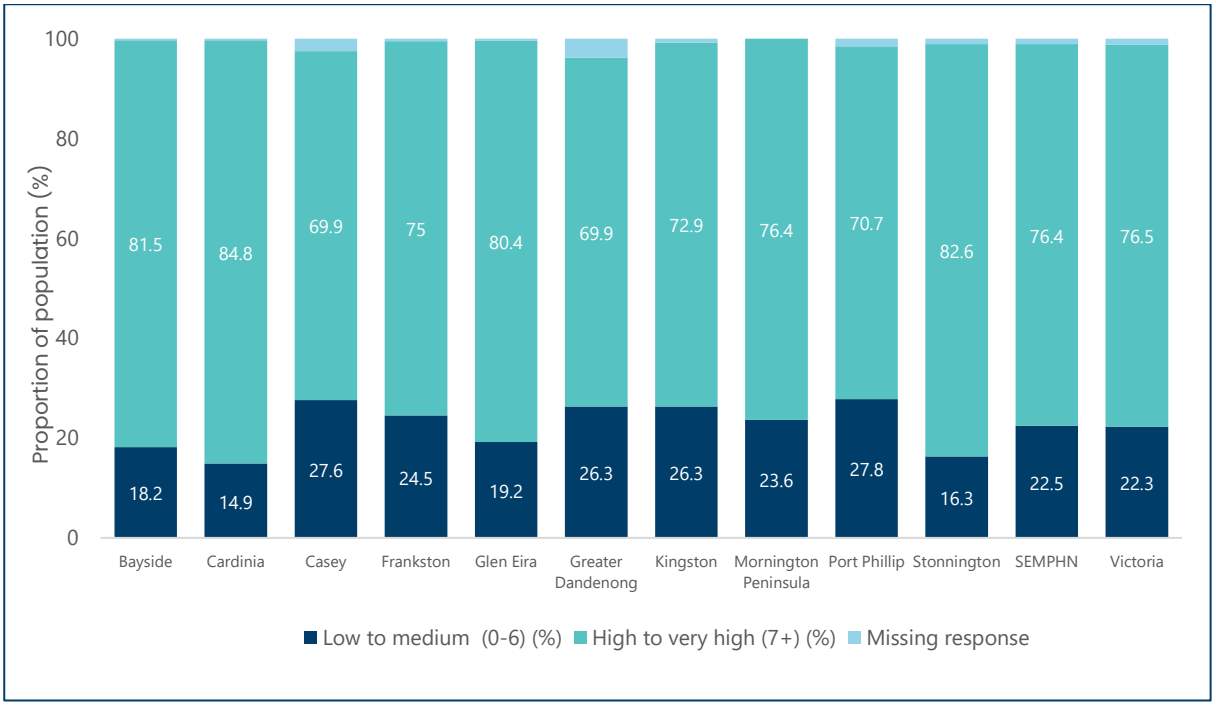
According to the latest 2022 Victorian Population Health Survey (Victorian Agency for Health Information 2023), the SEMPHN catchment area had rates of life satisfaction[20] that were mostly comparable to the Victorian average. In the SEMPHN catchment, 17.9% of residents reported low or medium life satisfaction, 51.7% reported high life satisfaction, and 29.0% reported high life satisfaction. The corresponding rates for Victoria were 20.0% for low or medium life satisfaction, 51.5% for high life satisfaction, and 27.7% for very high life satisfaction.

While LGA-level data were not available from the most recent 2022 survey, the 2020 Victorian Population Health Survey (Victorian Department of Health 2021) showed that half of the LGAs in south east Melbourne had lower rates of life satisfaction compared with the Victorian average. High rates of low to medium life satisfaction were observed in Port Phillip (27.8%), Casey (27.6%), Greater Dandenong (26.3%) and Kingston (26.3%) (

[20] Life satisfaction is a self-reported measure of a person's well-being and happiness. Using the Office of National Statistic 4 (ONS4) scale in 2020, survey respondents were asked to indicate how satisfied they were with their lives by choosing a score on an 11-point scale of 0 to 10, where 0–4 was classified as low, 5–6 medium, 7–8 high and 9–10 very high. The survey found that life satisfaction in Australia fell from a score of 7.5 out of 10 in 2019 to 7.2 in mid-2020.

Figure 7.2).

Figure 7.2 Life satisfaction by LGA, 2020



Source: Victorian Population Health Survey, 2020; Estimates by LGA (mental health and well-being – life satisfaction).

Psychological distress

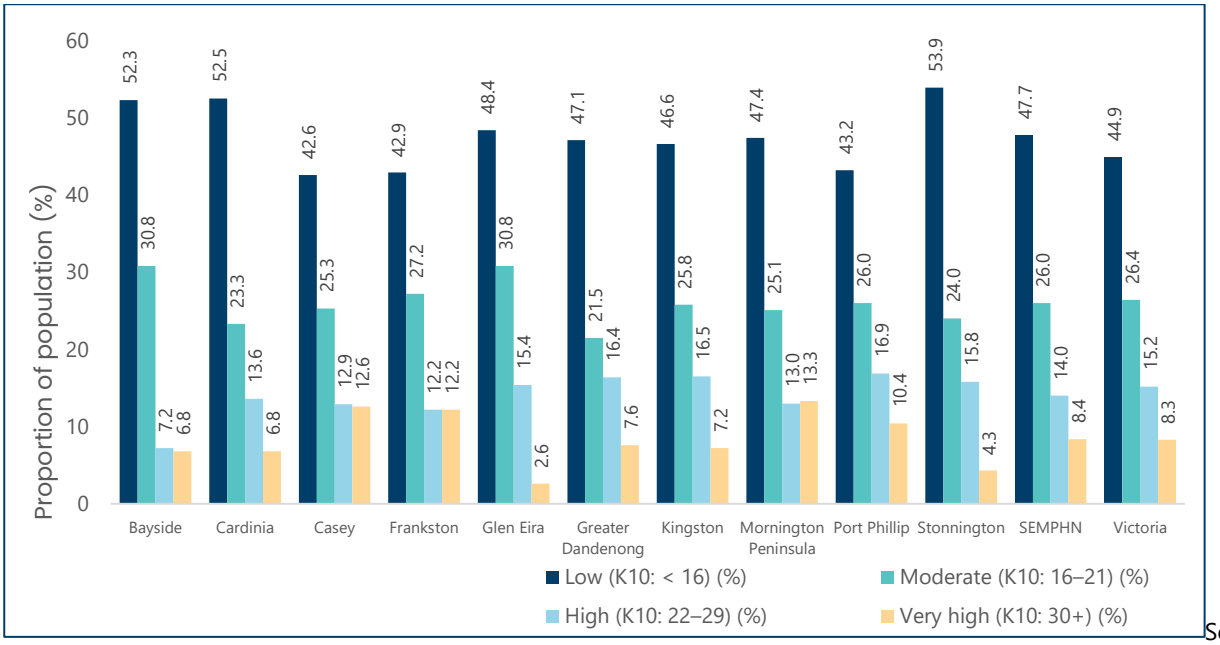
Psychological distress is a category of mental and physical symptoms associated with mood. More than one in 4 (27%) people living in Victoria experienced high or very high levels of psychological distress, compared with 18% in other jurisdictions across Australia (Australian Bureau of Statistics 2021).

According to the most recent 2022 Victorian Population Health Survey (Victorian Agency for Health Information 2023), the levels of psychological distress in the SEMPHN catchment were consistent with the Victorian average. In the SEMPHN region, 47.8% of residents reported low psychological distress, 25.7% moderate, 14.5% high and 7.9% very high psychological distress. The corresponding rates for Victoria were 45.8% for low psychological distress, 26.1% for moderate, 15.2% for high and 8.1% for very high psychological distress.

While the most recent LGA-level data were not available, the previous 2020 Victorian Population Survey (Victorian Department of Health 2021) showed that higher levels of psychological distress (score of 22 or above) were recorded in Port Phillip (27.3%), Mornington Peninsula (26.3%), Casey (25.5%) and Frankston (24.4%) (

Figure 7.3).

Figure 7.3 Psychological distress (K10) by LGA, 2020



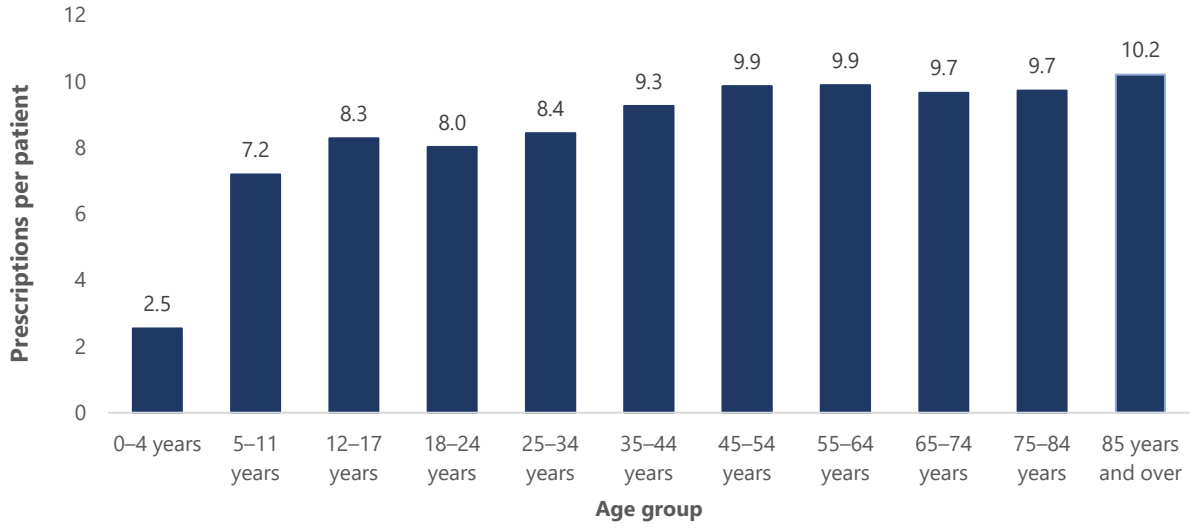
Source: Victorian Population Health Survey Dashboard, 2020; Estimates by LGA (mental health and well-being – level of psychological distress).

MH-RELATED PRESCRIPTIONS

In the 2021-22, 4.7 million patients (18% of the Australian population) filled a prescription for a MH-related medication, with an average of 9.4 prescriptions per patient (Australian Institute of Health and Welfare 2021b). MH-related prescriptions were classified according to the ATC Classification System (World Health Organization 2019). The MH-related medications dispensed to SEMPHN residents in the 2021-22 FY included psycholeptics, antipsychotics, anxiolytics, hypnotics, sedatives, psychoanaleptics, antidepressants, and psychostimulants and other agents used for ADHD and nootropics (Australian Institute of Health and Welfare 2021b)[21]. Figure 7.4 shows the proportions of MH-related prescriptions dispensed per patient across all SEMPHN resident age groups in 2021-22. For those above 45 years, the average prescriptions across the catchment was higher than the national average of 9.4 prescriptions per patient, in 2021-22 (Australian Institute of Health and Welfare 2021b).

[21] Table PBS.1: Drug groups defined for this report as MH-related medications in the Pharmaceuticals Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) data.

Figure 7.4 MH-related prescriptions in SEMPHN catchment by age, 2021–22

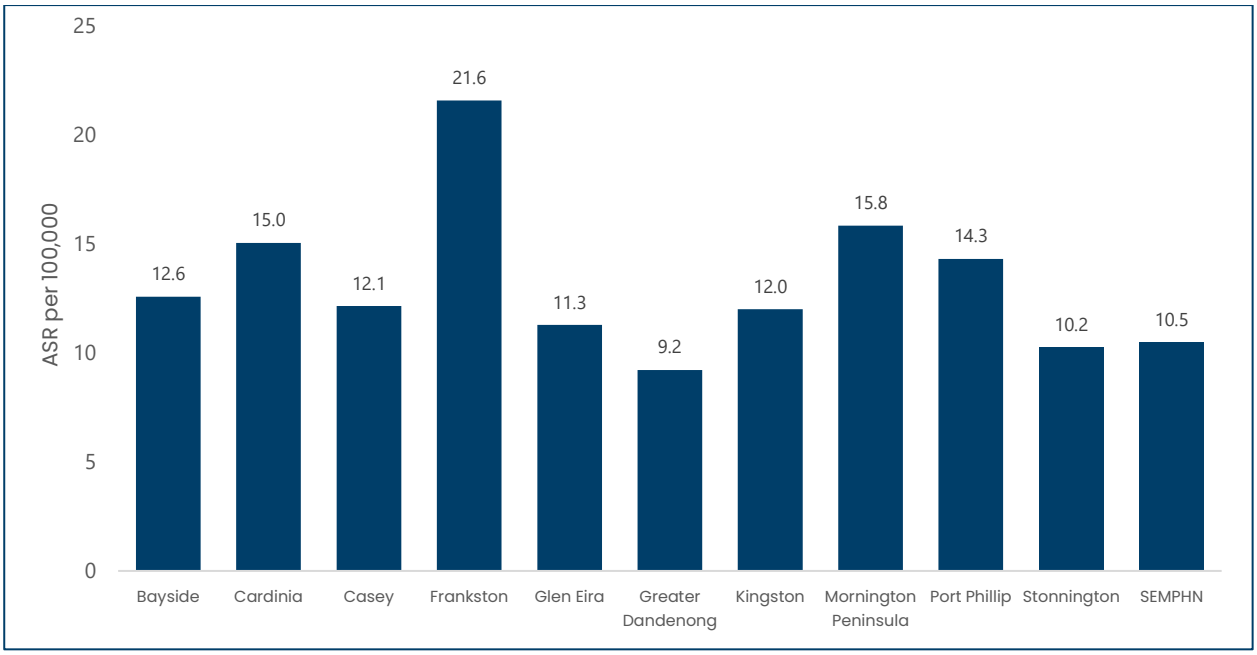


Source: AIHW, Table PBS.23: Patients and mental health-related prescriptions dispensed (subsidised and under co-payment), by PHN and demographic variables, 2014-15 to 2021–22

Suicide

In 2022, 3,249 Australians died by suicide (ASR 12.3 per 100,000). Each day, 8 to 9 Australians took their life; 3 in 4 were male. Nationally, suicide has been recognised as the leading cause of death for people aged between 15 and 44 years (Lifeline 2022; Australian Institute of Health and Welfare 2022a). Between 2016 and 2020, the rate of death by suicide or self-inflicted injuries in south east Melbourne among those under 75 years of age (10.5 per 100,000) was similar to the Victorian rate (10.6 per 100,000) (Figure 7.5). The highest rates of death by suicide were observed in Frankston (21.6 per 100,000), Mornington Peninsula (15.8 per 100,000) and Cardinia (15.0 per 100,000).

Figure 7.5 Deaths by suicide and self-inflicted injuries in persons <75 years by LGA, 2016-2020



Source: PHIDU, 2021.

Primary care insights

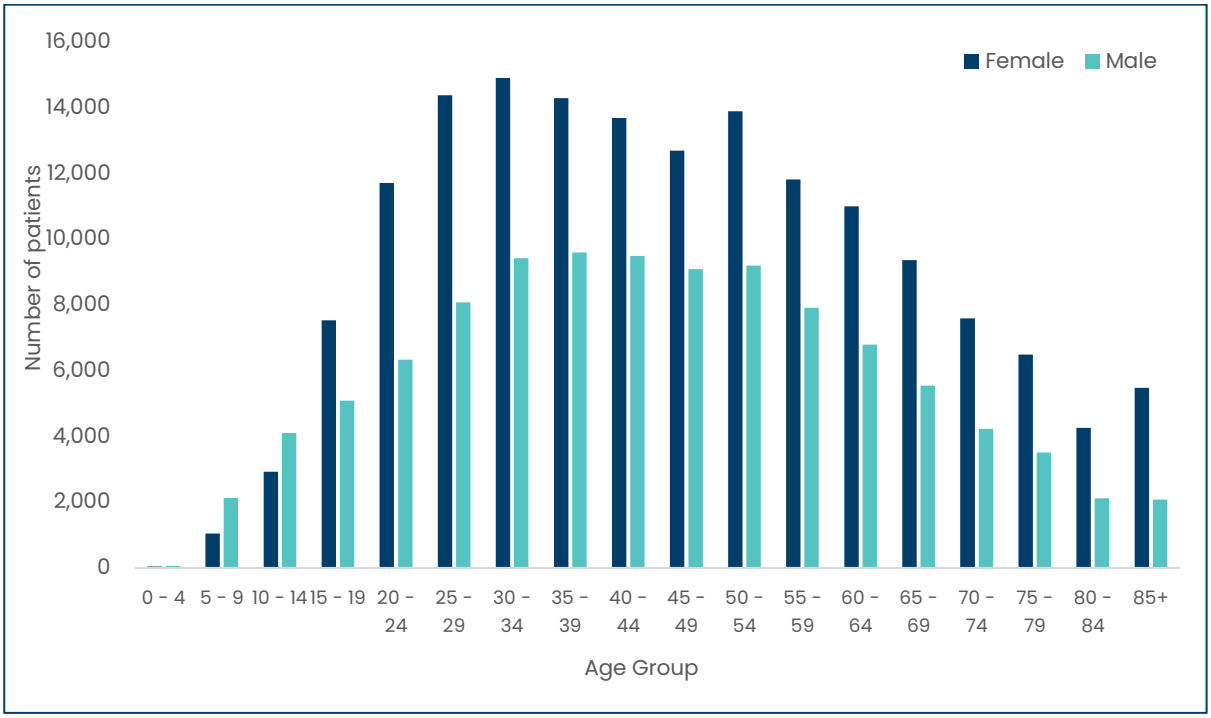
MH in General Practice

Data from general practices across the SEMPHN region show that of the approximate 1.6 million unique active patients in POLAR from May 2022 to May 2024, females (52.8%) were slightly more likely to access primary care for MH reasons, particularly those aged 20–39 years. The largest proportion of general practice patients were aged 35-39 years (9.7%), followed by 30-34 years (9.3%) and 40-44 years (9.3%). This age distribution was consistent with the SEMPHN region.

One in 6 (17.2%, n=268,742) patients had at least one recorded MH diagnosis, with approximately one-quarter of these having multiple comorbid MH diagnoses (e.g. anxiety and depression). Of these patients, 60.1% were female and 39.9% were male. While this was a higher proportion of females compared with the general practice patient population, it was consistent with the contemporary understanding of higher MH prevalence in females (Australian Institute of Health and Welfare, 2021). These findings are indicative of the higher MH burden among females and the increased rate of primary healthcare use for MH-related concerns compared to males (Figure 7.6).

Patients with an MH diagnosis may also have a diagnosis in another broad chronic disease category grouping (e.g. cardiovascular, diabetes, cancer), often referred to as chronic disease comorbidity. Among individuals with an active MH diagnosis, the most frequent chronic disease comorbidity was musculoskeletal for one in 4 patients (specifically diagnoses of backache, osteoarthritis and lower back pain), followed by cardiovascular and respiratory conditions for one in 6 patients.

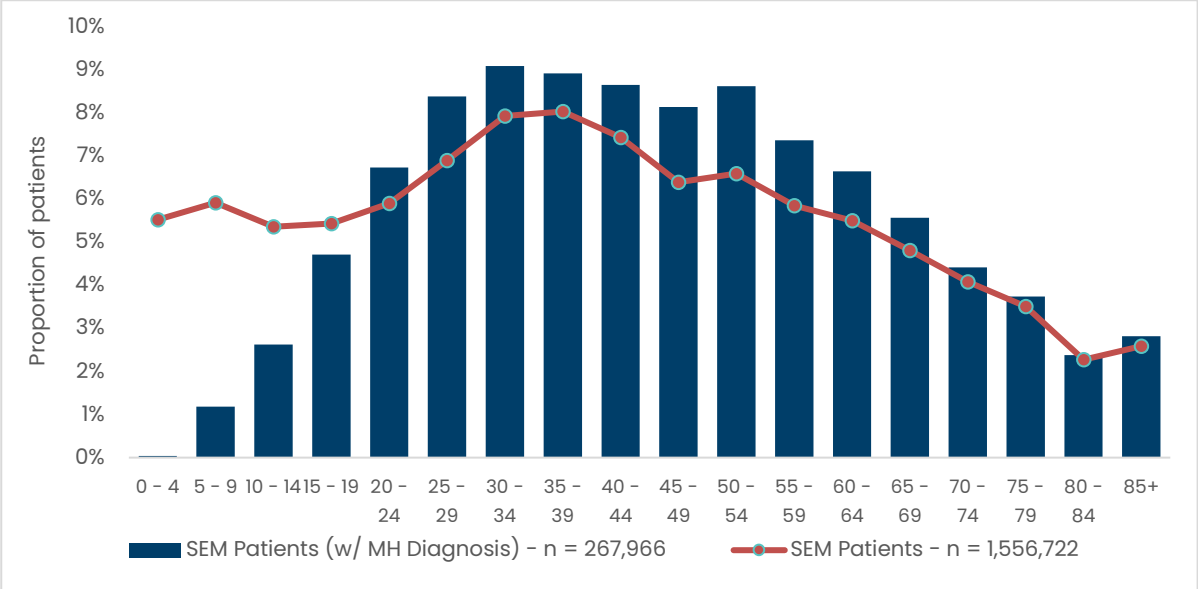
Figure 7.6 General practice patients with an active MH diagnosis by age and gender



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Figure 7.7 shows a higher proportion of patients aged 25–54 years with an active MH diagnosis (51.8%) compared with all active patients in the SEMPHN catchment (43.8%), as well as a low proportion of children with an active MH diagnosis (0-14 years).

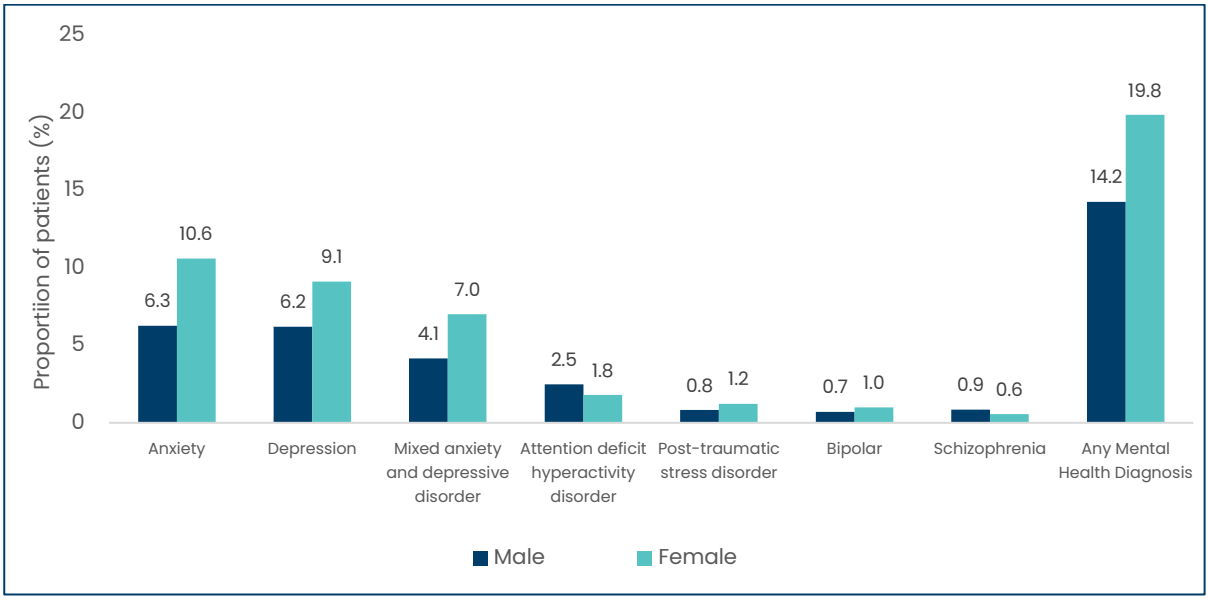
Figure 7.7 General practice patients by MH diagnosis and age



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Anxiety was the most prevalent MH-related diagnosis (8.5%) followed by depression (7.7%), mixed anxiety and depressive disorder (5.6%) and ADHD (2.1%). The prevalence of diagnoses more commonly associated with severe and complex MH needs such as PTSD (1.0%), BPD (0.9%) and schizophrenia (0.7%) varied from 0.7-1.0%. Females had a higher prevalence of previously listed MH diagnoses, with the exceptions of attention ADHD and schizophrenia (Figure 7.8).

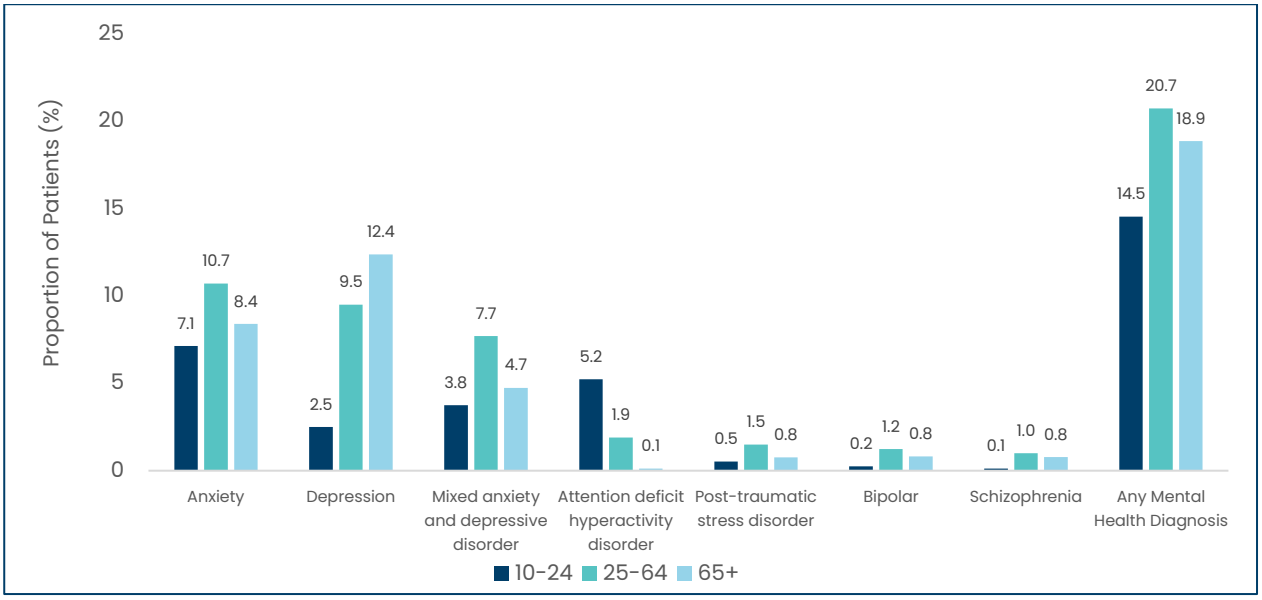
Figure 7.8 Prevalence of MH diagnoses for general practice patients by gender



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Patients with a MH diagnosis aged 10-24 years demonstrated the highest prevalence of ADHD (5.2%). Patients aged 25-64 years (approximately 850,000 people) had the highest proportional prevalence of any MH diagnosis, including anxiety, mixed anxiety and depression, PTSD, BPD and schizophrenia. Although patients aged 65 and over had the highest proportional prevalence of depression (12.4%), providing potential insight into this specific MH-related need for older people (Figure 7.9).

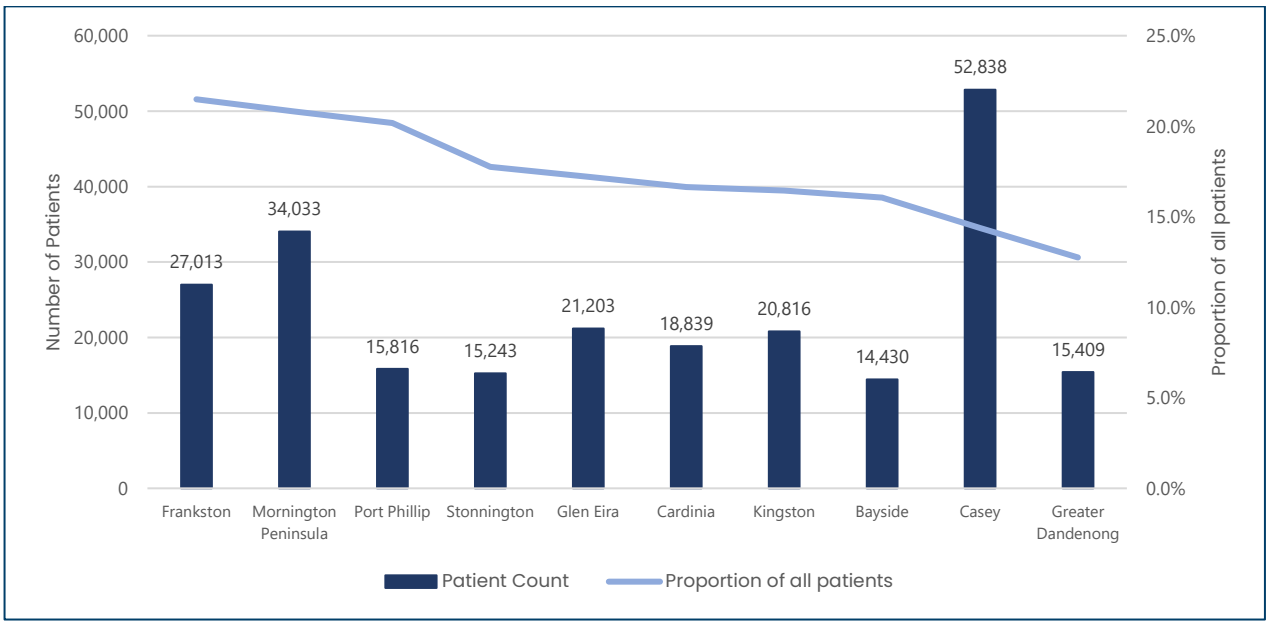
Figure 7.9 Prevalence of MH diagnoses for general practice patients by age



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Casey was home to the largest amount of unique active patients with a MH-related diagnosis (n=52,838), followed by Mornington Peninsula (n=34,033) and Frankston (n=27,013). Proportionally, just over 20% or one in 5 patients had an active MH-related diagnosis in Frankston (Figure 7.10).

Figure 7.10 Prevalence of MH diagnoses for general practice patients by LGA

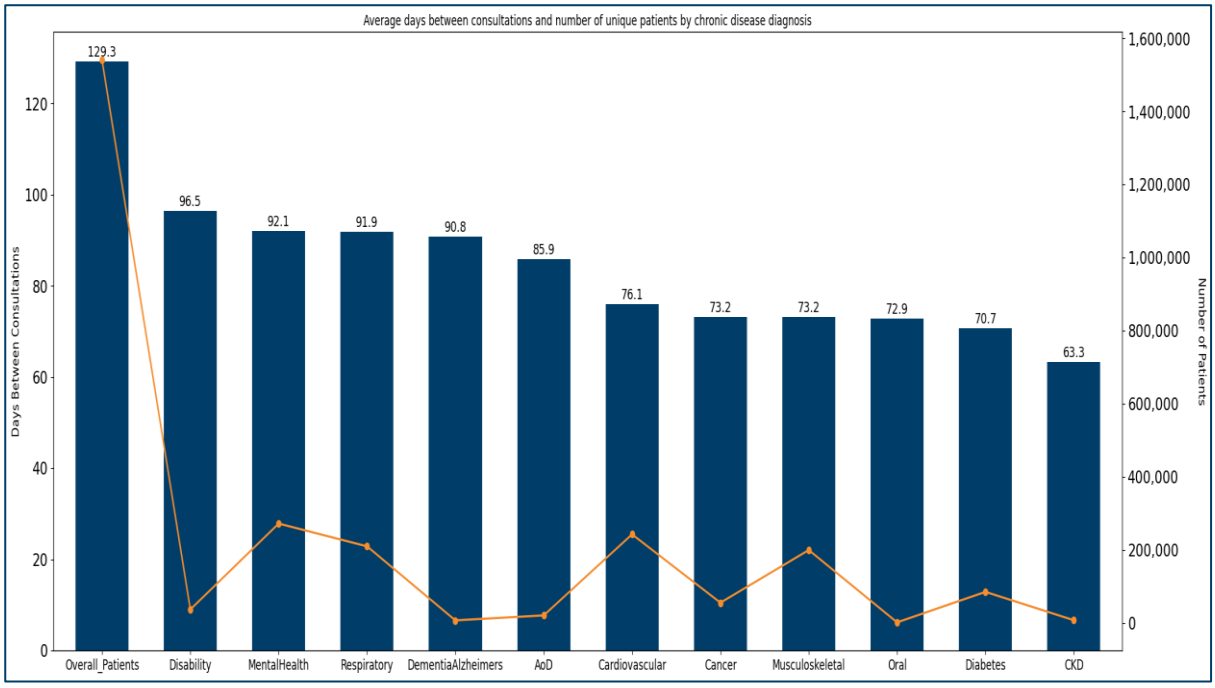


Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Patients with an active MH-related diagnosis (e.g. anxiety, depression, mixed anxiety and depression) on average attended one consultation with a POLAR-registered general practice every 3 months (92.1 days between consultations). For patients with a MH-related diagnosis, the time between consultations was shorter than the 4.3 month (129.3 day) average for patients with a chronic disease diagnosis (

Figure 7.11).

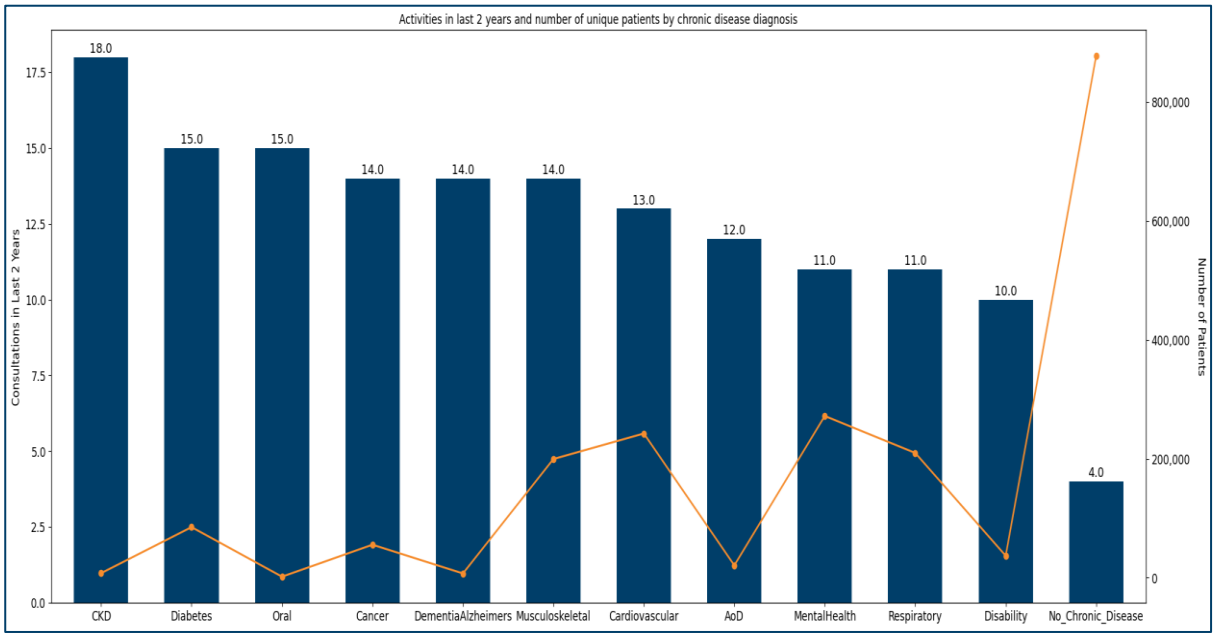
Figure 7.11 Average days between GP consultations by chronic disease diagnosis, July 2024



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Patients with an active MH-related diagnosis had attended a higher amount of GP consultations in the past 2 years (11 consultations) when compared with the median across the SEMPHN catchment (6 consultations). This is indicative of a higher primary healthcare need for this patient cohort (Figure 7.12).

Figure 7.12 Median number of GP consultations in past 2 years by chronic disease diagnosis, July 2024



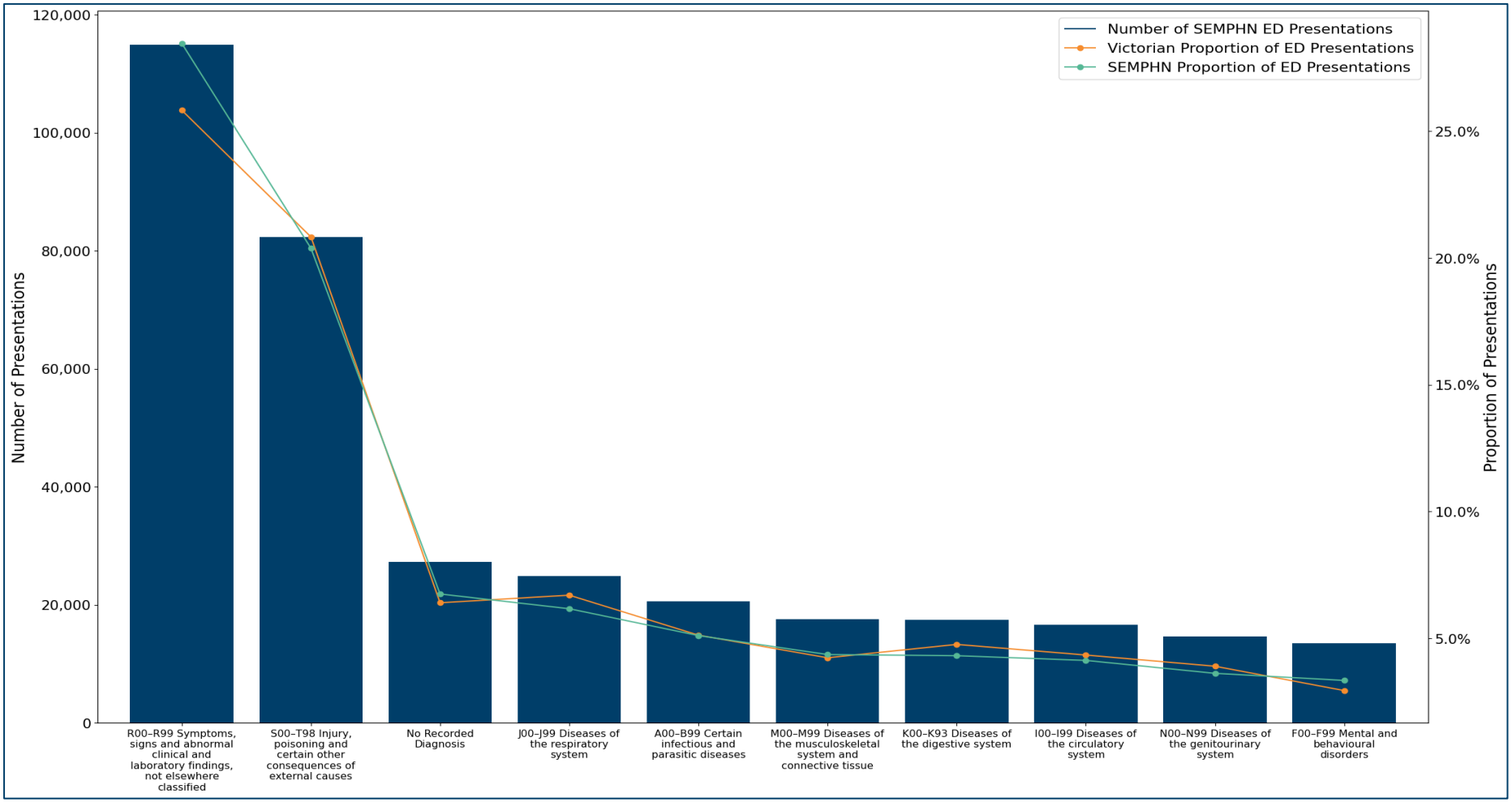
Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024. Note: Information surrounding chronic disease groups other than MH is available in Chapter 9 – Chronic Disease.

Tertiary care insights

ED PRESENTATIONS

A MH condition (e.g. F00-F99 Mental and Behavioural Disorders) was the 10th most frequent type of ED presentation in south east Melbourne, representing 3.3% of all ED presentations in the 2022-23 FY. This was marginally higher than the Victorian average for that same period (2.9%) (Figure 7.13).

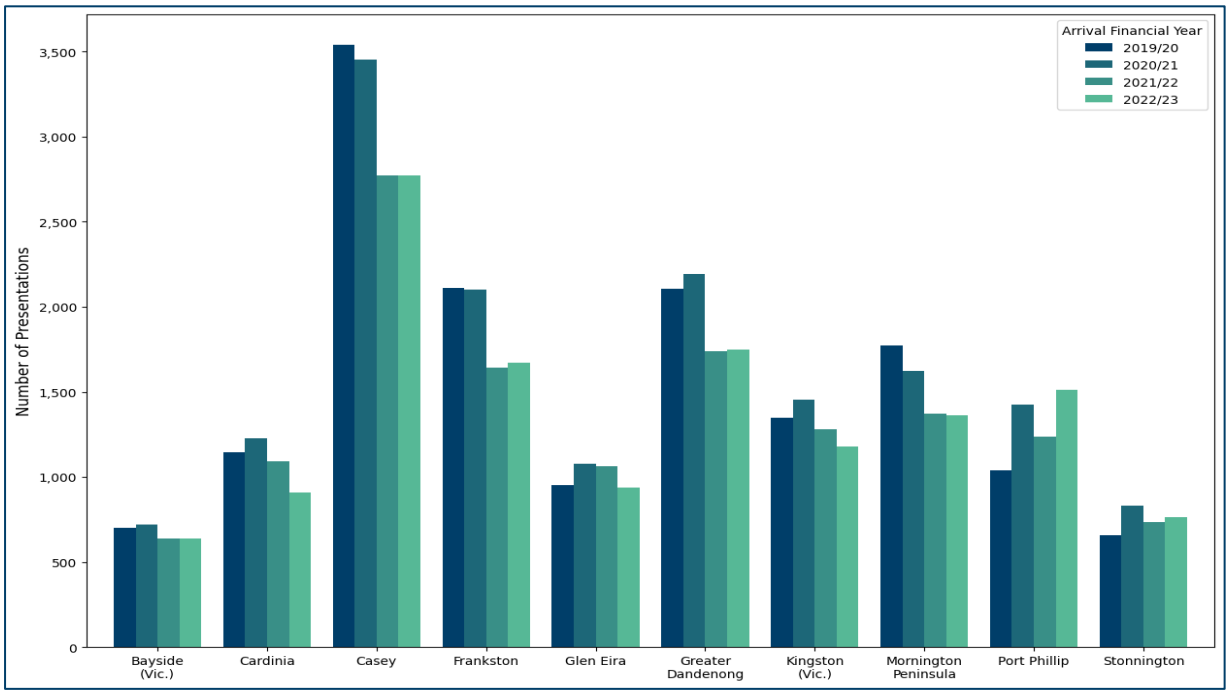
Figure 7.13 ED presentations by broad diagnosis category, FY2022-23



Source: VEMD, Department of Health - Victoria, FY2022/23.

MH-related ED presentations were at their highest in the FYs 2019-20 and 2020-21, representing approximately 4.1% and 4.3% of all ED presentations, respectively. These results were higher compared with the FYs 2021-22 (3.4%) and 2022-23 (3.3%). Most likely due to its large population size, residents from Casey made up the largest overall proportion (~20%) of all MH-related ED presentations across south east Melbourne over the last 4 FYs (Figure 7.14).

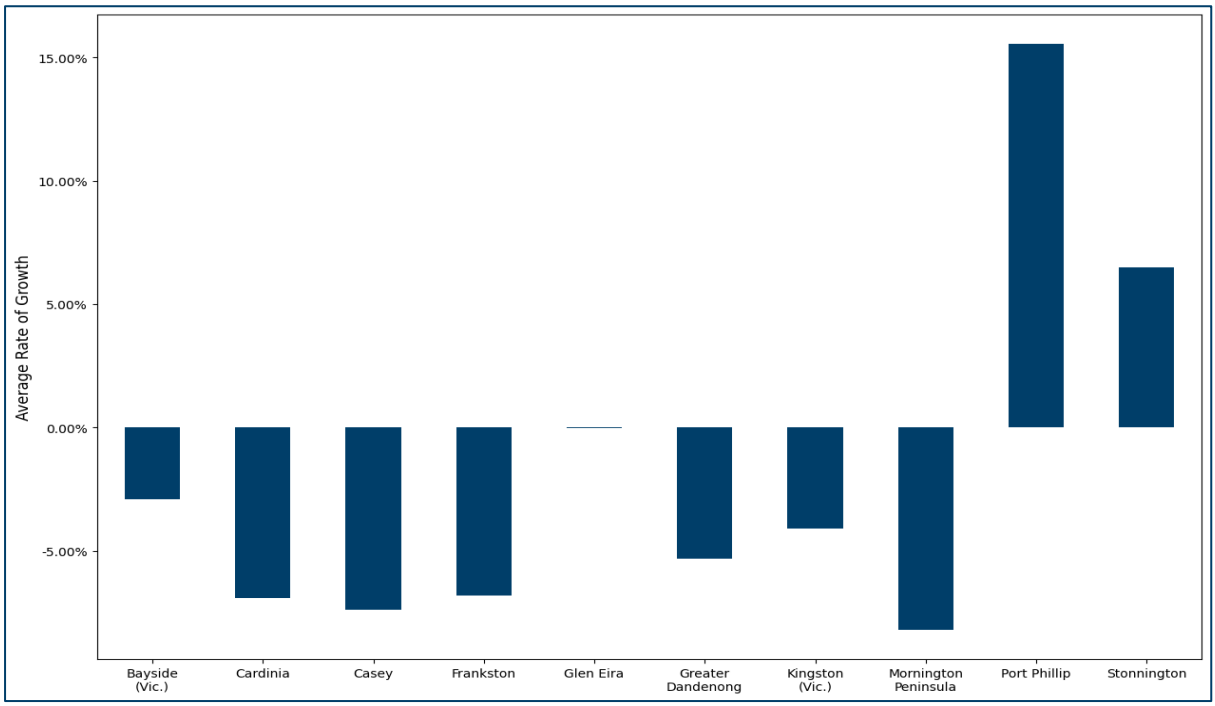
Figure 7.14 MH-related ED presentations by LGA, FY2019-20 to FY2022-23



Source: VEMD, Department of Health - Victoria, 2019-20 to 2022-23.

All LGAs in south east Melbourne experienced an overall decrease in the number of MH-related ED presentations between the FYs 2019-20 and 2022-23, except for the inner-city LGAs of Port Phillip and Stonnington. Port Phillip experienced a substantial average annual increase of 15.5%, while Stonnington experienced an average annual increase of 6.5% in MH-related ED presentations across this time period (Figure 7.15).

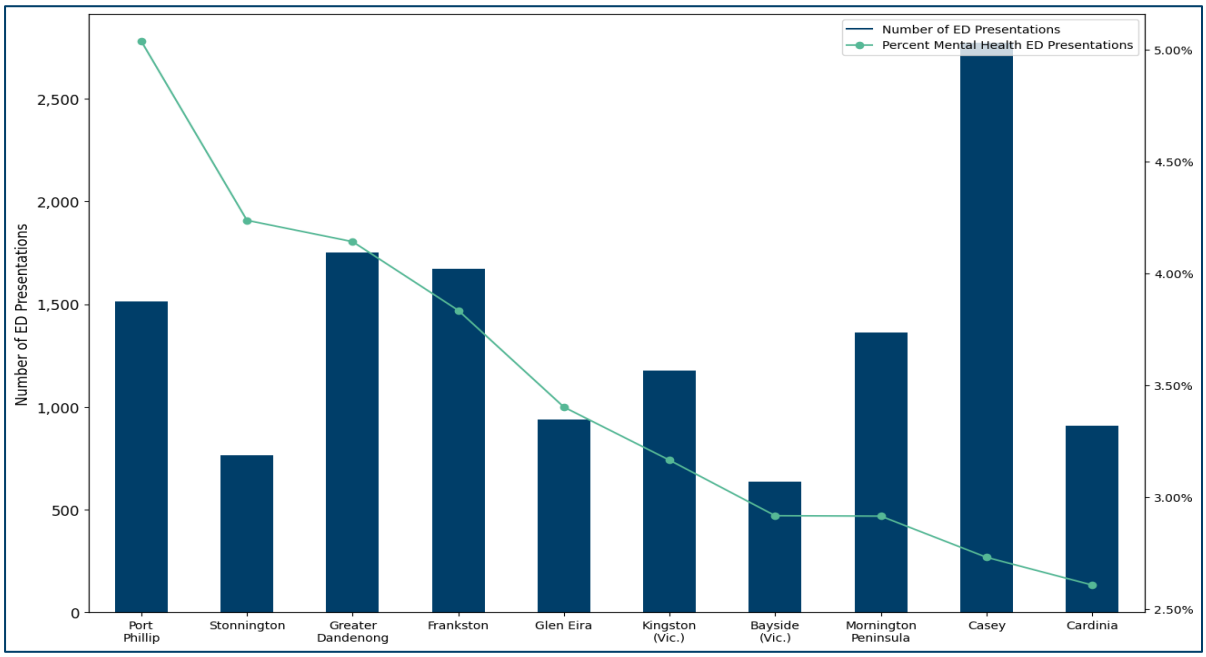
Figure 7.15 MH-related ED presentation growth between FY2019-20 and FY2022-2023



Source: VEMD, Department of Health - Victoria, 2019-20 to 2022-23.

In the 2022-23 FY, Port Phillip had the highest proportion of ED presentations related to MH (5.0%), followed by Stonnington (4.2%), Greater Dandenong (4.1%) and Frankston (3.8%). Casey and Cardinia had the lowest proportions of MH-related ED presentations at 2.7% and 2.6%, respectively (Figure 7.16).

Figure 7.16 MH-related ED presentations by LGA, FY2022-23

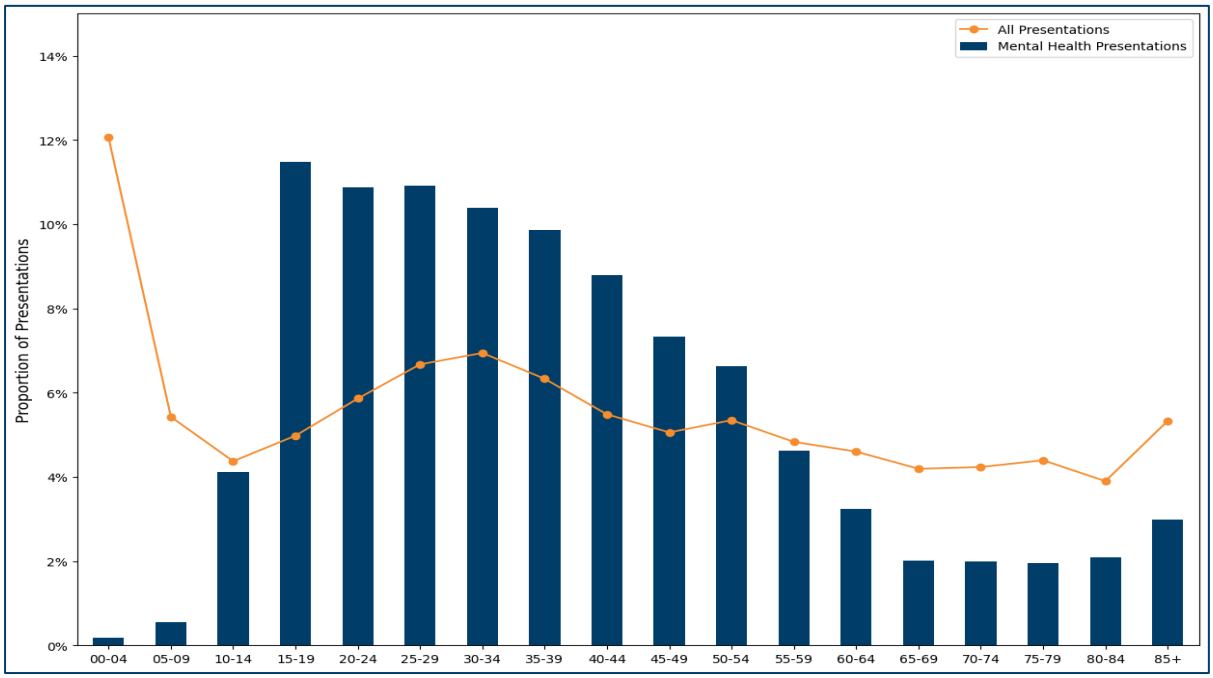


Source: VEMD, Department of Health - Victoria, 2022-23.

Throughout the 2022-23 FY, there were 13,497 ED presentations by patients residing in south east Melbourne related to MH concerns. Of these presentations, 50.1% were female, 49.7% were male and

0.25% were intersex, which was generally representative of the gender distribution of all ED patients. However, the age distribution differed significantly among patients presenting with MH-related concerns. There was a higher representation among younger age groups (15-39 years) and a lower representation among older groups (65+) and young children (0-9 years) (Figure 7.17).

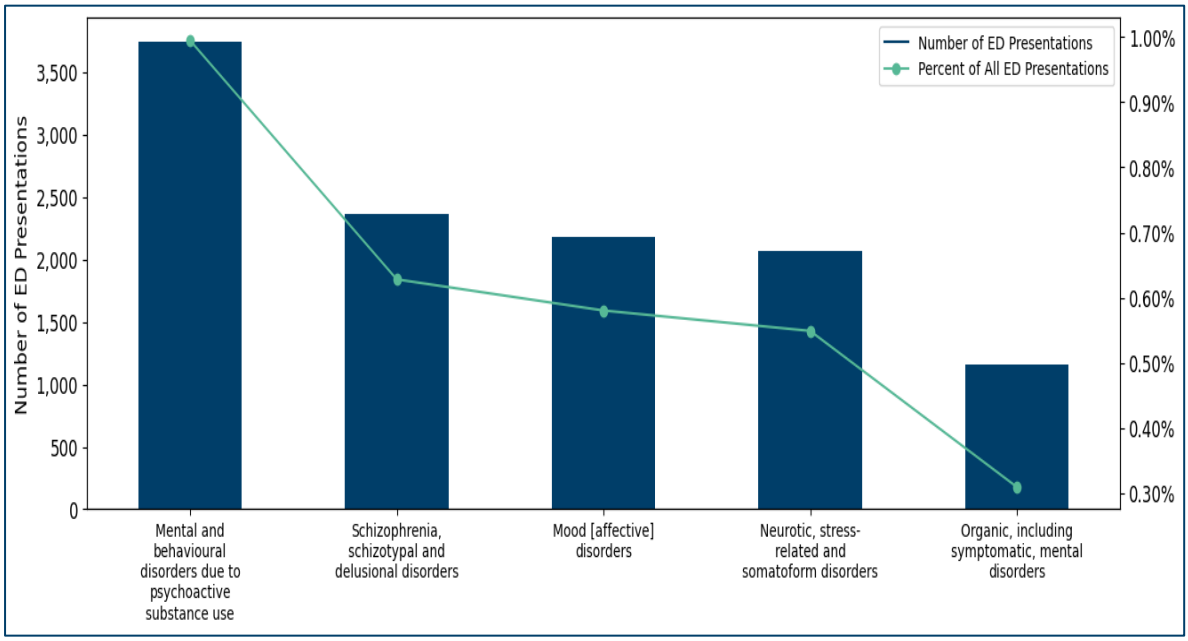
Figure 7.17 MH-related ED presentations by age, FY2022-23



Source: VEMD, Department of Health - Victoria, 2022-23.

Among the MH-related ED presentations, the most common specific diagnosis was mental and behavioural disorders due to psychoactive substance use. This was followed by schizophrenia, schizotypal and delusional disorders, and mood disorders.

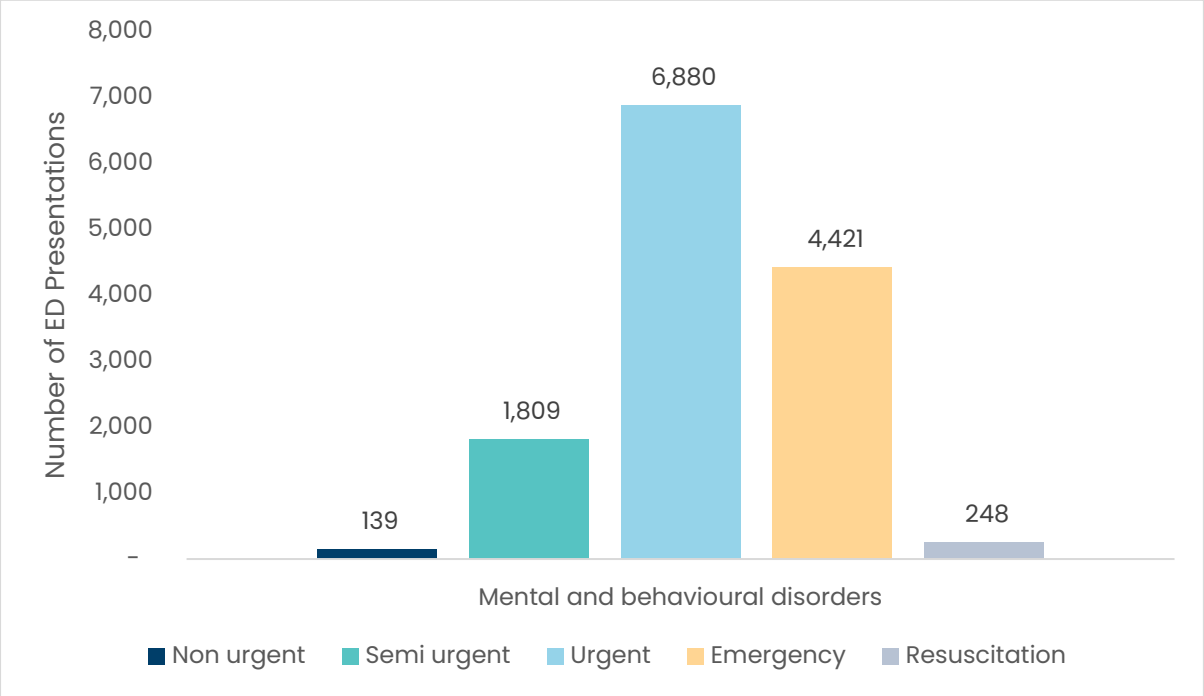
Figure 7.18 ED presentations by specific MH-related diagnosis category, FY2022-23



Source: VEMD, Department of Health - Victoria, 2022/23.

MH-related ED presentations were primarily (51%) categorised as urgent (triage category 3), followed by emergency (33%), which likely contributed to these presentations having the sixth shortest time-to-treatment of all primary diagnoses. Just under one in 6 MH-related ED presentations were of lower urgency (non-urgent or semi-urgent). Furthermore, MH-related ED presentations had the third longest average length of stay at 518 minutes (approximately 8.5 hours), significantly exceeding the SEMPHN average for all ED presentations at 332 minutes.

Figure 7.19 MH-related ED presentations by triage category, FY2022-23

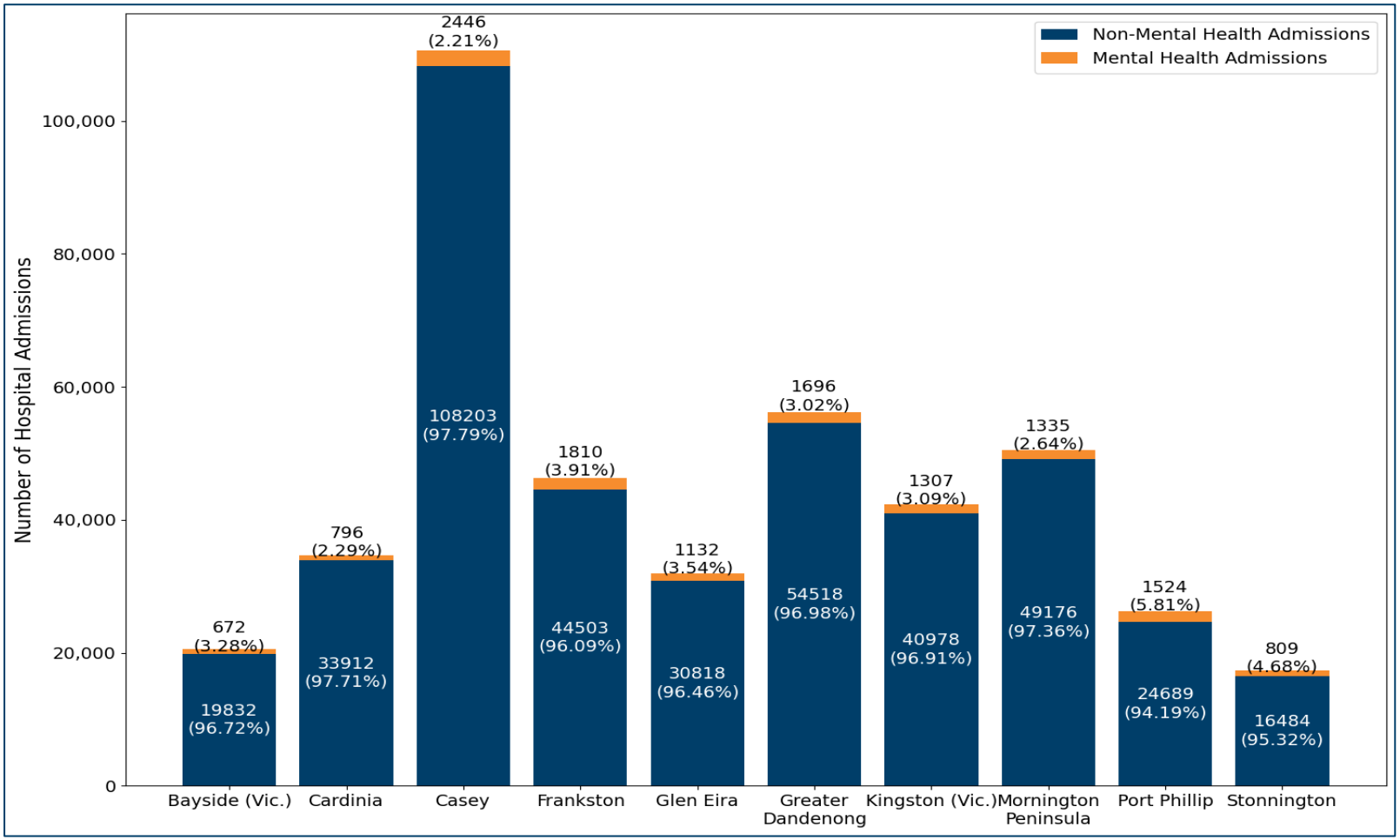


Source: VEMD, Department of Health - Victoria, 2022/23.

HOSPITAL ADMISSIONS

In FY2022-23, there were 13,527 (3.1%) admissions to hospitals with a primary diagnosis related to MH (Figure 7.19). Among these admissions, 53.5% were female, 46.2% males and 0.3% intersex/other. There was a higher prevalence of females when compared with all hospital admissions in south east Melbourne. MH was the 12th most common diagnosis for hospital admissions in FY2022-23. Port Phillip had the highest proportion of MH-related hospital admissions at 5.8%, followed by Stonnington (4.7%) and Frankston (3.9%) (Figure 7.20).

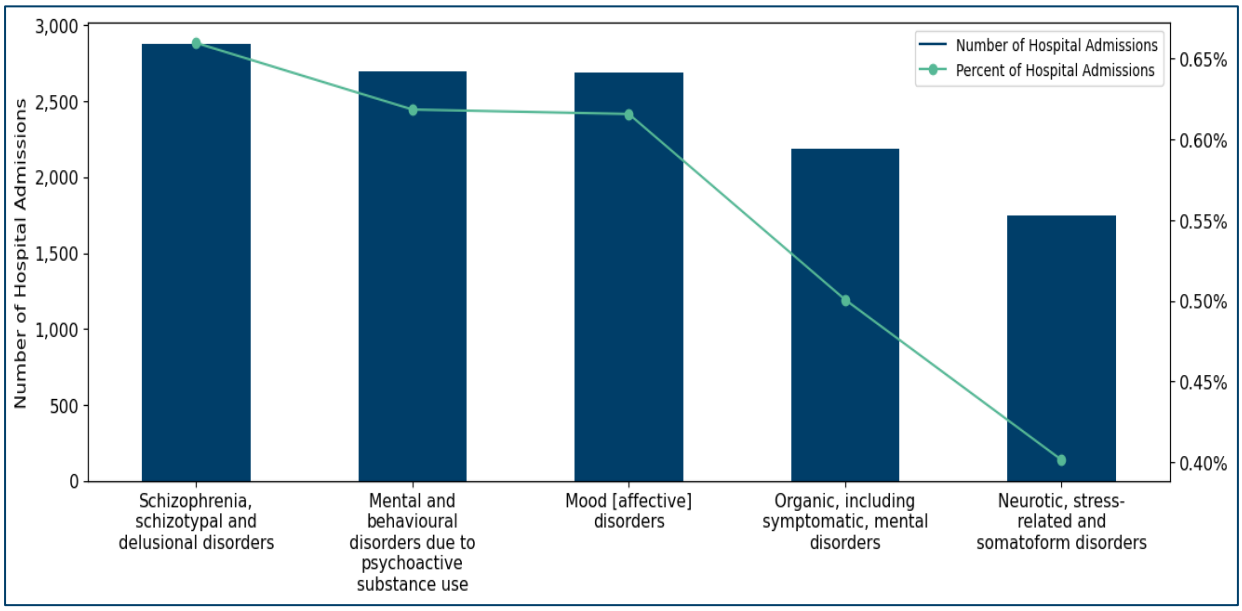
Figure 7.20 Hospital admissions by LGA, FY2022-23



Source: VEMD, Department of Health - Victoria, FY2022-23.

For MH-related admissions the most common specific diagnosis category was schizophrenia, schizotypal and delusional disorders, accounting for just over 2,800 admissions, or 0.65% of all hospital admissions in south east Melbourne (Figure 7.21).

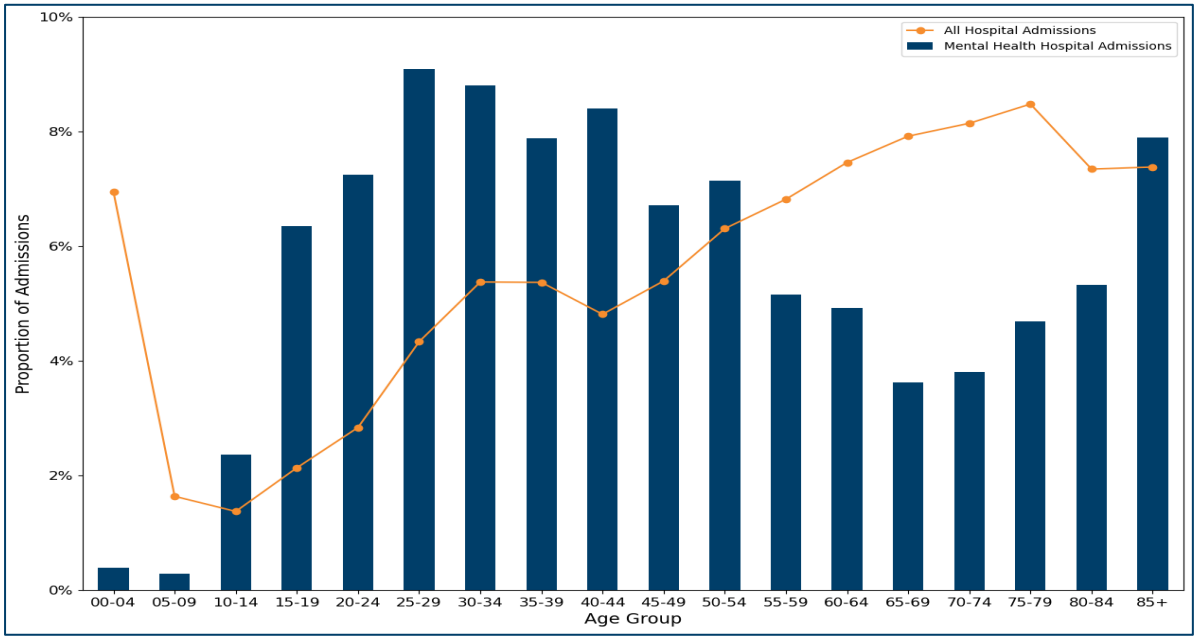
Figure 7.21 Hospital admissions by specific diagnosis category, FY2022-23



Source: VAED, Department of Health - Victoria, 2022-23.

In FY 2022-23, MH-related hospital admissions consisted of a younger cohort, based on a large proportion of patients aged 10-44 years. The largest number of admissions were observed for teenagers (10-19 years of age) and young adults (20-29 years of age), which comprised just over one-quarter (25.0%) of MH-related hospital admissions compared with 10.6% of all hospital admissions in south east Melbourne (Figure 7.22).

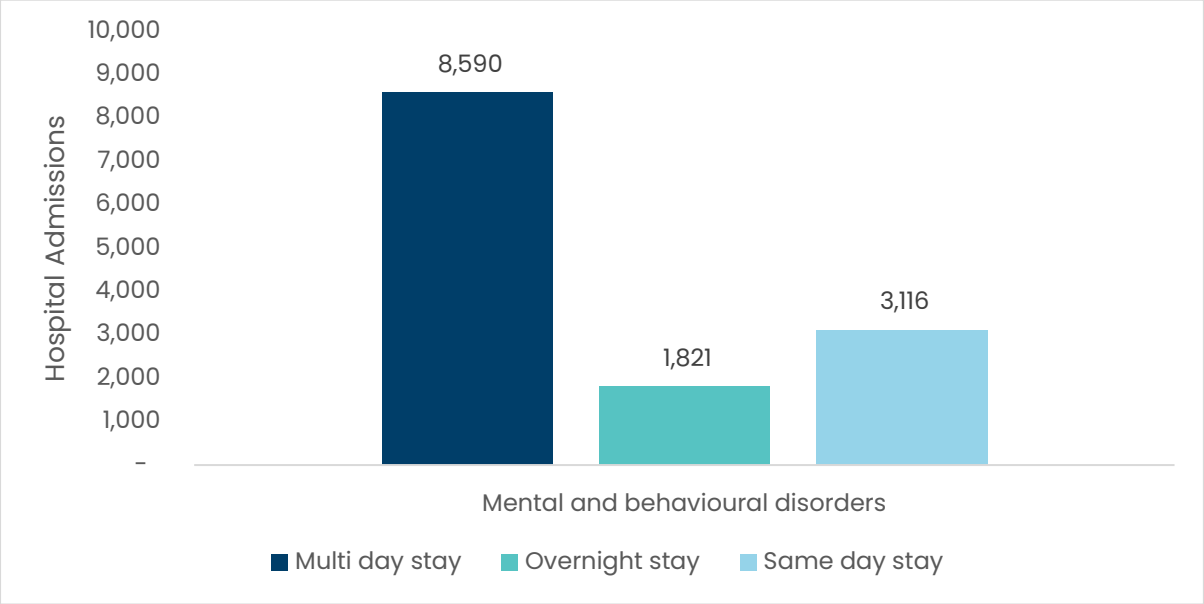
Figure 7.22 Proportion of MH-related hospital admissions by age group, FY2022-23.



Source: VAED, Department of Health - Victoria, 2022-23.

Two-thirds (64%) of MH-related hospital admissions resulted in a multi-day stay, followed by approximately one-quarter (23%) resulting in a same-day stay, and the remaining 13% resulting in an overnight but not multi-day stay (Figure 7.23). MH-related hospital admissions had the highest average length of stay of all broad category primary diagnoses (10.6 days), which was substantially higher than the SEMPHN average of 2.9 days.

Figure 7.23 MH-related hospital admissions by type of stay, FY2022-23



Source: VAED, Department of Health - Victoria, 2022-23.

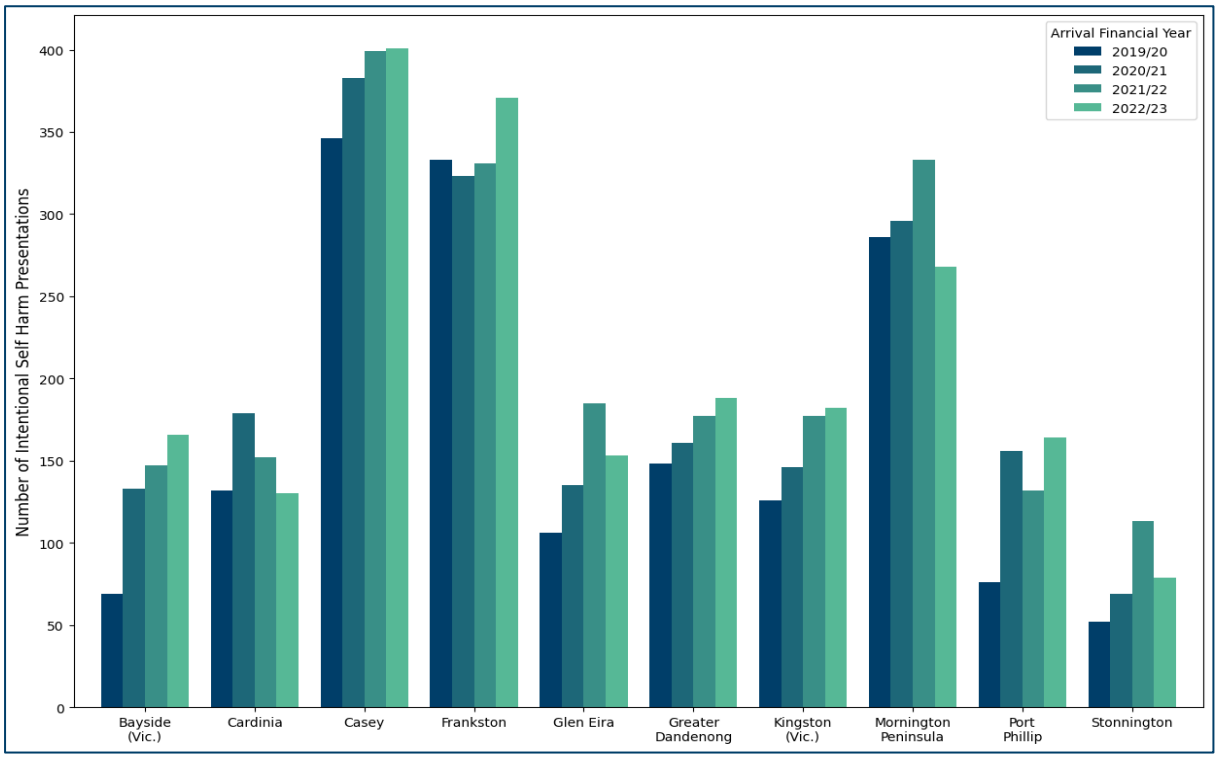
INTENTIONAL SELF-HARM ED PRESENTATIONS

The number of ED presentations attributed to intentional self-harm (with, without or undetermined suicidal intent) were reported in the VEMD via several 'human-intent' categories. Intentional self-harm (with, without or undetermined suicidal intent) across the south east Melbourne region increased by approximately 25.5% (n=428) between the 2019-20 and 2022-23, FYs at approximately 6.4% per annum.

The amount of intentional self-harm ED presentations varied geographically across south east Melbourne (by LGA). The largest amount of self-harm presentations (n=401) was observed in Casey, followed by Frankston (n=371) and Mornington Peninsula (n=268) in FY2022-23 (

Figure 7.24).

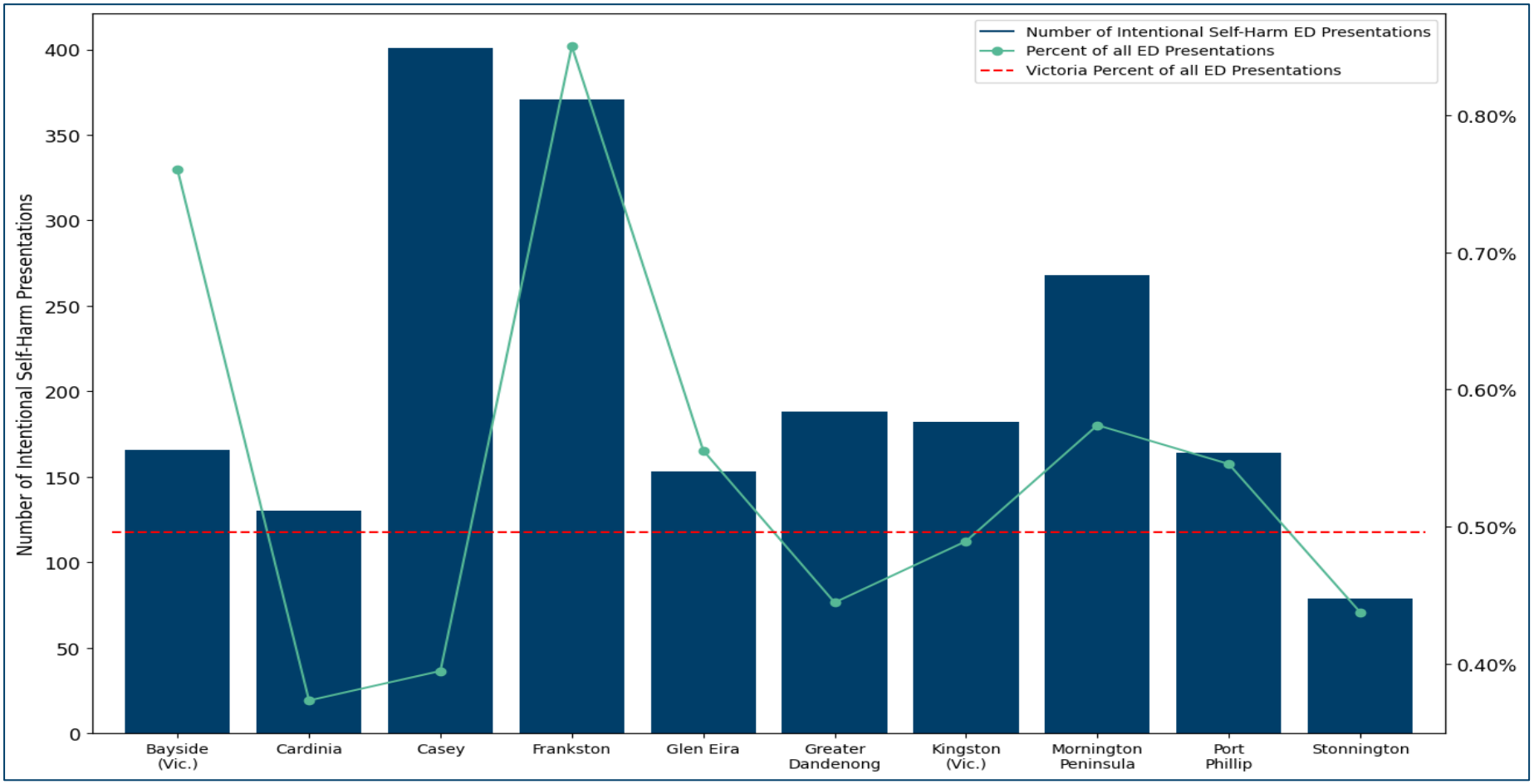
Figure 7.24 Intentional self-harm ED presentations by LGA, FY2019-20 to FY2022-2023



Source: VEMD, Department of Health - Victoria, 2019-20 to 2022-23.

As shown in Figure 7.25, in FY2022-23 Frankston had the highest proportion of ED presentations classified as intentional self-harm (0.85%), followed by Bayside (0.76%) and the Mornington Peninsula (0.57%). These were all substantially higher than the proportion of all Victorian ED presentations categorised as self-harm (0.49%). It is important to highlight the disproportional representation of self-harm related ED presentations in the Frankston region as an indicator of increased severe/complex MH burden or unmet MH need.

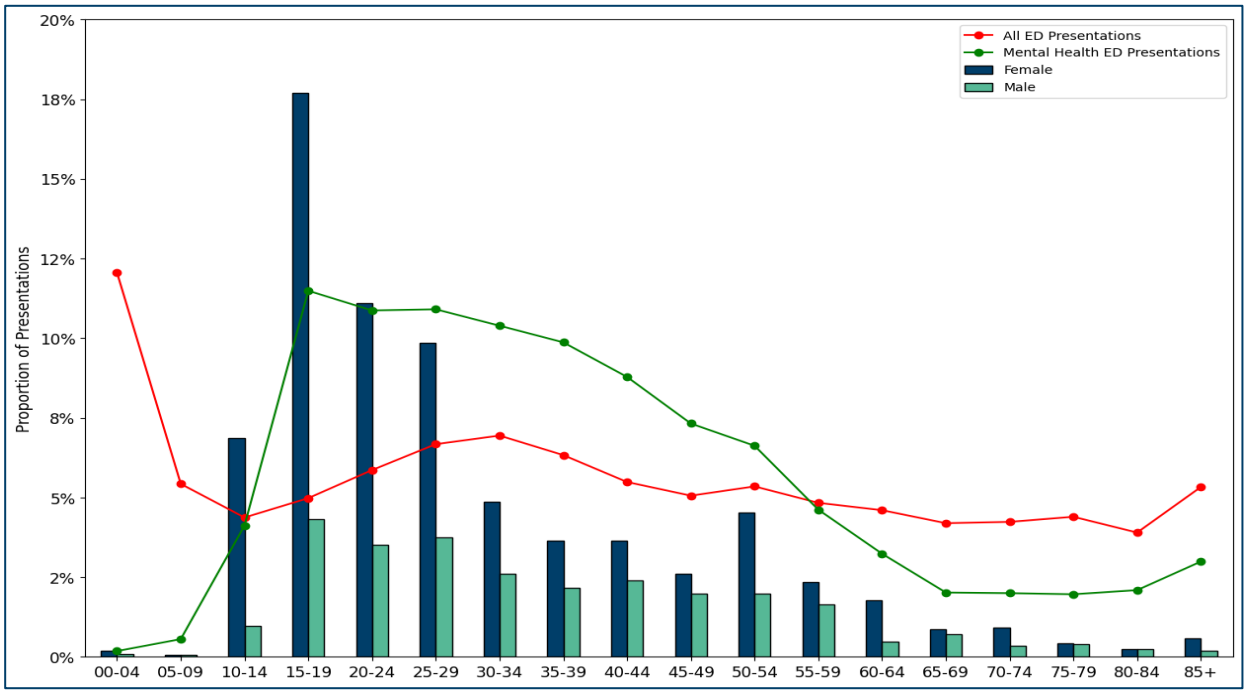
Figure 7.25 Intentional self-harm ED presentations by LGA, FY2022-23



Source: VEMD, Department of Health - Victoria, 2022/23.

Figure 7.26 shows that individuals attending the ED across south east Melbourne for intentional self-harm were predominantly younger, mostly aged 10-29. This age group represented 58.3% of all self-harm ED presentations, compared with 21.9% of all ED presentations. Females accounted for 3 out of 4 self-harm ED presentations (71.5%), which was higher than the female representation in all ED presentations at 50.1%. Among all ED presentations, the most prevalent age group was infants and toddlers aged 0-4 years.

Figure 7.26 Intentional self-harm ED presentations by age and gender, FY2022-23



Source: VEMD, Department of Health - Victoria, 2022-23.

Consumer insights

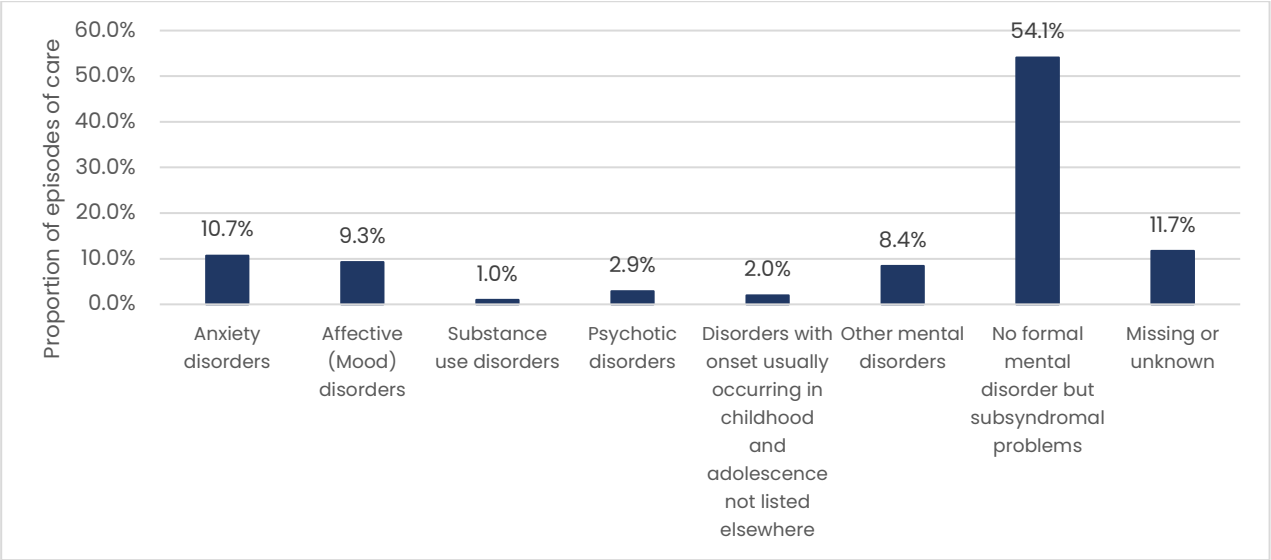
The SEMPHN funds MH programs across the south east Melbourne region, in alignment with the stepped-care model to support residents with mild, moderate, and severe or complex MH needs. Since 2016, approximately 31,519 unique consumers have accessed these MH programs, with 62% identifying as female, 36% as male and 2.3% as not stated or other.

Most consumers were aged 25–64 years (58.6%), followed by those aged 18–24 years (13.4%), 65+ years (13.0%) and 12–17 years (10.3%). Around 1,100 consumers (3.5%) identified as Aboriginal and/or Torres Strait Islander. These MH programs delivered 300,838 service contacts across 33,840 episodes of care. Treatment plans primarily focused on psychological therapy (50.2%), low-intensity psychological interventions (22.7%) and clinical care coordination (7.2%).

Just over half (54.1%) of episodes of care involved no formal principal diagnosis and addressed subsyndromal symptoms; that is, symptoms that did not meet the criteria for a formal clinical diagnosis. Among cases with a formal diagnosis, the most common were anxiety disorders (10.7%), followed by affective (mood) disorders such as depression and BPD (9.3%), and other mental disorders (8.4%) (

Figure 7.27).

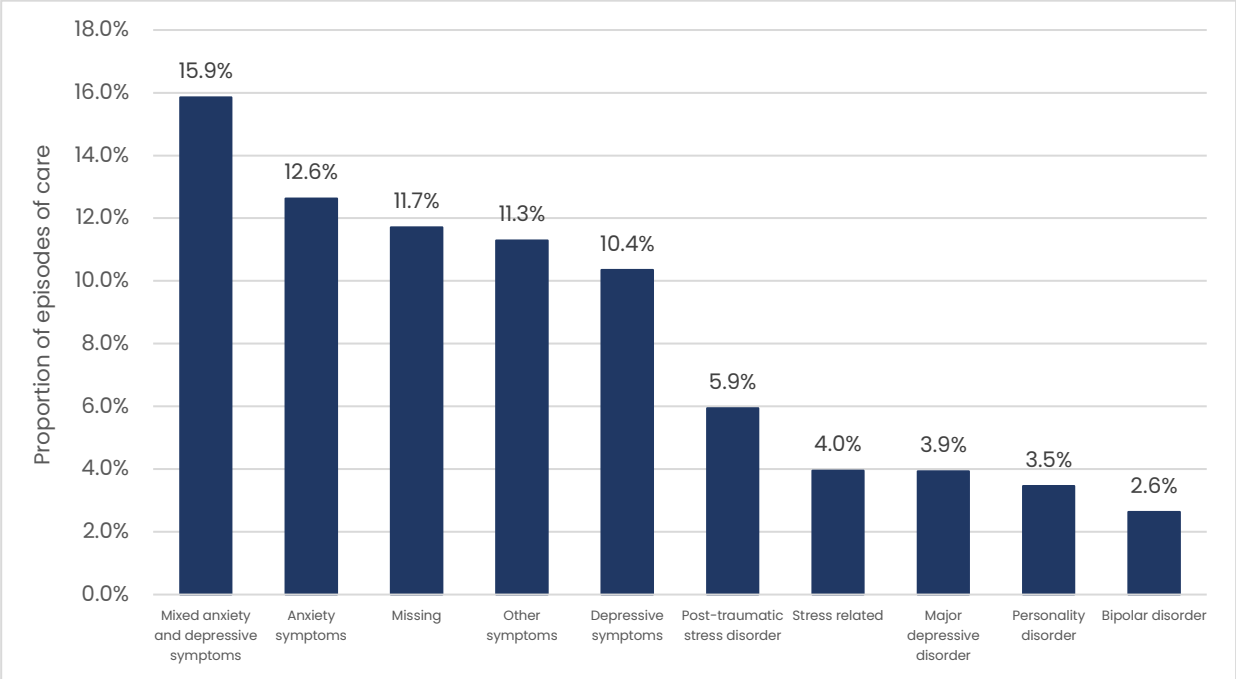
Figure 7.27 Grouped principal diagnosis for SEMPHN-funded MH program episodes of care, 2016-2024



Source: rediCASE data, SEMPHN Mental Health Report (data extraction for the period 01/07/2016 to 31/07/2024).

Since 2016, the most frequently recorded specific principal diagnoses for SEMPHN-funded episodes of care were mixed anxiety and depressive symptoms (15.9%), followed by anxiety symptoms (12.6%) (Figure 7.28).

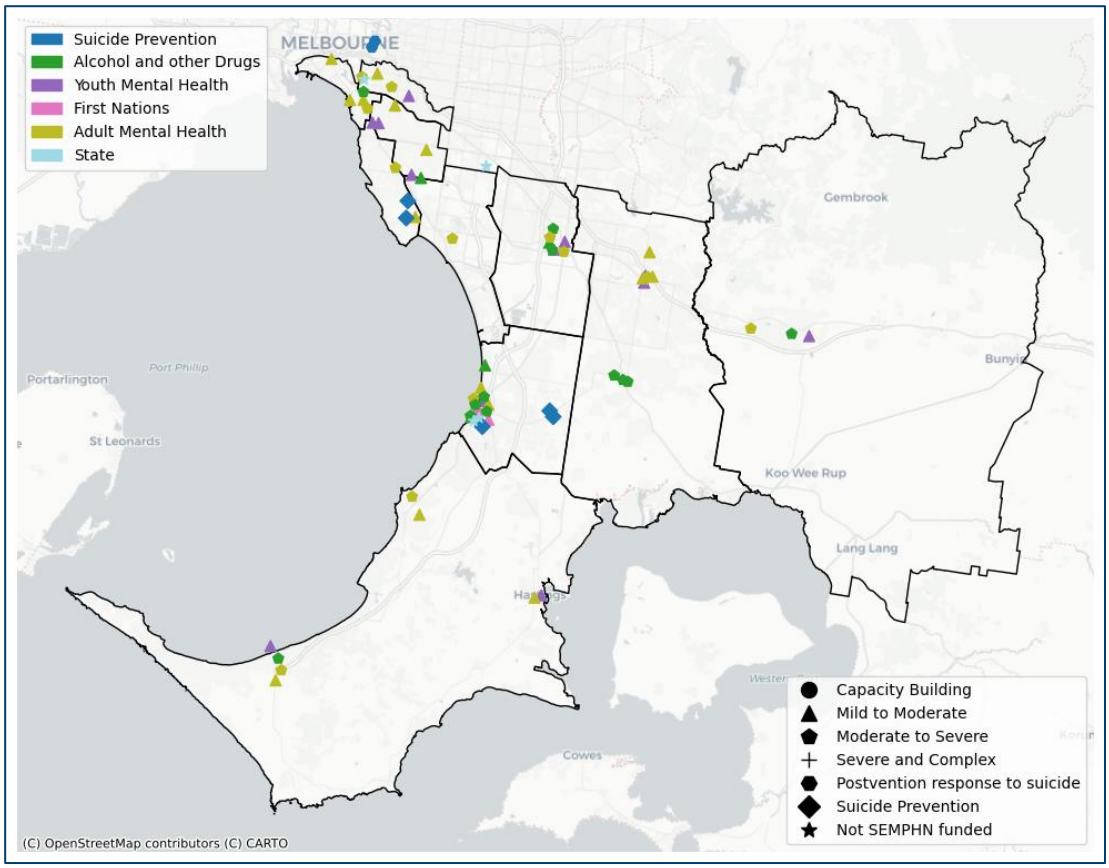
Figure 7.28 Specific principal diagnosis for SEMPHN-funded MH program episodes of care, 2016-2024



Source: rediCASE data, SEMPHN Mental Health Report (data extraction for the period 01/07/2016 to 31/07/2024).

Figure 7.29 provides an overview of the types and locations of programs and services delivered by SEMPHN-funded MH providers as of June 2024.

Figure 7.29 Map of SEMPHN-funded and state MH services, 2024



Source: Health Direct – Health Map, NHSD, June 2024.

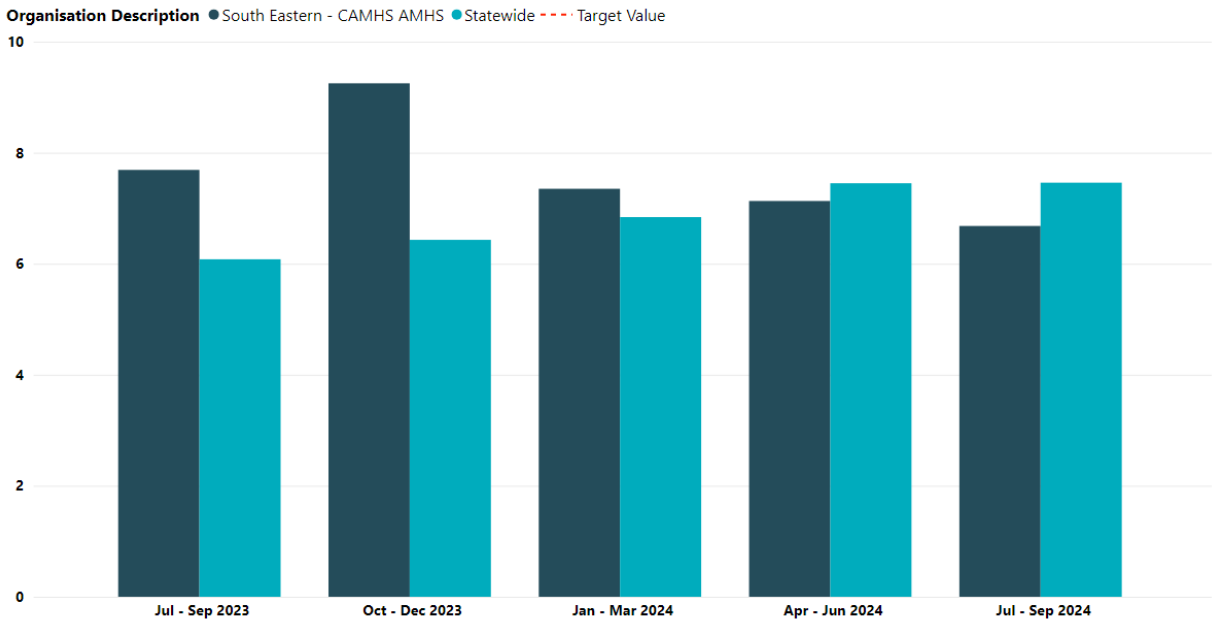
Child and youth services

A significant gap, referred to as the 'missing middle', exists for children and adolescents whose MH needs are not severe enough for Child and Adolescent Mental Health Services (CAMHS) but are too complex for many primary MH services. Consultations with service providers and community stakeholders including Headspace, indicate that they are not adequately resourced to support younger people with complex and persistent MH conditions. Yet these services frequently find themselves managing acutely unwell younger people due to the unavailability of hospital services and restrictive eligibility criteria for tertiary MH care (South Eastern Melbourne Primary Health Network 2023).

CAMHS provides specialist MH treatment and care for children and adolescents aged 0–18 years, focusing on moderate to severe, complex and disabling MH disorders. They also offer information, advice and referral support for those with less severe issues.

Figure 7.30 shows that from July 2023 to January 2024, younger people in south east Melbourne experienced longer average inpatient stays in CAHMS compared with the Victorian average. Conversely, younger people in the south east Melbourne region experienced shorter average inpatient stays in CAMHS compared with the Victorian average between April 2024 and September 2024.

Figure 7.30 Average length of stay (days) for younger consumers admitted to CAMHS inpatient units between July 2023 and September 2024



Source: Victorian Agency for Health Information (VAHI), 2024.

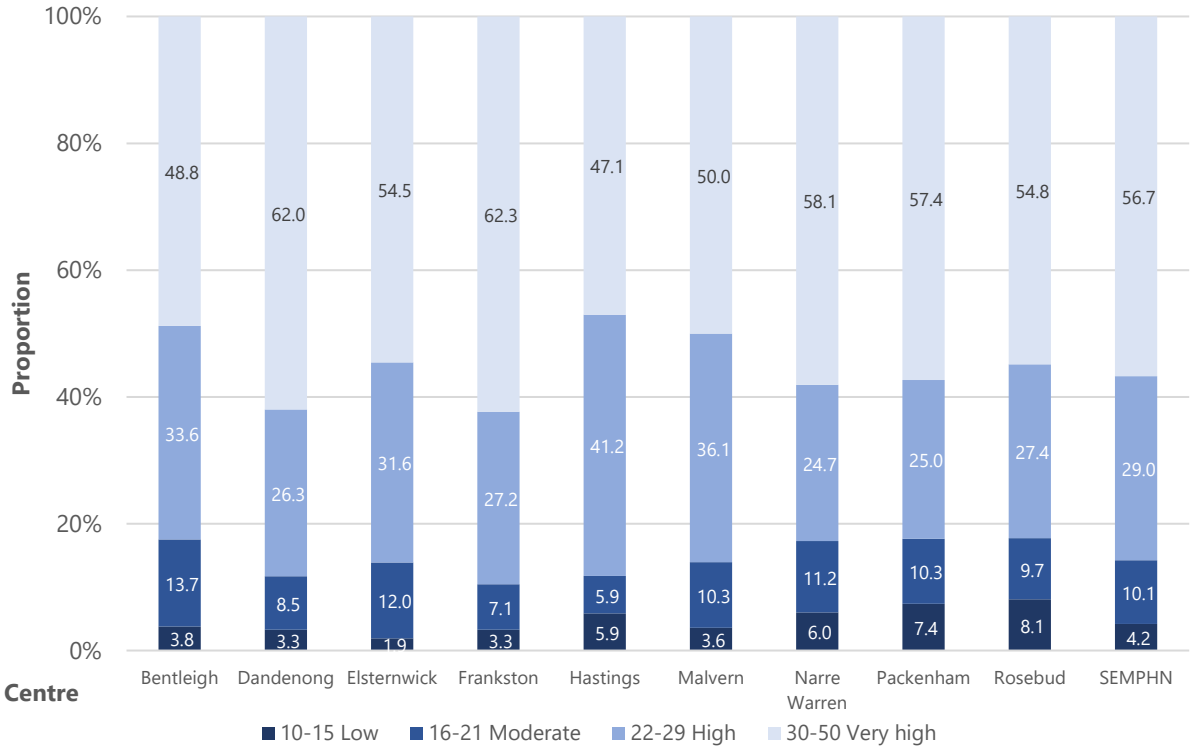
HEADSPACE

Headspace was established in 2006 as Australia's national youth MH initiative to provide a more accessible and effective health system for young people aged 12 to 25 years with MH and substance misuse disorders. The services offered by Headspace include telehealth MH consultations, sexual health services, alcohol and other drug services, work and study support, and an early psychosis intervention program, all designed to improve the lives of young people and their families affected by psychosis (headspace 2023).

There are 9 Headspace centres across the south east Melbourne region, located in Bentleigh, Dandenong, Elsternwick, Frankston, Hastings, Narre Warren, Pakenham, Malvern and Rosebud (Headspace 2021).

Figure 7.31 compares levels of psychological distress (as measured by K10 scores) at the commencement of episodes of care across various Headspace centres in the SEMPHN catchment in the 2022-23 FY. These findings highlight the prevalence of distress among young people seeking MH services.

Figure 7.31 K10 scores at the start of episodes of care across Headspace centres, 2022-23



Source: Headspace Dashboard. Table accessed via https://reporting.headspace.org.au/#/views/HeadspaceCentreReportingSuite6_0-Detail/6_0ClinicalPresentation?:iid=3.

Headspace centres define wait times as the number of calendar days between when the centre first receives either a young person's referral or the initial contact to make an appointment and the date of the young person's intake or access to occasions of service is recorded.

Figure 7.32 shows that across all centres in the 2022-23 FY, the 97.6% (n=3,939) of episodes of care that commenced with an intake/access session had the following distribution of wait times: 44.9% (n=1,767) commenced within 1 day, 24.2% (n=955) commenced between 2-7 days, 17.3% (n=682) commenced between 8-22 days, and 13.6% (n=535) commenced after 22 days. The average wait time to intake/access across all centres was 8.6 days (n=3,939), with wait times peaking in July and August 2022 at 10.7 and 10.6 days, respectively.

Figure 7.32 Number of episodes and average wait time by Headspace centre, FY2022-23

Centre	Number of episodes	Wait times (days)
Bentleigh	1,167	3.0
Dandenong	424	11.7
Elsternwick	948	3.1
Frankston	974	10.8
Hastings	55	14.8
Malvern	316	3.1
Narre Warren	447	21.2
Packenham	129	20.4
Rosebud	172	13.5
SEMPHN	**4,632**	**8.1**

Note: Out of the 4,632 episodes recorded across all centres, only 3,939 episodes had valid wait times recorded.
Source: Headspace, 2023. Accessed via https://reporting.headspace.org.au/#/views/headspaceCentres-WaitTimesV2/WaitTime1-Overview?:iid=4.

Workforce capacity insights

MH WORKFORCE

MH professionals are essential for ensuring access to and the quality delivery of MH care within our communities (Samartzis and Talias, 2020). In Australia, the MH workforce comprises GPs providing MH-related services, psychiatrists, MH nurses, psychologists and MH occupational therapists.

As shown in Table 7.1, south east Melbourne had a lower rate of MH professionals per 100,000 people compared with the Victorian average. In particular, the number of MH nurses in the SEMPHN region was significantly below the Victorian average.

Table 7.1 MH workforce in Victoria, 2021

Region	Psychiatrists		MH nurses		Psychologists		MH occupational therapists	
	N	Rate per 100,000	N	Rate per 100,000	N	Rate per 100,000	N	Rate per 100,000
South east Melbourne	237	13.0	1,248	78.5	2,055	129.2	163	10.3
Victoria	1,116	15.5	6,965	106.4	8,941	136.5	817	12.5

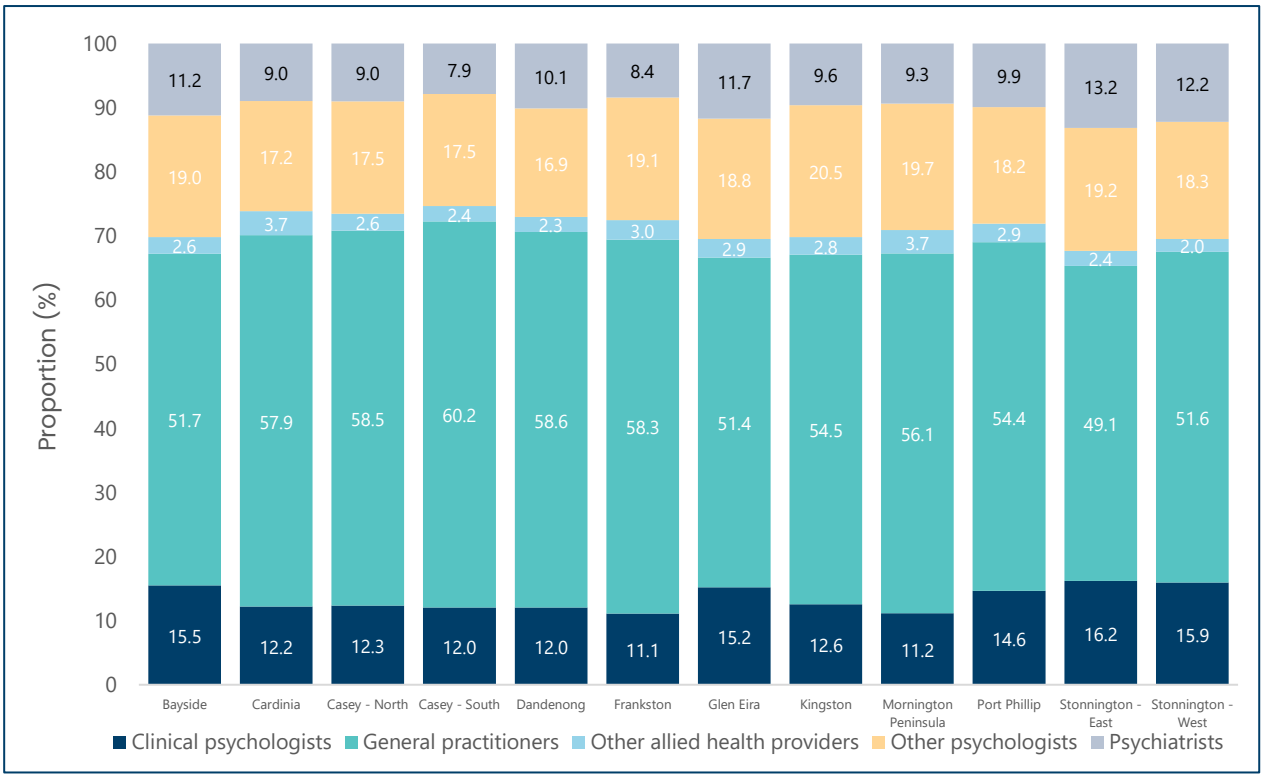
Source: AIHW, 2023, Table WK.2: Psychiatrists, average hours worked per week, full-time equivalent (FTE) and FTE per 100,000 population, geographical distribution, 2021; WK.5: Mental health nurses, average hours worked per week, FTE and FTE per 100,000 population, geographical distribution, 2021, WK.8: Psychologists, average hours worked per week, FTE and FTE per 100,000 population, geographical distribution, 2021; Table WK.11: Occupational therapists, average hours worked per week, FTE and FTE per 100,000 population, geographical distribution, 2020; accessed on 11 August 2023.

SERVICE PROVISION

In the 2021-22 FY, 2.7 million Australians (11% of the population) accessed Medicare Benefits Schedule (MBS) subsidised MH-related services, marking a significant increase from 1.5 million (6.9% of Australians) in the 2010–11 FY. Victoria and Queensland reported the highest proportions of populations receiving these services, both at 11% (Australian Institute of Health and Welfare, 2022b). Patients in Victoria utilised an average of 5 Medicare-subsidised MH services per person, aligning with the national average.

Figure 7.33 highlights the utilisation of MBS MH-related services within the south east Melbourne region during 2020-21. Across all Statistical Area Level 3 (SA3) regions, over half of those accessing these services did so through a GP. The number of MBS MH-related services provided by GPs in Victoria increased by 10% from 2019-20 to 2020-21 (Australian Institute of Health and Welfare 2020).

Figure 7.33 Consumer receiving MBS-subsidised MH services by statistical area 3 (SA3), FY2020–21



Source: AIHW (2020). Table MBS.22: Medicare-subsidised mental health-specific services and people receiving Medicare-subsidised mental health-specific services, by SA3 area and provider, 2020–21.

Stakeholder engagement

Stakeholder engagement and market analysis have provided valuable insights into the ongoing needs of consumers and the broader community for MH services. Since 2016, corresponding consultations and surveys across the south east Melbourne region have highlighted key barriers to MH service access, including:

- limited consumer awareness of existing services
- lack of affordable transport and challenges with distance to attend services
- insufficient availability of after-hours appointments
- poor consumer experiences
- shortages of culturally appropriate services
- privacy concerns
- stigma-related barriers, particularly in accessing suicide prevention services
- challenges in addressing mental illness and suicide prevention effectively.

Suicide prevention barriers

South east Melbourne community members identified the following barriers for accessing suicide prevention services:

- stigma surrounding suicide, which discourages individuals from seeking help or engaging in conversations
- reluctance among some population groups (e.g. older men) to interact with health professionals
- suicidal ideation or crises being treated as acute issues, often resulting in ED presentations.

Opportunities for improvement

Consultations with service providers, consumers and carers highlighted opportunities to enhance MH and psychosocial support services in the region. Key areas for improvement (also see Table 7.2) include incorporating the following elements into service delivery:

- assertive outreach
- patient navigation and support facilitation
- personalised assistance
- decision-making support
- peer support services.

These findings underscore the importance of tailored, community-focused approaches to reduce barriers and improve access to MH services.

Table 7.2 Proposed MH service delivery improvements in SEMPHN catchment

Service providers 	• Continue funding to create stability in service delivery. • Co-located, integrated services. • Intake processes tailored to the circumstances of people accessing the service (e.g. no phone, no permanent address, limited or no proficiency in English). • Increase efforts to allow same worker/service/care team to support consumers throughout their journey. • Increase focus on the functional needs of consumers (e.g. social skills, finance, physical health) alongside addressing MH needs. • Provide activities to increase social connections. • Access to services for communities or demographic groups identified by service providers as having unmet needs.
Consumer and carers 	• Individual and group therapies that are consumer-centred. • Provision of supported long-term, permanent accommodation that includes clinical care. • Strategies to facilitate low turnover of staff. • Improve the competency and skills of the workforce. • Availability of a 24/7 telephone helpline.

Market analysis

A robust MH service is critical to ensure access, quality and sustainability of care within the south east Melbourne region. Key dynamics shaping the MH service landscape include workforce challenges, service provider capability, service quality, diversification of service providers, market uncertainties and operational constraints. These factors collectively influence the ability of MH service providers to deliver effective, consumer-centred care and adapt to evolving community needs. By understanding these market trends and challenges, SEMPHN can identify opportunities to strengthen its commissioning approach and support a resilient, high-performing MH service ecosystem.

WORKFORCE AND SERVICE PROVIDER CAPABILITY

The shortage of MH professionals in the south east Melbourne region significantly impacts the service provider market and its ability to deliver MH programs. The MH service provider consultations identified the following key challenges affecting recruitment and retention of skilled MH professionals:

- shortage of qualified MH professionals in the region
- lack of secured continuity of funding for specific programs
- increased competition from state-funded services offering higher salaries
- lower reporting burdens in state-funded programs compared to SEMPHN requirements.

Despite such challenges, MH service providers (including prospective providers) have increased their capability to navigate SEMPHN's commissioning process. Notable improvements include:

- enhanced responses to market approaches (e.g., RFT, RFP, EOI), with local providers demonstrating improved ability to address selection criteria and articulate effective models of care

- greater familiarity with contract management processes, transitioning from grant funding to more structured relationship management and reporting, ensuring better communication about service delivery outcomes.

Service quality

SEMPHN operates in a highly competitive market for youth MH services. Each market approach for youth MH attracts high-quality, sustainable organisations with strong local reputations. This competitive environment ensures effective service delivery for young residents with MH concerns, enhancing opportunities and support within the region.

Diversification of service providers

In the SEMPHN region this is an increasing trend of MH service providers diversifying their offerings. For instance, alcohol and other drugs (AOD) service providers are leveraging their experience with comorbidities to lead MH services. Such diversification positively impacts the market by promoting the integration of care for individuals with co-occurring AOD and other MH concerns.

Uncertainty in the market

Findings from the Royal Commission into Victoria's Mental Health System (2021) have caused some uncertainty among service providers, particularly regarding the recommendation that local health networks (LHNs) deliver Headspace services in Victoria. This uncertainty also impacts Headspace's lead agencies, leaving them in a 'wait-and-see' position regarding the implementation of the Royal Commission recommendations.

Furthermore, confusion around funding structures (exacerbated by the Royal Commission recommendations and recent inquests) have amplified this uncertainty, making it challenging for service providers to plan long-term.

Increasing real estate and operational costs

Rising commercial real estate costs in key locations such as Dandenong, Cranbourne, Pakenham and Frankston, are a growing challenge for MH service providers. High lease costs and operational expenses can significantly affect service delivery in the following ways:

- **Service demand and space limitations:** Short-term (12–24 months) contracts make it difficult for service providers to secure or expand premises, hindering their ability to grow services and meet rising consumer demand.

- **Service model innovation challenges:** Service providers face limitations in customising facilities to meet consumer needs, such as improving culturally appropriate entry spaces or expanding consultation areas, as funding typically excludes capital improvements.

Such operational challenges further complicate the ability of service providers to innovate and adapt to growing service demands, impacting their ability to deliver high-quality, accessible care.

References

Australian Bureau of Statistics (2021) *Household impacts of COVID-19 survey* [data set].

Australian Institute of Health and Welfare (2020) *Medicare-subsidised GP allied health and specialist health care across local areas: 2013–14 to 2018–19*, https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2019/contents/gp-attendances/after-hours-gp-attendances.

——— (2021a) *Mental health services in Australia*, Australian Institute of Health and Welfare,, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia.

——— (2021b) *Mental health services in Australia: Mental health-related prescriptions* [data set], https://www.aihw.gov.au/getmedia/c6a0044e-6870-4523-b6a1-f6ea9f352a19/Mental-health-related-prescription-2020-21.xlsx.aspx.

——— (2022a) *Deaths in Australia*, https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death.

——— (2022b) *Mental health services in Australia*, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/medicare-subsidised-mental-health-specific-services.

——— (2022c) *Mental health: prevalence and impact*, https://www.aihw.gov.au/reports/mental-health-services/mental-health.

Beyond Blue (2022) *Beyond Blue statistics*, https://www.beyondblue.org.au/media/statistics.

Lifeline (2022) *Lifeline Statistics*, https://www.lifeline.org.au/resources/data-and-statistics/.

Mental Health Australia (2022) *Report to the Nation*, (Mental Health Australia, chairman).

National Mental Health Commission (2018) *Fifth National Mental Health and Suicide Prevention Plan*, National Mental Health Commission.

Victoria. Royal Commission into Victoria's Mental Health System (2021) Royal Commission into Victoria's Mental Health System: Final Report, Parliamentary paper (Victoria. Parliament).

Victorian Agency for Health Information (2023) *Victorian Population Health Survey*, Victoria Department of Health,, https://vahi.vic.gov.au/reports/victorian-population-health-survey.

Victorian Department of Health (2021) *Victorian Population Health Survey*, Victoria Department of Health,, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey.

World Health Organization (2019) *ATC: Structure and principles. Oslo: WHO Collaborating Centre for Drug Statistics Methodology*, http://www.whocc.no/atc/structure_and_principles/.

——— (2022) *Mental health*, https://www.who.int/westernpacific/health-topics/mental-health#tab=tab_1.

Chapter 8 Alcohol and other drugs (AOD)

- **Alcohol**: Consumption rates in the catchment are consistent with Victoria (ASR 14.4 per 100) and have remained steady, with higher risky drinking in Bayside (19.5), Port Phillip (19.0), Mornington Peninsula (21.3), and Stonnington (17.0).
- **Tobacco & Nicotine**: higher rates in Greater Dandenong (18.9 per 100), Frankston (18.1), Cardinia (17.0), and Mornington Peninsula (16.3).
- **Illicit Drugs**: 1.9% increase in recent illicit drug use (2019-2023), with cannabis (11.5%), cocaine (4.5%), and hallucinogens (2.4%) most common (2022-23).
- **Alcohol & Drug-Related Harms**: highest rates of serious road injuries in Greater Dandenong (44.3 per 100,000 residents) and Port Phillip (30.9 per 100,000 residents) in 2019-20; highest alcohol-related family violence in Port Phillip (215.4 per 100,000 residents), Frankston (199.6 per 100,000 residents), and Mornington Peninsula (170.2 per 100,000 residents) in 2021-22.
- **Treatment Services**: Port Phillip and Cardinia have the highest alcohol-related care episodes (at 268.3 and 195.6 per 100,000 residents, respectively), while Port Phillip and Greater Dandenong have the highest illicit drug-related care episodes (at 350.0 and 289.0 per 100,000 residents, respectively).
- **Active AOD Diagnoses:** higher prevalence among residents aged 30-59 (70.3%) of all SEMPHN residents; highest prevalence in Casey (17.1%), followed by Frankston (12.1%) and Mornington Peninsula (11.4%).

Approximately 40,000 Victorians receive treatment for addiction to AOD each year (Victorian State Government 2021). The consumption of AOD can significantly impact not only the individual but also their family, social connections and the community. The National Drug Strategy 2017-2026 has been designed to prevent and minimise alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities (Department of Health 2017). The approach works across 3 pillars – 1) demand reduction, 2) supply reduction and 3) harm reduction – and identifies key priority populations most at risk that are often underserviced such as:

- First Nations people
- people with MH conditions
- younger people (15-24 years)
- older people (65 years and over)
- people in contact with the criminal justice system
- CALD populations
- LGBTIQA+ communities.

Alcohol

There is no safe level of alcohol consumption. Drinking alcohol can increase the risk of injury, violence and a person developing health problems, including cancer, cardiovascular, cerebrovascular, liver and digestive diseases (Australian Institute of Health and Welfare 2017). The Australian Alcohol Guidelines recommend that to reduce health and injury risks, no more than 4 standard drinks should be consumed on any one day, and no more than 10 standard drinks should be consumed per week. These guidelines also specify that anyone under the age of 18 years should not drink alcohol (National Health and Medical Research Council 2020).

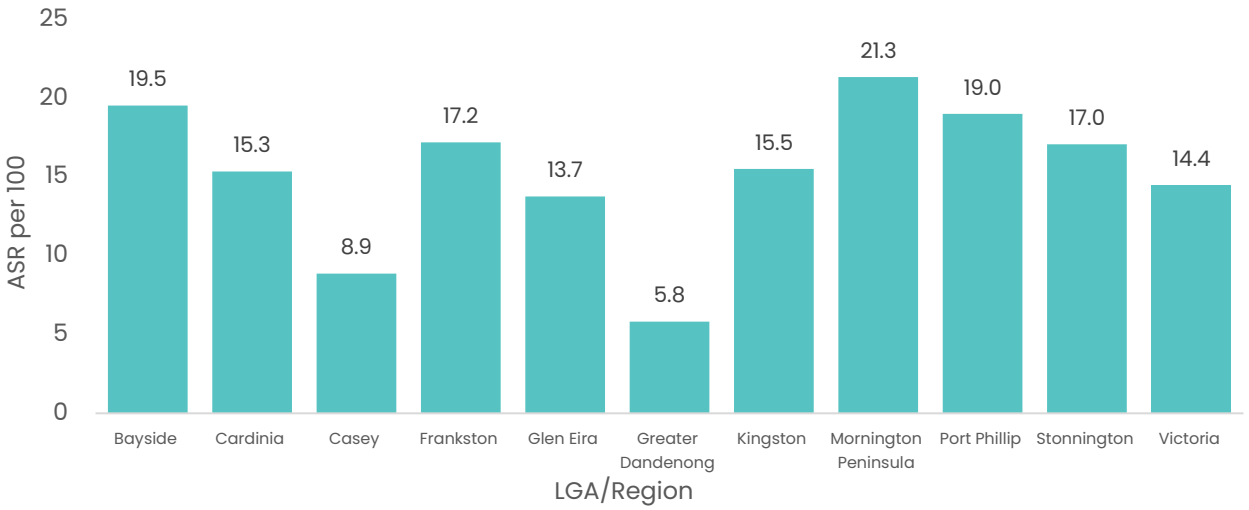
The National Drug Strategy Household Survey 2022-2023 (Australian Institute of Health and Welfare 2024b) reported that one in 3 (32.3%) Australians aged 18 years and over exceeded the guidelines[22] in 2023-23. This includes those who either consumed more than 10 drinks in the last week (26.0%) and/or consumed 4 or more drinks on any day at least monthly in the last 12 months (25.0%). This survey also found that people aged 18-24 years were twice (1.67) as likely as those aged 70 years and over to have exceeded the guidelines (41.8% compared to 24.9%).

Alcohol use has been associated with other risky behaviours such as tobacco use, unsafe sex, violence, drinking and driving, and suicide. Published research on the relationship between adolescent drinking patterns and parental attitudes towards drinking, modelling of alcohol use and supply of alcohol to adolescents recommend that interventions targeting teenage drinking adopt a family counselling approach (Ten to Men 2020; Australian Government Department of Health 2020; Australian Institute of Health and Welfare 2018, 2019).

According to the 2023 Victoria Population Health Survey (Victorian Agency for Health Information 2023), the risk of alcohol-related disease or injury in the SEMPHN region was comparable to the Victorian average. In the SEMPHN catchment, 28.1% of residents did not consume alcohol, 57.3% were at reduced risk and 14.6% were at increased risk. Across Victoria, the figures were 28.4% for non-drinkers, 58.8% for reduced risk and 12.8% for increased risk.

At the LGA-level, the National Health Survey 2017-18 found that rates of alcohol consumption among residents aged 18 years and over was highest in Mornington Peninsula (ASR 21.3 per 100), followed by Bayside (ASR 19.5 per 100), Port Phillip (ASR 19.0 per 100), and Stonnington (ASR 17.0 per 100) (Figure 8.1).

Figure 8.1 Adults who consumed more than 2 standard alcoholic drinks per day on average by LGA, 2017-18



Source: PHIDU, Social Health Atlas of Australia (September 2024), Table: Prevalence of selected health risk factors (modelled estimates), accessed phidu.torrens.edu.au/social-health-atlases/graphs. Data is based on the National Health Survey 2017-18. Accessed 21 October 2024.

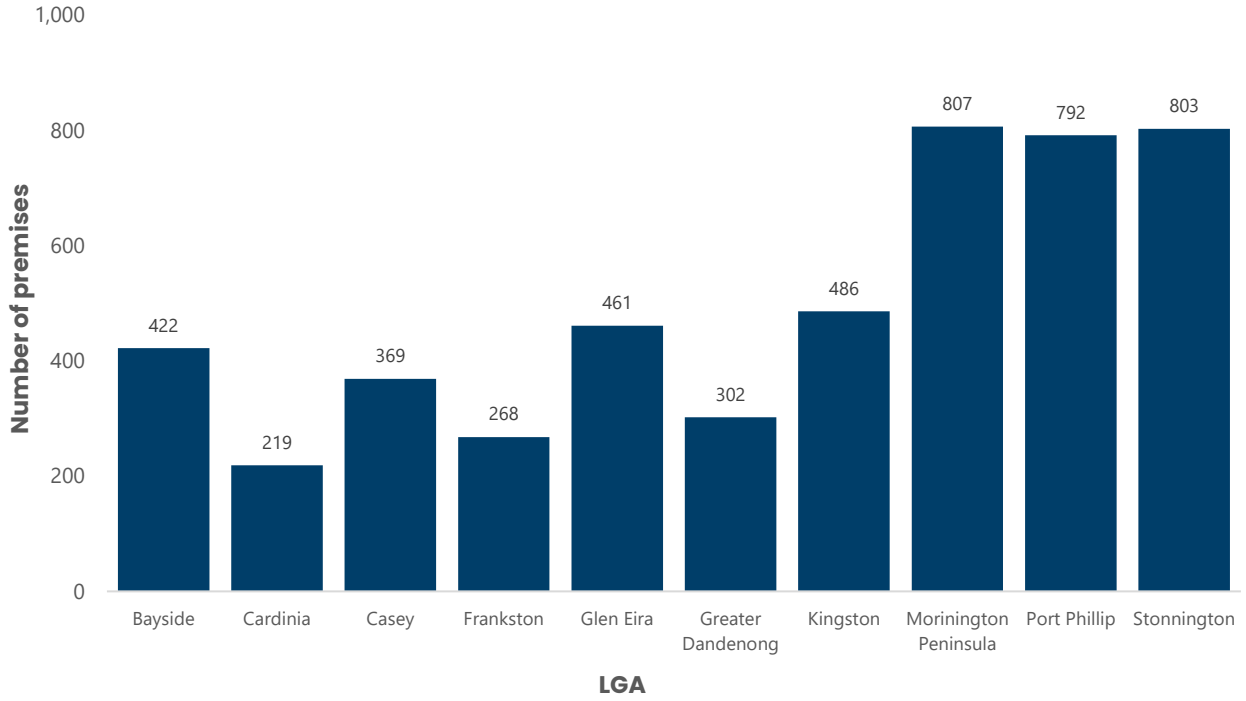
[22] Exceeding the guidelines was interpreted as consuming more than 10 standard drinks in the week prior to the survey, consuming 4 or more standard drinks on any day in the last year at least monthly (12 occasions per year). or exceeding both components.

Alcohol consumption is also monitored through the National Wastewater Drug Monitoring Program (NWMP). Data from the 2024 NWDMP report (The Australian Criminal Intelligence Commission 2024) showed that alcohol consumption levels remained consistent across February 2022 to February 2024 in Melbourne (at approximately 1,000 standard drinks per 1,000 people per day) but fell slightly across regional areas in Victoria. Yet the average regional alcohol consumption rate (approximately 1,250 standard drinks per 1,000 people per day) was higher than in Melbourne (approximately 1,100 per 1,000 people per day).

LIQUOR LICENSING

Research has indicated that the density of alcohol outlets may be related to excessive alcohol consumption and related harms in a region (Campbell et al. 2009).That is, higher alcohol outlet density is associated with increased alcohol consumption and related harms, including medical harms, injury, crime and violence in the community. As of 31 March 2024, Victoria had a total of 23,952 premises with a current liquor licence (Victorian Commission for Gambling and Liquor Regulation 2024). Figure 8.2 shows the number of premises with current liquor licences across LGAs in the SEMPHN catchment, with Mornington Peninsula (16.4%) having the highest proportion, followed by Stonnington (16.3%) and Port Phillip (16.1%).

Figure 8.2 Premises with a current liquor licence by LGA, 2024

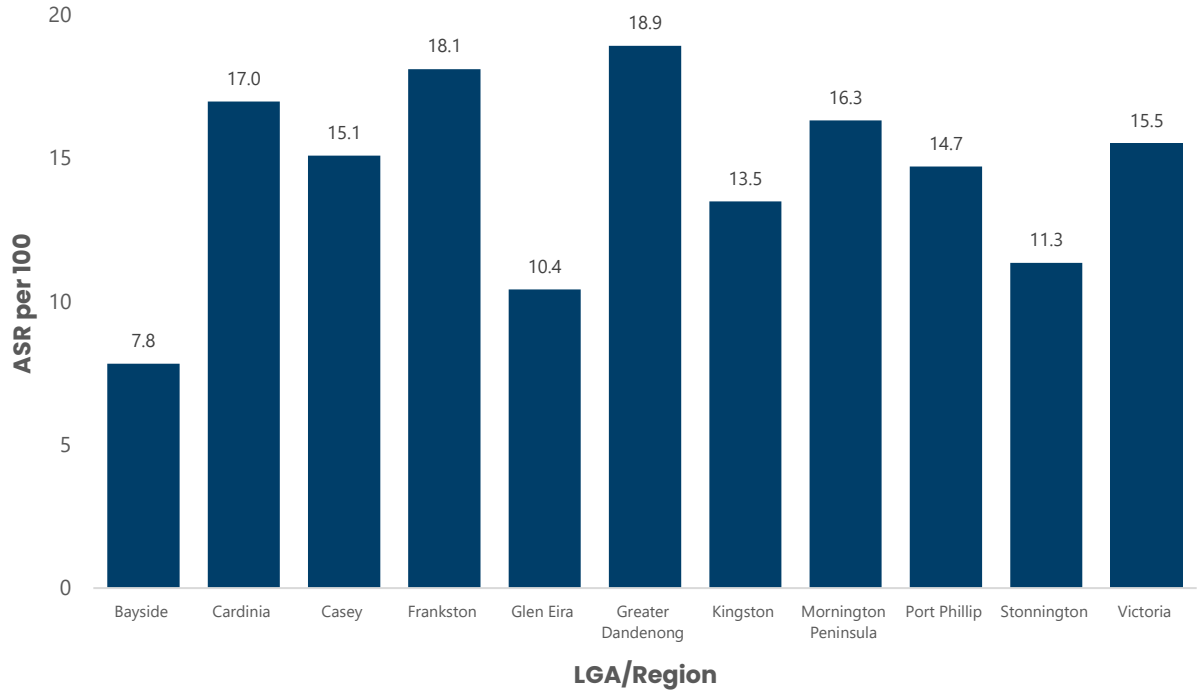


Source: Victorian Commission for Gambling and Liquor Regulation (2024).

Tobacco and nicotine

Data from the National Drug Strategy Household Survey 2022-2023 (Australian Institute of Health and Welfare 2024e) highlights a sharp decline in the number of smokers across Australia, with those aged 14 and over who identified as daily smokers declining to 8.3% (n=1,800,000) in 2022-2023 from 11.0% (n=2,300,000) in 2019; and the number of people (14 years and over) who identified their smoking status as 'never smoked' increasing to 65.4% (n=14,100,000) in 2022-2023 from 63.1% (n=13,200,000) in 2019. Figure 8.3 shows the estimated rates of adult smokers by LGA, with the highest rates recorded for Greater Dandenong (18.9 per 100), Frankston (18.1 per 100), Cardinia (17.0 per 100) and Mornington Peninsula (16.3 per 100).

Figure 8.3 Current adult smokers by LGA, 2017-18



Source: PHIDU, Social Health Atlas of Australia (June 2024), Table: Prevalence of selected health risk factors (modelled estimates), accessed via phidu.torrens.edu.au/social-health-atlases/graphs. Data is based on the National Health Survey 2017-18.

E-CIGARETTES

Data from the National Drug Strategy Household Survey 2022-2023 (Australian Institute of Health and Welfare 2024c) highlights a significant increase in the proportion of non-smokers using e-cigarettes between 2019 and 2022-2023, particularly among the age groups of 14-17 (9.6% vs 28.4%), 18-24 (26.1% vs 48.8%), and 25-39 (20.4% vs 41.1%). The 2022 Victorian Smoking and Health Survey found almost double the number of Victorian adults reporting vaping usage in 2022 (estimated 308,827 users) compared with 2018-19 (estimated 154,895 users). Almost one-quarter of all of these Victorian adults that used e-cigarettes had never smoked (VicHealth 2022). 'Out of curiosity' (57.9%) was the most commonly cited reason for using e-cigarettes among Australians aged 14 years and over in 2022-2023, followed by 'taste better than regular cigarettes' (22.1%) and 'to help them quit smoking' (21.5%), with 15.8% believing e-cigarettes were 'less harmful than regular cigarettes' (Australian Institute of Health and Welfare 2024c).

Illicit drugs

Illicit drugs include illegal drugs (e.g. cocaine), pharmaceuticals used for non-medical reasons (e.g. over the counter codeine) and other psychoactive substances (e.g. synthetic cannabis) (Department of Health and Aged Care 2021). It was reported in the National Drug Strategy Household Survey 2022-2023 (Australian Institute of Health and Welfare 2024d) that the proportion of people aged 14 and over who reported recent illicit drug use in the last 12 months had increased between 2019 and 2022-23 in the SEMPHN catchment area (1.9% increase), as well as Victoria (0.5% increase) and Australia (1.5% increase) (Table 8.1).

Table 8.1 Illicit drug use in Australia among people aged 14 and over, 2019 vs 2022-2023

Location	2019 (%)	2022-2023 (%)	Change (%)
SEMPHN	16.8	18.7	+1.9
Victoria	17.1	17.6	+0.5
Australia	16.4	17.9	+1.5

Source: AIHW, National Drug Strategy Household Survey (2024d). Table 9a.9: Recent illicit use of any drug, people aged 14 and over by state/territory, 2001 to 2022-2023 (%).

According to the same survey, the most used illicit drugs in Australia in 2022-2023 were cannabis (11.5%), cocaine (4.5%) and hallucinogens (2.4%) (Table 8.2).

Table 8.2 Recent illicit drug use among people aged 14 and over, 2019 vs 2022-2023

Illicit drug	Victoria			Australia		
	2019 (%)	2022/23 (%)	Change (%)	2019 (%)	2022/23 (%)	Change (%)
Illicit drug use excluding pharmaceuticals						
Cannabis	11.5	10.2	-1.3	11.6	11.5	-0.1
Ecstasy	3.7	2.9	-0.8	3.0	2.1*	-0.9
Meth/amphetamine[23]	1.5	1.5	-	1.3	1.0	-
Cocaine	5.2	5.3	-0.1	4.2	4.5	+0.3
Hallucinogens	1.1	2.0*	+0.9	1.6	2.4*	+0.8
Inhalants	2.0	3.2*	+0.7	1.4	1.4	0.0
Ketamine	0.1	0.2	+0.1	0.9	1.4*	+0.5
Any illicit[24] excluding pharmaceuticals	14.6	14.5	-0.1	14.1	15.1	+1.0
Illicit use of any drug						
Any opioid[25]	2.7	2.6	-0.1	2.8	2.3*	-0.5
Any illicit	17.1	+17.6	0.5	16.4	17.9*	+1.5
*Significant change between 2019 and 2022-2023.						

Source: AIHW, National Drug Strategy Household Survey (2024). Table 9a.11: Summary of recent drug use, people aged 14 and over, by state/territory, 2001 to 2022-2023.

[23] Drug category changed in 2022-2023. Results for 2019 and earlier are not comparable.

[24] Illicit use of at least 1 of 17 classes of drugs (excluding pharmaceuticals) in the previous 12 months in 2022-2023. The number and type of illicit drug used varied over time.

[25] Includes use of heroin, non-medical use of painkillers/pain-relievers and opioids or non-medical use of methadone/buprenorphine.

Data from the National Waterways Drug Program (The Australian Criminal Intelligence Commission 2024) also shows that in December 2023:

- Victoria had the highest estimated average capital city and regional consumption of heroin
- Melbourne had the highest estimated average capital city consumption of methylamphetamine
- regional Victoria had the highest estimated average consumption of methylenedioxyamphetamine (MDA) and ketamine.

Monthly consumption rates of illicit drugs in Melbourne and regional Victoria for available data over the last half a decade were comparable for ketamine, methylenedioxymethamphetamine (MDMA) and methylamphetamine, but were generally higher in regional Victoria for cannabis, fentanyl, MDA and oxycodone.

Patterns of use

Socioeconomic factors and marginalisation experiences often expose individuals to social and structural vulnerabilities that can result in financial instability, drug dependencies and violence. In Australia, a personal history of self-harm was the leading psychosocial risk factor in drug-induced deaths across all drug types (12%), followed by disappearance and death of family member (5.7%), and disruption of family by separation and divorce (5.1%) (Chrzanowska et al. 2024).

Among Australians aged 20 to 29, MDMA use declined from 9.8% in 2019 to 7.5% in 2022-2023. Although cocaine use in the same age group steadily increased from 2001, mostly between 2016 (6.9%) and 2019 (12.0%), and remained stable at 11.8% in 2022-2023. Hallucinogen use among Australians in their 20s also steadily increased since 2001. Their hallucinogen use doubled from 3.1% in 2016 to 6.8% in 2022-2023 (Australian Institute of Health and Welfare 2024d).

According to the Illicit Drug Reporting System interviews[26] (Wilson and Dietze 2023), heroin, methamphetamine and cannabis use patterns remained largely unchanged in Melbourne between 2022 and 2023, while cocaine and other opioid use was relatively low and stable:

- Heroin use in the previous 6 months was reported by 87% of participants. Most (78%) used heroin weekly or more frequently, which was similar to 2022 (79%). Perceived availability of heroin also remained stable, with 62% finding it 'very easy to obtain' in 2023 compared with 50% in 2022.
- Methamphetamine use was reported by 77% of participants, which was similar to 2022 (75%). Around three-fifths (61%) of recent users consumed methamphetamine weekly or more frequently in 2023 (60% in 2022).
- Cocaine use was low, with only 17% of participants reporting recent consumption, and few using it weekly or more frequently.
- Non-prescribed cannabis use remained stable, with 79% reporting recent use (82% in 2022). Daily use among recent users was reported by 53%, which was similar to 46% in 2022.
- On-prescribed use of other opioids like methadone (12%), buprenorphine-naloxone (6%), morphine (5%), oxycodone (7%) and fentanyl (5%) remained low and stable across 2022 and 2023.

[26] In 2023, interviews were conducted with 150 participants in Melbourne. Participants were recruited via advertisements in needle syringe programs and other harm reduction services, as well as via peer referral. The sample comprised of 74% males, with a mean age of 45 years. Most of the sample reported being unemployed (92%), over half (53%) reported having post-school qualification, and 25% reported not having a fixed address. One-quarter (25%) identified as Aboriginal and/or Torres Straight Islanders, which was a significant decrease compared with 2019 (24%).

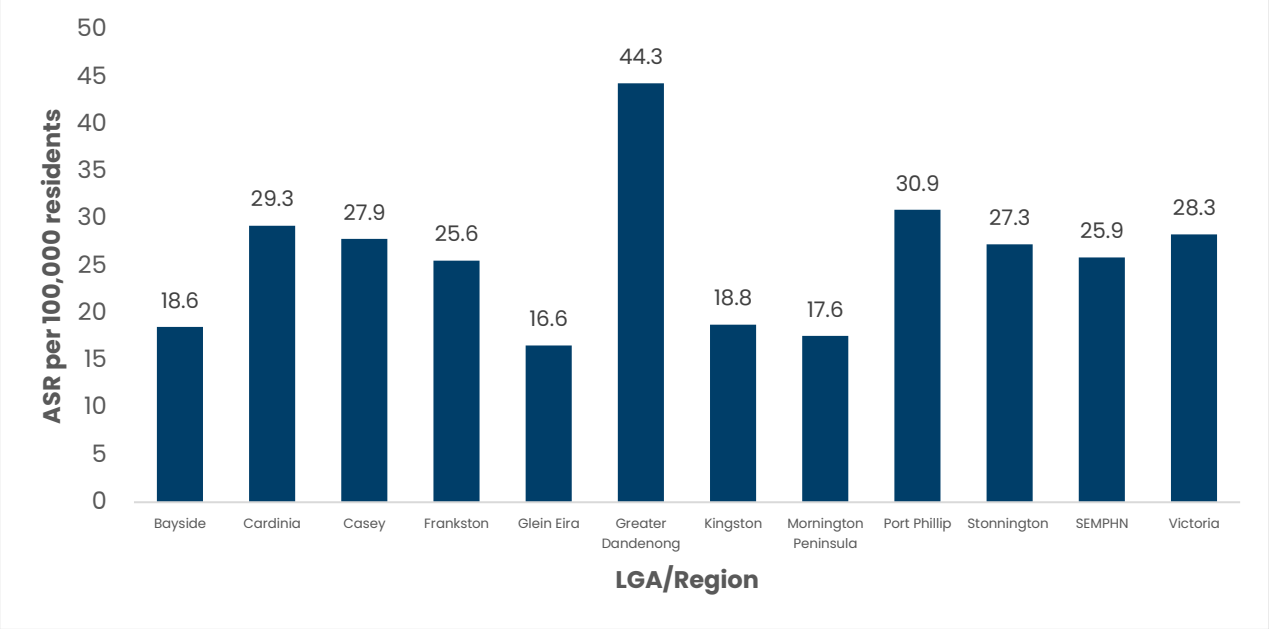
AOD harms

Road injuries

Each year in Victoria, approximately 17% of drivers who were killed in road crashes had a blood alcohol concentration (BAC) of 0.05 g/100 mL or above. In the last 5 years, 41% of all driver and motorcyclist fatalities had illicit drugs in their system (VicRoads 2022).

The highest rates of serious road injuries during alcohol hours[27] in the 2021-2022 FY were in Greater Dandenong (n=71, 44. 3 per 100,000 residents) and Port Phillip (n=32, 30.9 per 100,000 residents) (Figure 8.4) (Turning Point 2023). These were significantly higher than the rate for Victoria (13.7 per 100,000, n=1,809).

Figure 8.4 Serious road injuries during alcohol hours by LGA, FY2021-22



Source: Turning Point, 2023 (AODStats), accessed via https://aodstats.org.au/explore-data/serious-road-injuries/.

Analysis of 2,287 road traffic fatalities between 1 July 2006 and 30 June 2016 in Victoria identified alcohol was the most detected drug (18.4% with a BAC > 0.05 g/100 mL), followed by opioids (17.3%), tetrahydrocannabinol (13.1%), antidepressants (9.7%), benzodiazepines (8.8%), amphetamine-type stimulants (7.1%), ketamine (3.4%), antipsychotics (0.9%) and cocaine (0.2%) (Schumann et al. 2021).

Family violence and alcohol-related assaults

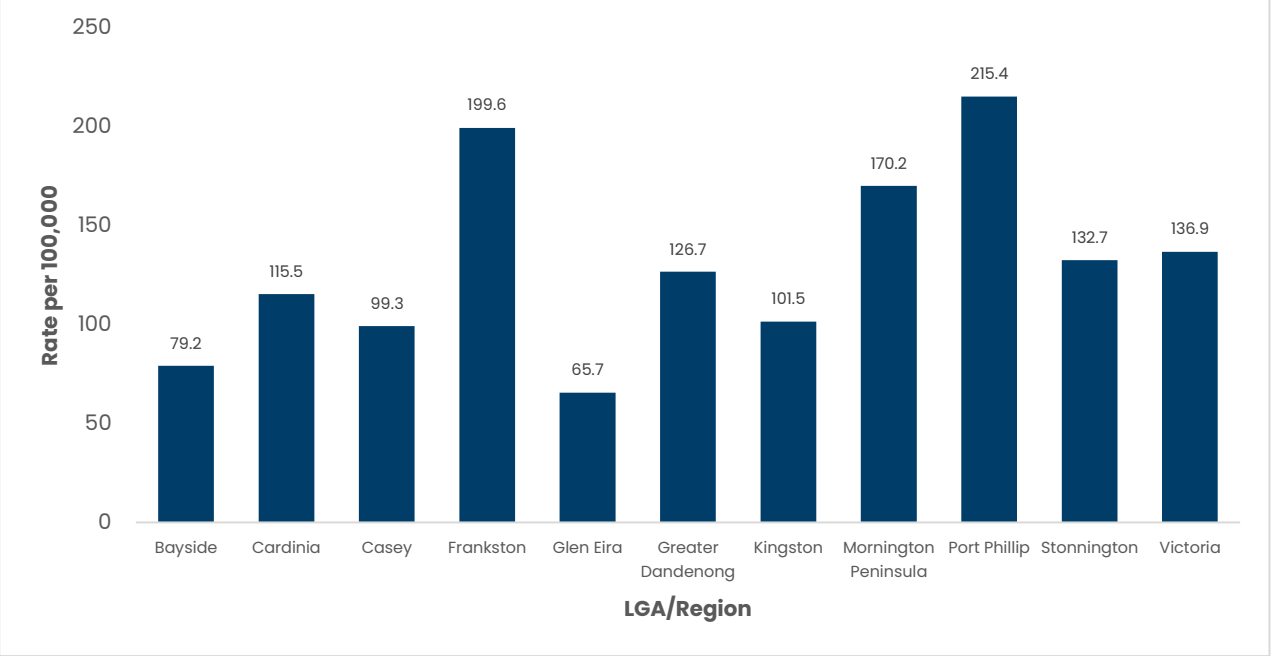
The COVID-19 pandemic saw the implementation of a range of public health measures to limit the spread of the virus in the community. During this time, there was a significant number of job losses, additional caring responsibilities, home schooling and other situational stresses, which in combination with social isolation increased financial stress and consumption of alcohol. These can be seen as underlying drivers of violence at home (Yates 2019). According to the Personal Safety Survey 2021-2022 (Australian Bureau of Statistics 2023), one in 17 (6.6%) females reported experiencing any violence (physical and/or sexual) in the last 2 years, and one in 35 (2.8%) females experienced intimate partner violence. These national rates were similar to those in

[27] It should be noted that alcohol involvement is not directly measured for this dataset, therefore an alternative surrogate measure of applying alcohol hours is used. Alcohol hours in metro areas are Sunday 6pm – Monday 6am, Monday 8pm – Tuesday 6am, Tuesday 6pm – Wednesday 4am, Wednesday 6pm – Thursday 6am, Thursday 6pm – Friday 6am, Friday or Saturday 8pm to 6pm

Victoria, where 5.3% of females experienced any violence and 2.1% experienced intimate partner violence in the last 2 years between 2021 and 2022.

Family violence attributed to definite or possible alcohol consumption[28] identified several LGAs of concern across the SEMPHN catchment. Most recent family violence data for south east Melbourne for 2021-2022 (Turning Point 2024) highlighted Port Phillip as having the highest rate of alcohol-related family violence incidents at 215.4 incidents per 100,000 people (Figure 8.5). In addition to Port Phillip, the LGAs of Frankston (199.6 per 100,000) and Mornington Peninsula (170.2 per 100,000) recorded rates higher than the Victorian average (136.9 per 100,000).

Figure 8.5 Family violence where alcohol might have been involved by LGA, FY2021-2022



Source: Turning Point, 2024 (AODStats), accessed via https://aodstats.org.au/explore-data/family-violence/.

AOD services

In 2022-2023, 350 AOD treatment agencies in Victoria provided 92,888 treatment episodes to 37,417 consumers (Australian Institute of Health and Welfare 2024a). Victoria reported more consumers using AOD services in 2022-2023 than 2013–2014, after adjusting for population growth (633 clients per 100,000 population compared with 580 per 100,000, respectively) (Australian Institute of Health and Welfare 2024a). This was a 2.9% increase in consumer numbers and a 6% increase in treatment episodes between 2021-2022 and 2022-2023. Alcohol was the most common drug of concern in 2021-2022, accounting for 39.4% (30,859) of treatment episodes, followed by amphetamines (26.2% or 20,514). Over half (53%) the consumers were aged 20–39 years (Australian Institute of Health and Welfare 2024a), and one in 10 identified as Aboriginal and Torres Strait Islander, while one in 5 (18%) were born overseas.

[28] Alcohol consumption in family violence incidents is not directly measured and therefore deemed definite or possible (as determined by Victoria Police).

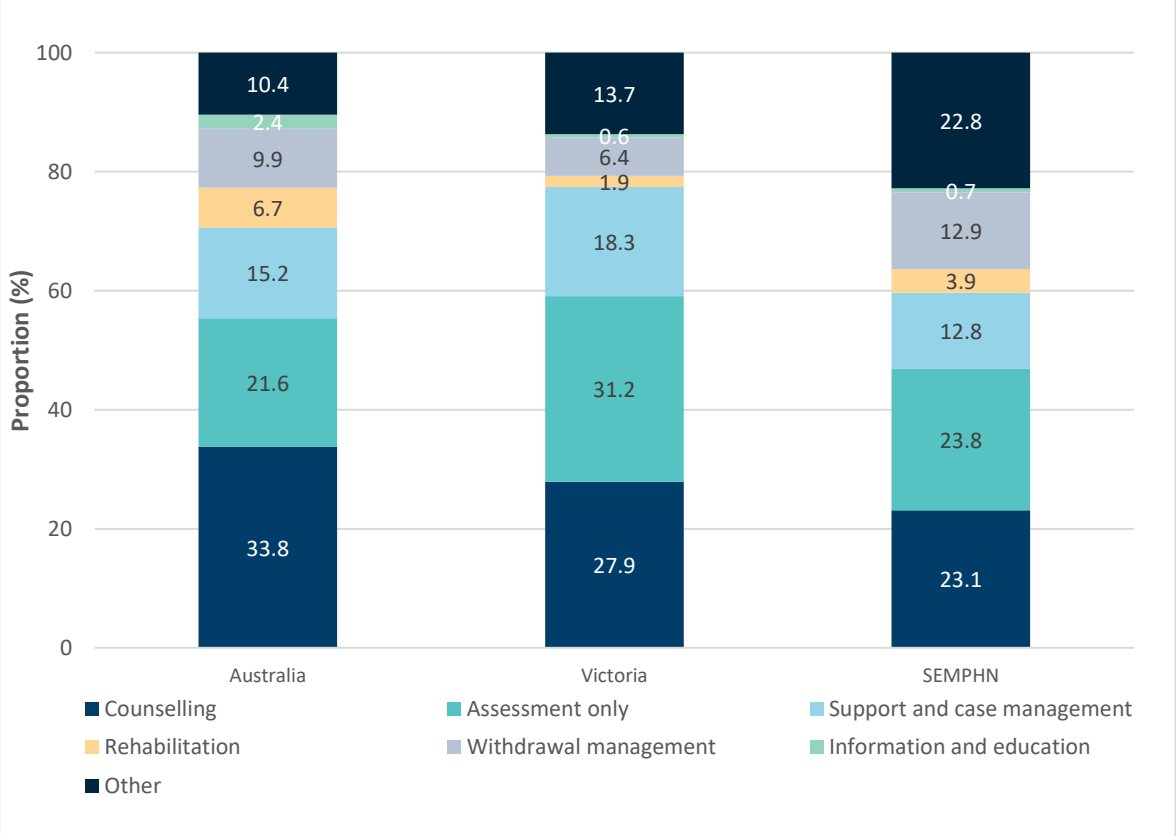
Treatment services

AOD treatment services across Australia provide a broad range of services and support to people who use alcohol or drugs, and to their families and friends. Delivery of these services can be provided in a residential treatment facility, non-residential treatment facility, outreach setting or in a home setting (Australian Institute of Health and Welfare 2024a). All publicly funded government and non-government agencies providing these treatment services (including community-based ambulatory services and outpatient services) are nationally mandated to collect and report via the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS-NMDS)[29].

Treatment types

Figure 8.6 illustrates the distribution of treatment types available to support individuals experiencing problematic drug use. Most treatments focus on harm reduction through services such as assessment (31.2% of episodes), counselling, or information/education provision. In 2022–2023, the most common treatment types in Victoria were assessments (31.2% of episodes), counselling (27.9%), and support and case management (18.3%) (Australian Institute of Health and Welfare 2024a). Nationally, counselling was the most prevalent treatment type, accounting for 33.8% of episodes. Psychosocial counselling, which includes evidence-informed talking therapies, aims to help individuals develop skills (e.g., psychological or practical) to reduce AOD consumption or related harms in line with personal goals. In Victoria, counselling as the main treatment type was reported less frequently than the national average (23.3% vs. 33.8%), with the SEMPHN catchment (23.1%) mirroring the state proportion. In the SEMPHN region, "assessment only" accounted for the largest proportion of treatment episodes (23.8%), aligning closely with Victorian (22.1%) and national (21.6%) figures.

Figure 8.6 Treatment episodes, as proportion of episodes by AOD treatment type and location, 2022-2023



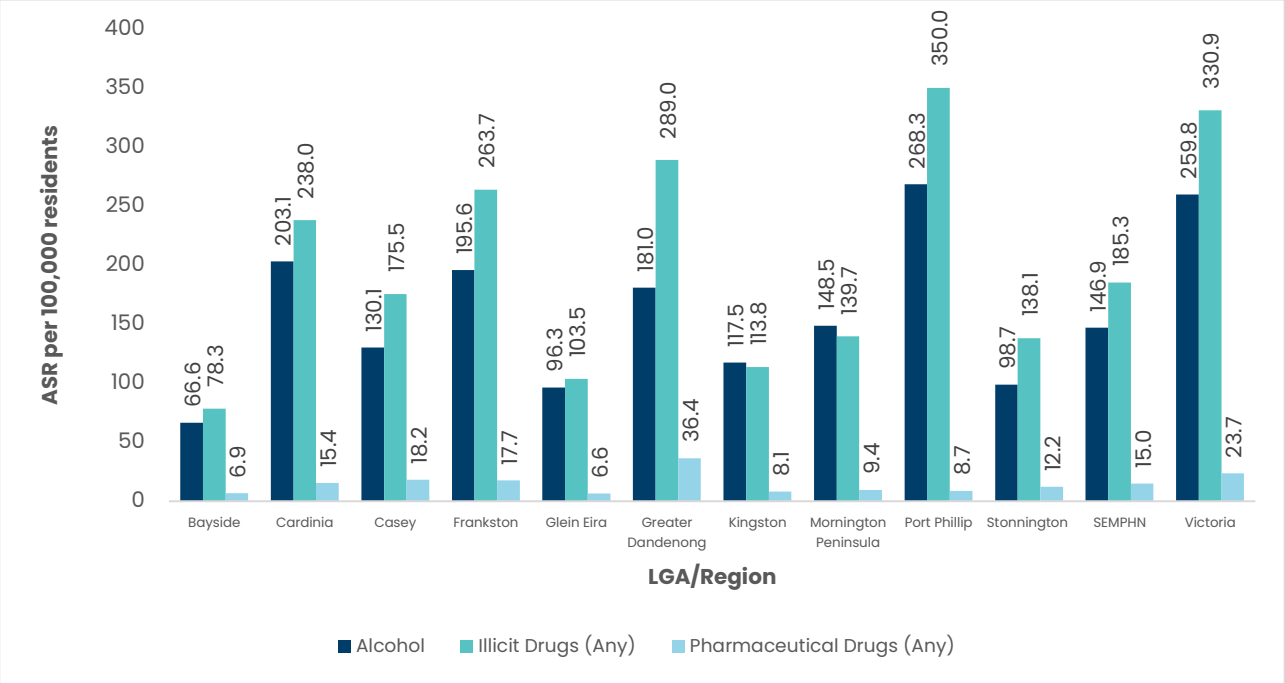
Source: AIHW, 2022-2023.

[29] For further detail, refer to Alcohol and Other Drug Treatment Services NMDS 2024-25 (aihw.gov.au).

Episodes of care

Figure 8.7 shows that, in the 2022-2023 FY, the highest rates of alcohol-related episodes of care occurred in Port Phillip (268.3 per 100,000) and Cardinia (203.1 per 100,000), which were higher than the Victorian average (259.8 per 100,000 population). The highest rates of illicit drug-related episodes of care were observed in Port Phillip (350.0 per 100,000 population), Greater Dandenong (289.0 per 100,000 population), and Frankston (263.7 per 100,000).

Figure 8.7 Episodes of care for alcohol, illicit drugs[30], and pharmaceutical drugs by LGA, FY2022-23



Source: Turning Point, 2024 (AODStats), accessed via https://aodstats.org.au/explore-data/treatment-services-vadc/.

Pharmacotherapy

Pharmacotherapy (also known as opioid replacement therapy) is the use of prescribed medication to assist in the treatment of addiction. Pharmacotherapy is one of the main treatment types used for opioid drug dependence. Depending on the individual, pharmacotherapy programs can be short-, medium- or long-term in duration and focus on different outcomes (e.g. reduce cravings, prevent withdrawal, block the reinforcing effects). These treatments aim to replace the opioid drug of dependence with a legally obtained, longer-lasting opioid that is usually taken orally. Since 1 February 2018, all formerly over-the-counter (non-prescription) codeine-containing medicines for pain relief, cough and colds became available by prescription only (Australian Institute of Health and Welfare 2021), and could therefore only be prescribed and dispensed through approved community pharmacy or a specialist clinic (Department of Health, 2019).

Consumers, prescribers and dosing sites

According to the most recent National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection, on a snapshot day in 2023, 53,272 consumers received pharmacotherapy treatment for their opioid dependence at 3,082 dosing points across Australia (Table 8.3). Victoria accounted for over 15,000 of these consumers from 1,204 prescribers at 790 dosing points. These included public prescribers such as AOD clinics

[30] Illicit drugs (any): Indicates case where any illicit drug was primarily involved in the event, including heroin, opioids, amphetamines, cannabis, stimulants, hallucinogens, inhalants or other illicit drugs not explicitly mentioned.

and public hospitals, private prescribers such as private GPs, and correctional facilities such as prisons or other correctional services. In Victoria, most prescribers were private (89.2%), with 10.8% being correctional facilities. There is no data for Victoria for public prescribers (Australian Institute of Health and Welfare 2024f).

While there was a small increase in the ratio of consumers to prescribers in Victoria from 2019 to 2023 (8.3 clients per prescriber to 12.5 clients per prescriber), these were much less than those observed nationally (17.1 clients per prescriber). The ratio of consumers to dosing points steadily declined in Victoria between 2019 and 2023 (from 20.4 to 19.1 consumers per dosing point), but was higher than the national estimate of 17 clients per dosing site (see Table 8.3).

Table 8.3 Ratio of clients, prescribers and dosing points by location, 2019 and 2023

Number/Ratio	Victoria		Australia
	2023	2019	2023
Total number of clients	15,106	14,085	53,272
Total number of prescribers	1,204	1,700	3,123
Total number of dosing points	790	689	3,082
Ratio of clients to prescribers	12.5	8.3	17.1
Ratio of clients to dosing points	19.1	20.4	17.0

Source: NOPSAD, 2024.

Prescribers and dispensers

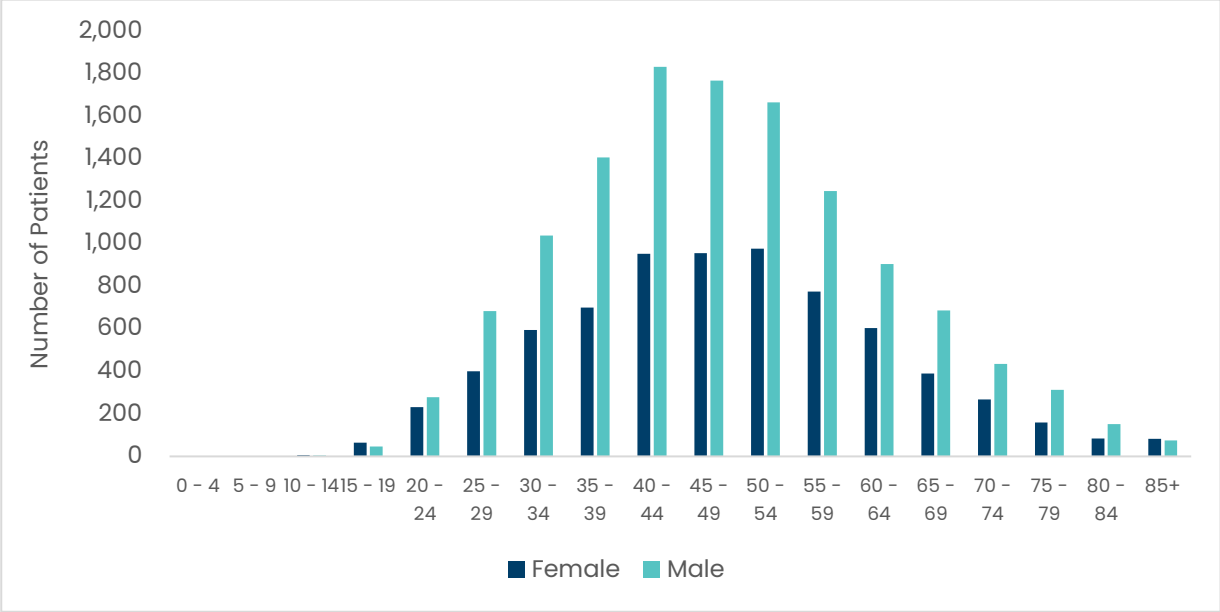
Based on the most recent data in 2020 (Menon et al. 2022), the highest number of patients prescribed with pharmacotherapy treatments were in the suburbs of Frankston (postcode 3199, n=373) and Greater Dandenong (postcode 3175, n=353), followed by Cranbourne (postcode 3977, n=268), St Kilda (postcode 3182, n=227) and Noble Park (postcode 3174, n=207). The highest number of authorised prescribers and dispensers were in Frankston (postcode 3199), with 8 prescribers and 7 pharmacies. Greater Dandenong (postcode 3175) had 8 pharmacies and 5 prescribers. This disparity between the number of prescribers and pharmacies continues to grow in other high-need areas such as Cranbourne (postcode 3977) with 6 pharmacies and only 2 prescribers, and Narre Warren (postcode 3805) with one prescriber and 5 pharmacies. St Kilda (postcode 3182) instead had notably more prescribers (n=7) than pharmacies (n=3). Such imbalances in the ratio of prescribers to pharmacies in high-need areas may lead to an increased burden on prescribers in neighbouring LGAs.

In addition to an imbalance in the ratio of prescribers to pharmacies, the data showed strong disparity in the proportion of residents receiving pharmacotherapy treatment versus the availability of prescribers and/or dispensers. For example, while a large proportion of Noble Park residents were receiving pharmacotherapy treatment (n=207, 2.8%), the LGA only had 4 pharmacies and no prescribers. This was similar in Pakenham (postcode 3810), with about 150 patients being prescribed pharmacotherapy treatments, where there were only 2 prescribers and one pharmacy. Such imbalances could result in an increased burden on neighbouring LGAs with a higher number of prescribers and dispensers, as well as a burden on patients to move to alternative LGAs to receive the treatment needed. This indicates a strong need to identify, explore and establish pathways to help convert Medication Assisted Treatment for Opioid Dependence (MATOD) trained GPs to active prescribers to help shift the balance and improve the well-being of the south east Melbourne community.

Primary care insights

As of May 2024, there were approximately 20,000 unique active patients with a current AOD diagnosis who attended a POLAR-registered south east Melbourne general practice in the past 2 years. Of these patients, 36.6% were female and 63.4% were male, potentially reflecting the higher prevalence of AOD diagnoses in males (Figure 8.8).

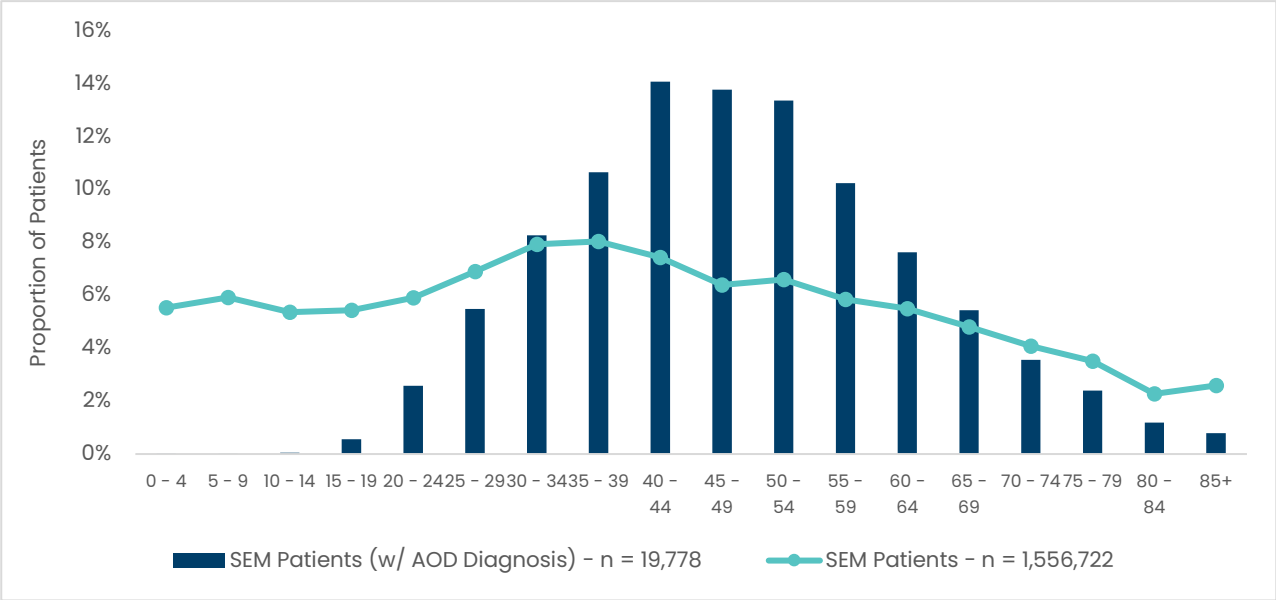
Figure 8.8 General practice patients with active AOD diagnosis by age and gender, 2022-2024



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Patients with an active AOD diagnosis were generally older than age distribution of primary care patients across south east Melbourne, with most of these AOD patients (70.3%) aged between 30-59 (compared to 42.2%). A small proportion (>5%) were aged under 20 or over 75 (Figure 8.9).

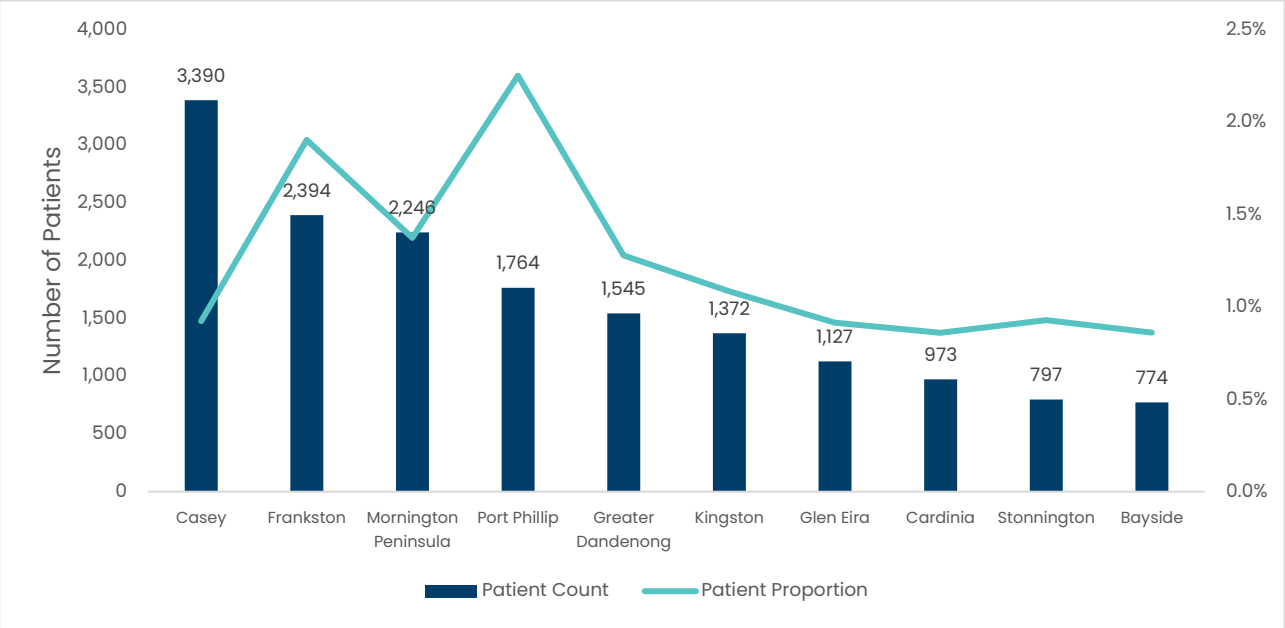
Figure 8.9 General practice patients with active AOD diagnosis by age, 2022-2024



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

General practice patients with a current AOD diagnosis were primarily located in Casey, which comprised 17.1% of all AOD patients in south east Melbourne, followed by Frankston (12.1%) and the Mornington Peninsula (11.4%). Although when analysed proportionately against all patients within each locality, Port Phillip had the highest proportion of patients with an active AOD diagnosis at 2.3%, followed by Frankston (1.9%) and Mornington Peninsula (1.4%) (Figure 8.10).

Figure 8.10 General practice patients with active AOD diagnosis by LGA, 2022-2024



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Among all patients in SEMPHN, including those with and without a chronic disease diagnosis, general practices recorded a median of 6 consultations per patient over 2 years. Patients with an active AOD diagnosis attended general practice consultations almost twice as frequently as patients without an active AOD diagnosis. The median number of consultations for AOD patients over a 2-year period was 12.

Over three-quarters (85.2%) of patients with a current AOD diagnosis also had a comorbid chronic disease diagnosis of a different category (e.g. MH, diabetes and respiratory) (Table 8.4). The top 3 chronic disease comorbidities for patients with an AOD diagnosis were for MH (one in 2), cardiovascular (one in 4) and cancer (one in 10) conditions.

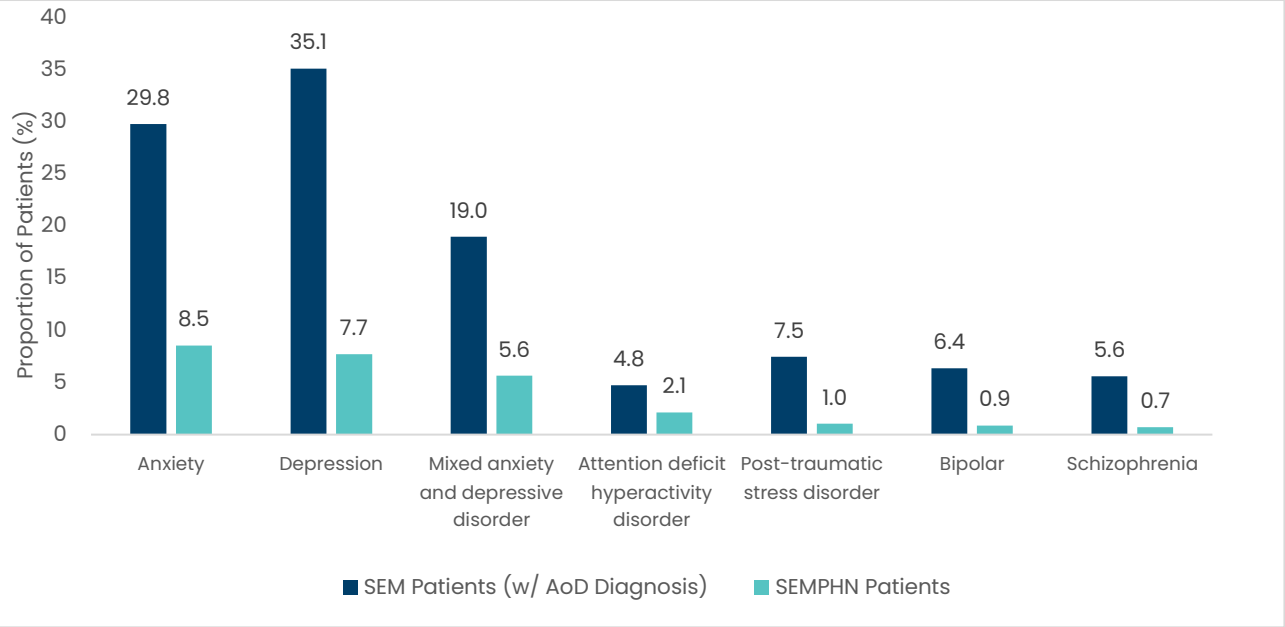
Table 8.4 Top 3 chronic disease comorbidities for general practice patients with current AOD diagnosis in SEMPHN catchment

Ranking	Condition	Proportion of patients (%)
1st	MH	50.52
2nd	Cardiovascular	22.32
3rd	Cancer	4.30

Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

Among patients with a current AOD diagnosis, depression was the most common MH comorbidity (35.1%), followed by anxiety (29.8%), mixed anxiety and depressive disorder (19.0%), and PTSD (7.5%). The prevalence of more severe and complex MH conditions such as BPD I and II (6.4%) and schizophrenia (5.6%) was substantially higher than among the wider south east Melbourne population (Figure 8.11).

Figure 8.11 Prevalence of MH-related diagnoses for patients with an active AOD diagnosis



Source: SEMPHN Primary Care Utilisation Data (POLAR), May 2022 – May 2024.

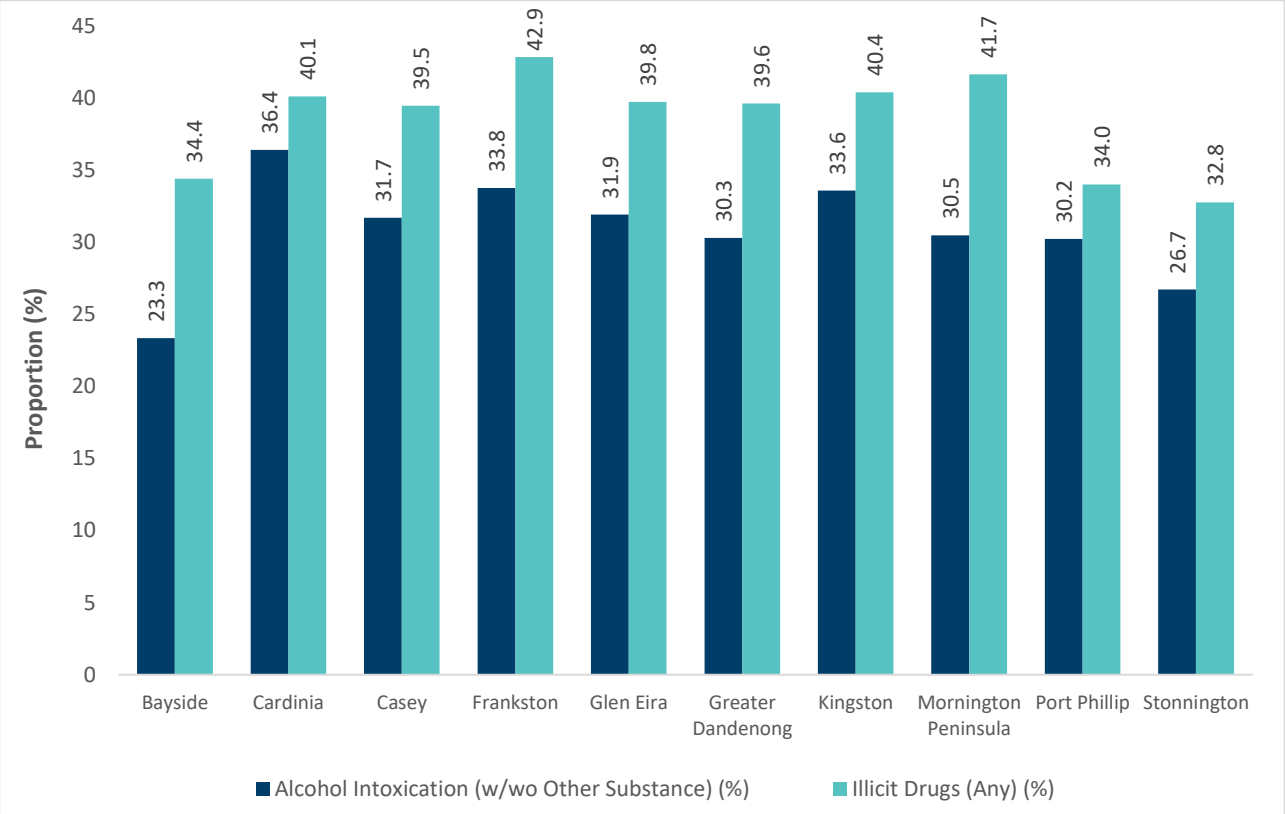
Tertiary care insights

In Victoria, there were 44,237 drug-related ambulance attendances in the 2022-23 FY (Turning Point 2023). Alcohol accounted for the highest proportion of these attendances (47.9%), followed by illicit drugs (30.6%) and pharmaceutical drugs (23.7%). The amount of drug-related ambulance attendances has increased by approximately 50% in Victoria since the 2012-13 FY.

The growing rates of AOD-related ambulance attendances highlight that AOD care needs are not being met within the community.

Figure 8.12 illustrates the proportion of ambulance attendances for AOD-related events that have also involved police attendances in the 2022-23 FY. The amount of police and ambulance co-attendances for AOD-related events was higher in the LGAs of Mornington Peninsula and Cardinia compared with the Victorian average of 32.8%. The rates of alcohol intoxication and illicit drug use were higher in Casey, Frankston, and Greater Dandenong compared to the Victorian averages. The Victorian average for alcohol intoxication was 31.7%, while for illicit drugs it was 36.9%. This demonstrates the complexity and safety concerns for health professionals, as well as the increased burden on community and financial resources that AOD issues can cause in the catchment.

Figure 8.12 Police co-attendance rates for AOD-related ambulance attendances by LGA, FY2022-2023



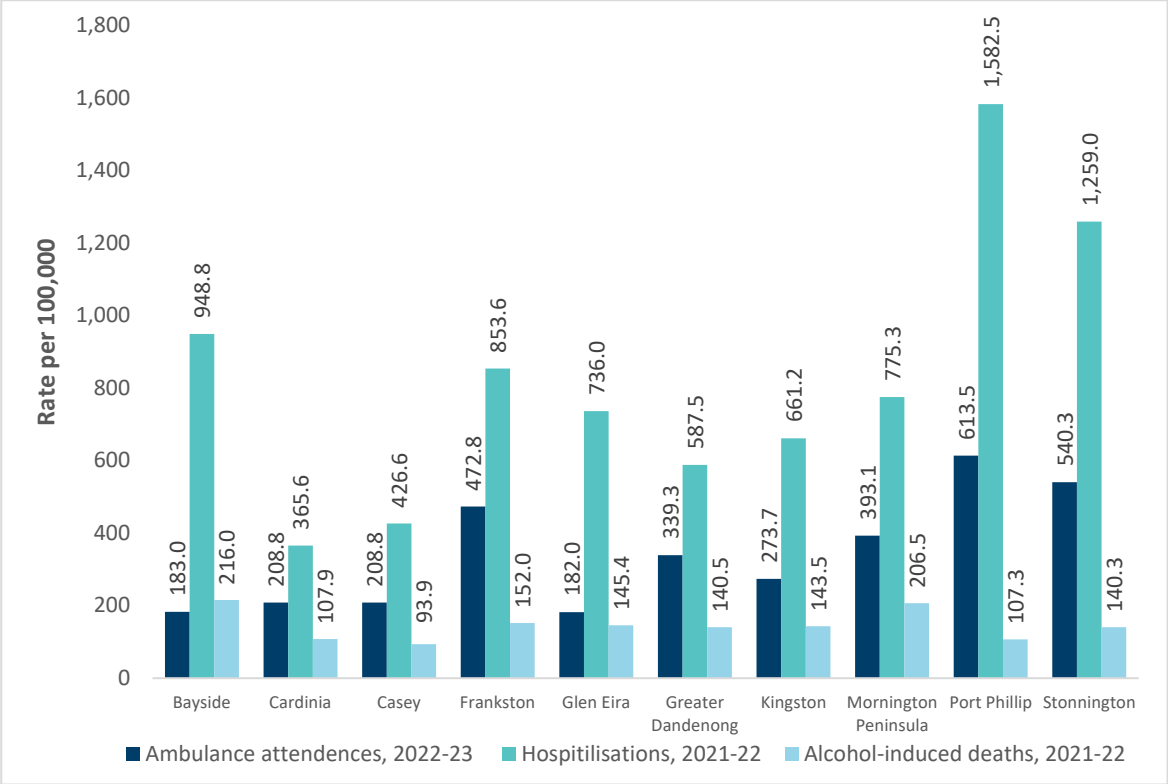
Source: Turning Point, 2024 (AODStats), accessed via https://aodstats.org.au/explore-data/ambulance-attendances/.

HOSPITAL ADMISSIONS

The rates of people being transported to hospital by ambulances due to AOD incidents generally increased between the 2014-15 and 2021-22 FYs (Turning Point 2023). This is likely due to the severity and complexity of AOD-related attendances. South east Melbourne's sharpest increase in AOD-related ambulance attendances in the 2018-19 FY was related to cannabis, heroin and amphetamines. The growing rate of AOD hospital admissions or hospitalisations is an indication of the AOD care needs that are currently not being met within the community.

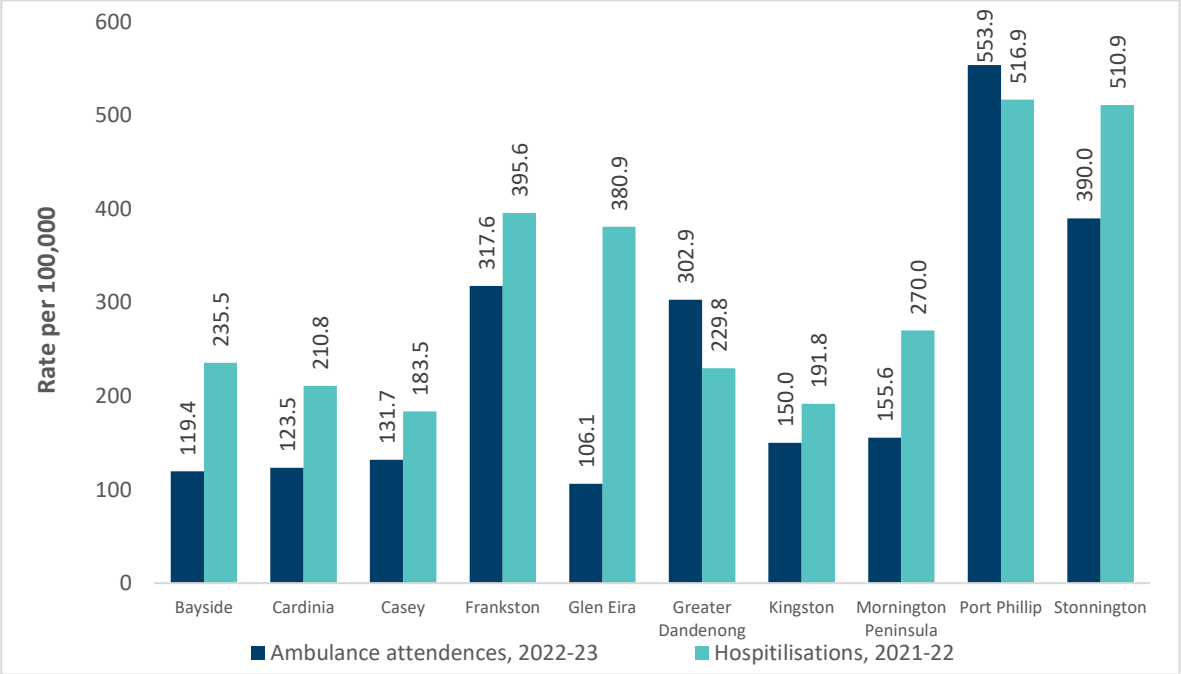
Figure 8.13 and Figure 8.14 report on the AOD-related events across SEMPHN catchment.

Figure 8.13 Alcohol-related emergency service use and deaths by LGA



Source: Turning Point, 2024 (AODStats), accessed via https://aodstats.org.au/explore-data.

Figure 8.14 Illicit drug-related[31] emergency service use by LGA



Source: Turning Point, 2024 (AODStats), accessed via https://aodstats.org.au/explore-data.

[31] Illicit drugs (any): Indicates case where any illicit drug was primarily involved in the event, including heroin, opioids, amphetamines, cannabis, stimulants, hallucinogens, inhalants or other illicit drugs not explicitly mentioned.

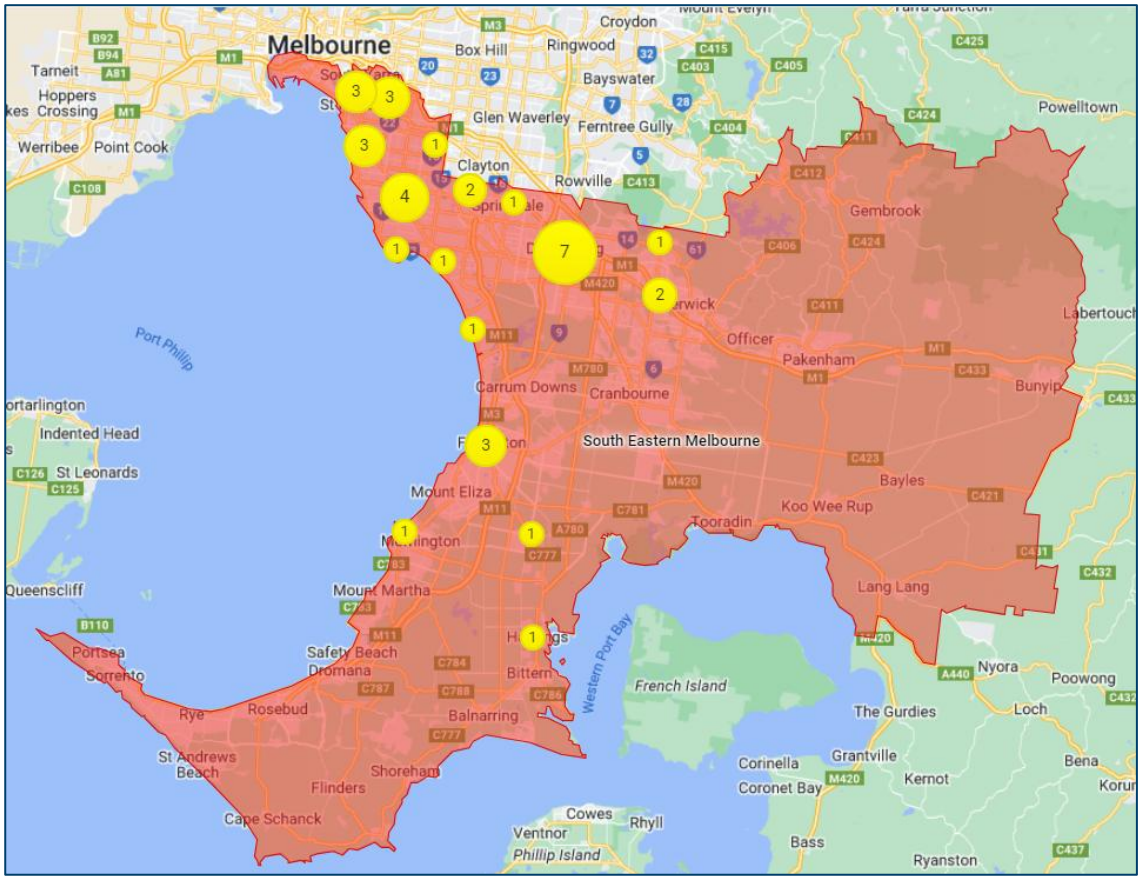
AOD-INDUCED DEATHS

The number of Australians dying from AOD overdoses each year continues to rise. There were 1,693 drug-induced deaths reported in Australia in 2022, representing an ASR of 6.5 per 100,000 people, of which 1,175 (69.4%) were unintentional. Within the SEMPHN catchment, the rate of AOD-related deaths in the 2020-21 financial was mapped across LGAs as an indication of the AOD care needs that were not being met in the community. As illustrated in Figure 8.13, the highest rate of alcohol-induced deaths was in Bayside, with 216.0 deaths per 100,000 people, 52.2% higher than the Victorian average (141.9 per 100,000)(Turning Point 2023). Mornington Peninsula had the second highest rate, with 206.5 deaths per 100,000people. The lowest rates were in Casey (93.9), Port Phillip (107.3) and Cardinia (107.9). Rates of drug-induced deaths across the SEMPHN catchment due to any illicit drug use were very low (fewer than 5 or 0 in most LGAs). In comparison, Victoria had 39 drug-induced deaths in the 2021-22 FY, with an ASR of 0.60 per 100,000 people.

AOD services

As of June 2023, the NHDS had records for at least 36 AOD counselling clinics (or clinics that offered the same services) in the south east Melbourne region. Services were primarily located in the north western (inner-city) portion of the region, in the LGAs of Port Phillip, Stonnington, Bayside and Dandenong. A notable absence of services was identified in Casey (South), Cardinia and Mornington Peninsula (South) (Figure 8.15).

Figure 8.15 Map of AOD counselling services, June 2023



Source: Health Direct – Health Map, National Health Services Directory (NHSD), June 2023.

Stakeholder engagement insights

In July 2022, stakeholder consultations were conducted with service providers and lived-experience community members to identify the key principles that underpin a 'good' service and the current challenges or pressure points that are potentially impeding this.

The consultation with AOD service providers (n=19), consumers and the AOD community (n=12) identified the following key risk factors for harm from AOD use in the region:

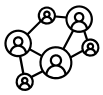
- family history of addiction
- mental illness
- peer pressure, especially in young people
- lack of family involvement
- using AOD at an early age
- using a highly addictive drug such as cocaine or opioids
- living in areas of socioeconomic disadvantage where there are increased rates of unemployment, poor support systems and low rates of school retention
- a lack of housing.

CHALLENGES ACROSS THE CONSUMER JOURNEY

The challenges experienced by consumers across the AOD treatment journey were identified during the lived experience and service provider consultations. These are summarised in Table 8.5 below.

Table 8.5 Summary of workshop findings

Family and carers 	• Lack of an intentional and structured approach to intersectionality. • Need to focus on connection and engagement. • Limited family integration across the system.
Lived experience 	• Identifying appropriate services for an individual's needs. • Some marginalised groups lack access to technology to support identifying and accessing pathways to care or available services. • Lack of affordable services and limitation in accessing care (e.g. transport). • Overservicing (significant time spent going between AOD and MH services). • Lack of cultural and gender diverse representation. • Lack of safe housing options while receiving treatment. • Individualised assertive outreach. • Holistic approach to after-care (e.g. social supports). • Long waitlists in the public system. • Limited family integration in the treatment process. • Disconnect between MH and AOD services. • Safe housing options after exiting a service. • Lack of after-care services (e.g. allocation of an exit support worker).

Service providers 	• Lack of knowledge of pathways even when they do exist. • Lack of awareness of existing pathways to support NES communities. • Lack of understanding regarding the separate intake systems (e.g. state versus PHN). • Ensuring there are access pathways for transient populations.

References

Australian Institute of Health and Welfare (2021) *Alcohol and other drug treatment services in Australia annual report*, AIHW, , https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/about.

Australian Bureau of Statistics (2023) *Personal Safety Survey 2021-22*, https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/2021-22.

Australian Government Department of Health (2020) *Standard drinks guide*, Australian Government Department of Health,, Canberra, https://www.health.gov.au/health-topics/alcohol/about-alcohol/standard-drinks-guide.

Australian Institute of Health and Welfare (2017) *National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics* Australian Institute of Health and Welfare

——— (2018) Australia's Health, Australia's health series no. 16, Canberra.

——— (2019) Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment, 2016–17, Cat. no. HSE 212, Canberra.

——— (2024a) *Alcohol and other drug treatment services in Australia annual report*, https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/about.

——— (2024b) *National Drug Strategy Household Survey 2022–2023: Alcohol consumption* [data set], https://www.abs.gov.au/statistics/health/health-conditions-and-risks/alcohol-consumption/latest-release.

——— (2024c) National Drug Strategy Household Survey 2022–2023: Electronic cigarettes and vapes [data set].

——— (2024d) National Drug Strategy Household Survey 2022–2023: Illicit drugs [data set].

——— (2024e) National Drug Strategy Household Survey 2022–2023: Tobacco smoking [data set].

——— (2024f) *National Opioid Pharmacotherapy Statistics Annual Data collection*, https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/opioid-pharmacotherapy-prescribers.

Campbell CA, Hahn RA, Elder R, Brewer R, Chattopadhyay S, Fielding J, Naimi TS, Toomey T, Lawrence B and Middleton JC (2009) 'The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms', *American journal of preventive medicine*, 37(6):556-69.

Chrzanowska A, Man N, Sutherland R, Degenhardt L and Peacock A (2024) *Trends in overdose and other drug-induced deaths in Australia, 2003-2022*, Sydney.

Department of Health (2017) National Drug Strategy 2017-2026.

Department of Health and Aged Care (2021) *Types of drugs*, https://www.health.gov.au/health-topics/drugs/about-drugs/types-of-drugs.

Menon N, Miyazaki K, Ievlieva S and Daraganova G (2022) *Needs Assessment Report*, South East Melbourne Primary Health Network.

National Health and Medical Research Council (2020) *Australian guidelines to reduce health risks from drinking alcohol*, https://www.nhmrc.gov.au/health-advice/alcohol.

Schumann J, Perkins M, Dietze P, Nambiar D, Mitra B, Gerostamoulos D, Drummer OH, Cameron P, Smith K and Beck B (2021) 'The prevalence of alcohol and other drugs in fatal road crashes in Victoria, Australia', *Accident Analysis & Prevention*, 153:105905.

Ten to Men (2020) *Alcohol use among Australian men - Chapter 2*, Ten to Men - The Australian Longitude Study on Male Health,, https://tentomen.org.au/research-findings/insights-report/alcohol-use.

The Australian Criminal Intelligence Commission (2024) *National Wastewater Drug Monitoring Program—Report 22*.

Turning Point (2023) *AODStats* [data set], https://aodstats.org.au/.

——— (2024) *AODStats* [data set].

VicHealth (2022) *Rise in Victorian e-cigarette use & purchasing behaviours*, https://www.vichealth.vic.gov.au/media-and-resources/media-releases/alarming-rise-in-victorian-ecigarette-usage-purchasing-behaviours.

Victorian Agency for Health Information (2023) *Victorian Population Health Survey*, Victoria Department of Health,, https://vahi.vic.gov.au/reports/victorian-population-health-survey.

Victorian Commission for Gambling and Liquor Regulation (2024) *Victorian liquor licences by location* [data set].

Victorian State Government (2021) *Alcohol & other drugs*, https://www.health.vic.gov.au/alcohol-other-drugs.

Wilson J and Dietze P (2023) Victorian Drug Trends 2023: Key Findings from the Illicit Drug Reporting System (IDRS) Interviews., Sydney.

Yates S (2019) '"An exercise in careful diplomacy": Talking about alcohol, drugs and family violence', *Policy Design and Practice*, 2(3):258-74.

Chapter 9 Chronic disease

- **Leading Causes of Death and Disability:** dementia (including Alzheimer's disease) among females (12.6%) and coronary heart disease among males (12.4%).
- **Multiple Chronic Conditions:** highest proportion with reported comorbidities in Mornington Peninsula (75.6 per 1,000), Frankston (70.9 per 1,000), Kingston and Cardinia (56.0 per 1,000).
- **Cancer Screening:** lowest bowel cancer screening participation rates in Casey South (35.9%), Dandenong (38.3%), and Frankston (39.3%); lowest breast cancer screening participation rates in Stonnington West (37.5%), Port Phillip (40.6%), and Frankston (41.4%); lowest cervical cancer screening rates lowest participation rates in Casey South (57.0%), Cardinia (58.6%), and Frankston (60.4%).
- **General practice attendance:** on average, those with chronic conditions have higher GP consultation rates, with chronic kidney disease (CKD) patients attending the most (18 visits in the last 2 years), followed by patients with diabetes (15 visits in the last 2 years).
- **ED Presentations:** highest in Frankston (323 per 1,000 residents) and Greater Dandenong (342 per 1,000 residents), where injury and poisoning-related admissions were most common.
- **Hospital Admissions:** highest rates in Greater Dandenong (258 per 1,000 residents), followed by Frankston (305 per 1,000 residents) and Mornington Peninsula (274 per 1,000 residents).

Australia has a growing ageing population with one of the highest life expectancies in the world, ranking fifth among Organisation for Economic Co-operation and Development (OECD) member countries[32]. In 2021, life expectancy at birth in Australia was 81.3 years for men and 85.4 years for women. Data from 2016 to 2020 show that the median age at death[33] among males in south east Melbourne was 80.6 years and among females was 85.7 years (Australian Institute of Health and Welfare 2021).

In Australia, chronic conditions are the leading cause of illness, disability and death, and can substantially affect a person's quality of life (Australian Institute of Health and Welfare 2022a). In June 2021, nearly one in 3 Australians (31.7%, n=8,064,000) reported they had at least one long-term health condition (Australian Institute of Health and Welfare 2022c), including MH (8.8%), arthritis (8.1%), diabetes (4.7%), heart disease (3.9%) and cancer (2.9%).

Many people with chronic conditions have comorbidities; that is, the presence of 2 or more chronic conditions at the same time. There has been a 5% increase in the prevalence of Australians reporting one or more chronic conditions in the last 10 years (Australian Bureau of Statistics 2018a). This has been attributed to several factors including an ageing population because of longer life expectancy and an increase in social and behavioural risk factors such as poor diet and physical inactivity (Australian Bureau of Statistics 2018b). The Australian Burden of Disease Study (Australian Institute of Health and Welfare 2018) estimated that Australians had lost almost 199 years of healthy life per 1,000 population due to living with illness and dying prematurely (Australian Institute of Health and Welfare 2018). To address this increasing burden, the Australian government's National Preventive Health Strategy 2021-2030 (Department of Health 2021), has acknowledged the need to respond to the increasing burden of disease and reduce heath inequities across population groups.

[32] The OECD is an international organisation with 38 member countries. It works with governments, policymakers and citizens to establish evidence-based international standards for a range of social, economic and environmental challenges.

[33] Median age at death is interpreted as the age at which exactly half the deaths are those of people above that age and half are below that age. Median age at death is calculated based on the age at death in single years.

Leading causes of death and disability

Table 9.1 shows the top 10 leading causes of death in the SEMPHN catchment between 2017 and 2021 were from chronic diseases. Dementia including Alzheimer's disease was the leading cause of death among females (accounting for 12.6% of all causes), while coronary heart disease was the leading cause for death among males (accounting for 12.4% of all causes). Ischemic health diseases and cancers in the digestive and respiratory organs were the top 3 causes of death in the 65+ years age group. Among the 85 years and over cohort, dementia including Alzheimer's was the leading cause of death, followed by organic including symptomatic mental disorders[34].

The data show there is a substantially higher rate ratio for accidental falls compared with other causes of death among older persons. Falls are Australia's largest contributor to hospitalised injuries and a leading cause of injury deaths for the older population. In 2019-2020, 42% of hospitalised injuries and 40% of injury deaths were due to older population falls. The SEMPHN catchment ranked fourth across all PHNs in Australia for deaths due to accidental falls among men (ASR 16.9 per 100,000) and fifth for deaths due to accidental falls among women (ASR 11.9 per 100,000).

Table 9.1 Leading causes of death in south east Melbourne, 2017–2021

Cause of death	Deaths (n)	All causes (%)	Rate (per 100,000)	Rate ratio (relative to Australia)
Coronary heart disease (I20–I25)	4,959	10.50	48.3	0.89
Dementia including Alzheimer's disease (F01, F03, G30)	4,464	9.46	40.7	0.96
Cerebrovascular disease (I60–I69)	2,860	6.06	27.3	0.92
Lung cancer (C33, C34)	2,387	5.06	25.1	0.92
Chronic obstructive pulmonary disease (COPD) (J40–J44)	1,805	3.82	18.0	0.81
Accidental falls (W00–W19)	1,512	3.20	14.1	1.45
Colorectal cancer (C18–C20, C26.0)	1,473	3.12	15.3	0.90
Diabetes (E10–E14)	1,341	2.84	13.2	0.84
Heart failure and complications and ill-defined heart disease (I5.)	1,299	2.75	12.2	1.22
Influenza and pneumonia (J09–J18)	1,058	2.24	9.8	1.08

Source: AIHW, 2021.

[34] Definition of organic including symptomatic mental disorders: comprises a range of mental disorders grouped together on the basis of having in common a demonstrable etiology in cerebral disease, brain injury, leading to cerebral dysfunction.

Population prevalence

Chronic conditions are long-term and persistent illnesses. The number of chronic conditions can be used to indicate the health status (and risk of death) of individuals. Healthcare can be challenging as well as extremely costly for consumers with multiple comorbidities, resulting in unmet care needs and inadequate communication with care providers.

Table 9.2 provides data on the rates of various chronic health conditions and individuals with 2 chronic conditions per 1,000 people based on the ABS 2021 Census. The data is examined in more detail in the following sections.

Table 9.2 Prevalence of chronic conditions by LGA per 1,000 older residents, 2021

LGA	Arthritis	Asthma	Diabetes Mellitus	CVD	COPD	Cancer	2 chronic conditions
Mornington Peninsula	117.3	89.5	45.8	56.0	21.8	46.6	75.6
Frankston	93.0	103.6	51.3	42.1	20.9	31.4	70.9
Bayside (Vic.)	78.1	75.2	30.6	41.3	12.9	37.9	52.1
Kingston (Vic.)	77.8	80.7	45.9	40.2	14.1	30.6	56.0
Cardinia	75.2	94.2	44.0	32.4	14.9	24.3	56.0
Glen Eira	62.7	71.6	37.9	34.0	9.7	27.0	47.7
Greater Dandenong	60.7	64.3	61.1	32.3	11.4	18.9	45.7
Casey	60.1	76.7	52.1	29.7	11.1	19.0	47.0
Stonnington	58.3	76.3	26.8	31.0	9.1	29.2	45.3
Port Phillip	54.1	76.7	25.3	26.6	10.3	25.5	46.8

Source: 2021 Census, ABS (June 2022 release) Table G20: Count of selected long-term health conditions by age by sex. The bolded and highlighted cells indicate the highest prevalence rates for each chronic condition. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%). CVD=cardiovascular disease; COPD=chronic obstructive pulmonary disease.

Below is a detailed breakdown of the prevalence for each chronic condition as reported in the ABS 2021 Census across the SEMPHN catchment.

Multiple chronic conditions

As shown in Table 9.2, Mornington Peninsula (75.6 per 1,000), Frankston (70.9 per 1,000), and Kingston and Cardinia (56.0 per 1,000) had the highest proportion of residents who reported comorbidities (2 or more chronic conditions) across the SEMPHN catchment.

Arthritis

Arthritis describes a range of inflammatory conditions affecting the bones, muscles and joints, including osteoarthritis and rheumatoid arthritis (Australian Institute of Health and Welfare 2020a). One in 5 Australians (22%) with arthritis experience high to very high levels of psychological distress, which is twice as likely as those without arthritis (10%) (Australian Institute of Health and Welfare 2020b). As shown in Table 9.2, the highest rates of arthritis were observed in Mornington Peninsula (117.3 per 1,000), Frankston (93.0 per 1,000)

and Bayside (78.1 per 1,000). Demographic profiling shows a higher proportion of older females living with arthritis aged between 55–84 years (n=52,788; 46%), compared with men (n=27,722; 25%).

Asthma

Asthma is a chronic respiratory condition. In Australia, around one in 10 Australians (10.7%) had asthma in 2020-21. Higher asthma rates were observed in Frankston (103.6 per 1,000) and Cardinia (94.2 per 1,000) (Table 9.2). There is a higher proportion of males aged 0–14 years (n =10, 414; 8%) living with asthma in the SEMPHN catchment compared with females (n=6,616; 5%) in the same age group (Australian Bureau of Statistics 2022). Across all other age groups, a higher proportion of women were living with asthma compared to males. Asthma was the anomaly among other chronic conditions reported because very high prevalence was observed in the 0-14 years age group (n=17,030; 13%) (Australian Bureau of Statistics 2022).

Diabetes mellitus

Diabetes mellitus is a group of chronic diseases (Type 1, 2 and gestational) that affect how the body metabolises glucose. Type 2 diabetes is the most common type and mostly preventable chronic condition (Diabetes Australia 2021). In 2020, approximately 1 in 20 Australians lived with diabetes (Type 1 and 2), and almost 1 in 5 older people aged 80-84 (Australian Institute of Health and Welfare 2022b). National data also indicates an association between diabetes and socioeconomic indicators, suggesting that the prevalence of diabetes is twice as high in those living in the lowest socioeconomic areas (7.0%) compared with the highest socioeconomic areas (3.3%) (Abouzeid et al. 2013). Migrant groups have a higher prevalence of Type 2 diabetes than the Australian-born population, which is often attributed to genetics, lifestyle, environmental and migration-related factors (Tewari and Lin 2019). As shown in Table 9.2, higher rates of diabetes (excluding gestational diabetes) were observed in Greater Dandenong (61.1 per 1,000), Casey (52.1 per 1,000) and Frankston (51.3 per 1,000). Gender and age distribution analysis (excluding gestational diabetes) shows that there was a higher proportion of men (n=38,145; 54%) living with diabetes compared with women (31,884; 46%) in south east Melbourne. Males aged 55-84 years accounted for 38% (n=26,205) of all residents living with diabetes in the region.

Cardiovascular

Cardiovascular conditions (heart, stroke and vascular disease) are a leading cause of death in Australia. In 2017-2018, 6.2% of adults had one or more cardiovascular conditions (Australian Institute of Health and Welfare 2021). There was a higher prevalence of cardiovascular conditions observed among males and First Nations people. The proportion of Australians who reported having heart, stroke and vascular disease was significantly higher among those living in the most socioeconomically disadvantaged areas compared with those in the least disadvantaged areas (6.4% and 4.8%, respectively).

Table 9.2 shows that higher rates of cardiovascular conditions were observed in Mornington Peninsula (56 per 1,000), Frankston (42.1 per 1000) and Bayside (41.3 per 1,000). When comparing rates of strokes in south east Melbourne, it was highest in Mornington Peninsula (13.4 per 1,000), Frankston (11.4 per 1000) and Kingston (9.8 per 1000). A higher prevalence of heart diseases was observed in males aged between 55-84 years (n=26,082; 47%) compared with females in the same age group (n=15,020; 26%).

COPD

COPD is a group of breathing-related diseases affecting the lungs, including emphysema and chronic bronchitis. COPD is more prevalent in Australians aged 45 years and among First Nations people (Australian Institute of Health and Welfare 2020c). Based on national self-reported data (2018-2019), 10% of First Nations people aged 45 and over had COPD (an estimated 17,800 people), with a higher rate among women (13%) compared with men (6.7%). The prevalence of COPD among First Nations people was 2.3 times as high as for non-First Nations people after adjusting for the difference in age structure (Australian Bureau of Statistics 2020). Prevalence was higher in the lowest socioeconomic area compared to the highest socioeconomic area (men 7.5% and 3.1%, respectively; women 6.6% and 4.0%, respectively) (Australian Institute of Health and Welfare 2020c).

Even though the prevalence of COPD for the SEMPHN region was lower than the Victorian average, high prevalence was observed in Frankston, Cardinia and Port Phillip (Table 9.2).

CANCER

In 2020, there were 48,266 deaths from cancer in Australia (Cancer Australia 2020). The most common cancers (excluding non-melanoma skin cancer) are prostate, breast, bowel, melanoma and lung cancer (Cancer Council 2021). As of 30 June 2021, 43,316 residents in the SEMPHN catchment were living with some form of cancer, including those in remission. Of this, 22,523 (52.0%) were female. Table 9.2 shows that higher rates were observed in Mornington Peninsula (46.6 per 1,000), Bayside (37.9 per 1,000) and Frankston (31.4 per 1,000). The gender and age analysis indicates a higher prevalence among residents between 55 and 84 years (n=12,725; 29%), with gender distribution consistent across all age groups, with prevalence increasing across both males and females over 55 years of age.

Cancer screening

Cancer screening programs are a way to detect cancer in the early stages and can improve survival rates and produce better health outcomes. Australia has 3 national cancer screening programs:

- National Bowel Cancer Screening Program (NBCSP)
- BreastScreen Australia Program
- National Cervical Screening Program (NCSP).

Table 9.3 Cancer screening participation in SEMPHN catchment by SA3, 2022

SA3	Cancer screening participation		
	Bowel cancer (%) (2020-2021)	Breast cancer (%) (2019-2020)	Cervical cancer (%) (2018-2021)
Bayside	49.9	48.1	76.9
Cardinia	41.7	44.4	58.6
Casey – North	40.1	44.7	62.8
Casey – South	35.9	42.0	57.0
Dandenong	38.3	42.4	61.2
Frankston	39.3	41.4	60.4
Glen Eira	42.8	47.2	68.3
Kingston	44.4	47.9	69.2
Mornington Peninsula	46.9	48.7	64.7
Port Phillip	41.2	40.6	70.1
Stonnington – East	46.7	48.7	70.9
Stonnington – West	39.6	37.5	73.0
South east Melbourne	41.9	44.7	64.7
Victoria	43.9	50.6	61.9

Source: AIHW, Cancer screening programs: quarterly data (15 July 2023), National Cancer Screening Programs participation. SA3 = Statistical Area Level 3. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Bowel cancer

Bowel cancer screening participation rates have been captured for males and females who were invited to screen during the relevant 2-year period and returned a completed screening test within that period or by 30 June of the following year. These rates have steadily increased since 2014, when participation rates increased from 37.4% (invited: 154,608 people) to 42% in 2020 (invited: 363,618). The number of SEMPHN residents who participated in the bowel screening programs in 2019-2020 (152,500) was more than double those who participated in 2014 (57,748).

The SA3 with the lowest bowel cancer screening participation rate in 2020-2021 was Casey – South (35.9%), followed by Dandenong (38.3%), and Frankston (39.3%), which were all below the Victorian average participation rate of 43.9%, and the national average of 41.8% (Table 9.3).

Breast cancer

Breast cancer screening participation rates were recorded for women in the eligible population age of 50-74 years by BreastScreen Australia over 2 calendar years (2019-2020). There has been a slight dip since 2014-2015 where participation rates have decreased from 48.9% (invited: 187,473) to 44.7% in 2019-2020 (invited: 214,454). The number of women participating has increased from 91,674 in 2014, to 95,939 in 2019-2020.

The SA3s with the lowest breast cancer screening participation rates in 2019-2020 were Stonnington – West (37.5%) followed by Port Phillip (40.6%) and Frankston (41.4%), which were all below the Victorian average participation rate of 43.9%, and the national average of 49.9% (Table 9.3).

Cervical cancer

Cervical cancer screening rates were measured for women in the eligible population (aged 25-75 years) who had at least one cervical screening test (primary screening or 12-month repeat HPV test) between 2018 and 2021. Fewer than half of the SA3s in the SEMPHN catchment reported participation rates higher than the Victorian average of 69.1%. SA3s with the lowest participation rates were Casey – South (57.0%), Cardinia (58.6%) and Frankston (60.4%) (Table 9.3).

Primary care insights

General practice patients

Chronic disease diagnoses recorded by POLAR-registered SEMPHN general practices were separated into broad chronic disease categories (e.g. MH, cardiovascular, musculoskeletal). Prevalence surrounding MH, AOD and dementia are not detailed below as the prevalence of these chronic diseases are further detailed in the relevant dedicated chapters:

- Dementia and Alzheimer's – Chapter 5
- MH – Chapter 7
- AOD – Chapter 8.

Chronic disease prevalence, measured by the proportion of patients with a current diagnosis of that category, is provided in Table 9.4 by LGA to highlight the most prominent chronic diseases by geographic location across the SEMPHN catchment. These results highlight key health issues for primary care consumers in these LGAs and the related services they are most likely to require.

Table 9.4 Prominent chronic diseases among primary care patients by LGA, July 2024

LGA	Cancer	Cardiovascular	CKD	Diabetes	Disability	Musculoskeletal	Respiratory
Mornington Peninsula	6.76 (1)	22.97 (1)	0.93 (1)	5.90	3.07 (1)	17.68 (1)	16.74 (2)
Frankston	3.91	17.74 (2)	0.63 (2)	6.19 (3)	3.01 (2)	15.14 (2)	17.13 (1)
Bayside	5.29 (2)	17.67 (3)	0.45	3.98	2.41	13.56 (3)	12.81
Kingston	4.09	16.39	0.44	5.28	2.49 (3)	12.42	14.00
Greater Dandenong	2.34	15.44	0.43	7.68 (1)	2.36	13.12	12.06
Glen Eira	3.53	14.87	0.45	4.74	2.25	11.79	12.50
Cardinia	2.90	14.57	0.48 (3)	5.54	2.29	13.50	14.87 (3)
Casey	2.45	14.47	0.45	6.60 (2)	2.45	13.14	14.60
Stonnington	4.18 (3)	13.96	0.46	3.38	2.00	11.53	11.87
Port Phillip	4.10	13.44	0.46	3.48	2.15	10.93	11.48
South east Melbourne	3.60	15.74	0.49	5.52	2.40	12.95	13.61

Note: The proportion of patients with a specific chronic disease conditional on an individual having at least one active diagnosis by a GP within the respective category. Therefore, these figures provide an approximate representation of chronic disease prevalence among SEMPHN primary care consumers and should be interpreted with care. Note: Highlighted cells denote the highest 3 rates of chronic conditions across all age groups.

Mornington Peninsula had a relatively high proportion of patients (1st, 2nd or 3rd highest in SEMPHN) with an active diagnosis across, except for diabetes. Over one in 5 patients in Mornington Peninsula had at least one cardiovascular diagnosis (e.g. hypertensive disorder, atrial fibrillation, ischaemic heart disease), and one in 6 had a musculoskeletal condition. A higher prevalence of chronic conditions is consistent with the age demographics of the Mornington Peninsula, with the oldest average age and proportion of adults aged 65+ in the across the SEMPHN region.

Frankston also had a high proportion of patients with an active diagnosis across all but one chronic disease grouping (cancer). One in 6 patients had an active respiratory condition, most frequently asthma, consistent with the 2021 ABS Census. Frankston primary care patients had a particularly high recorded prevalence of both individual and comorbid chronic disease diagnoses across several health areas (e.g. cardiovascular, respiratory, CKD), indicating the influence of other health-related risk factors in the region, such as socioeconomic, age demographics and service accessibility, which may benefit from targeted population health and service planning interventions.

Greater Dandenong and Casey, with a relatively high proportion of young residents and CALD populations had the highest and second-highest prevalence of diabetes, respectively.

Table 9.5 Prominent chronic diseases among primary care patients by age, July 2024

Age group (years)	Cancer	Cardiovascular	CKD	Diabetes	Disability	Musculoskeletal	Respiratory
0-9	0.04	0.14	0.01	0.07	0.44	7.57	2.06
10-19	0.11	0.21	0.02	0.35	1.10	14.10	4.48
20-29	0.28	0.90	0.05	0.70	3.76	11.12	2.16
30-39	0.69	2.99	0.10	1.64	6.12	11.08	1.46
40-49	1.68	9.07	0.18	4.10	9.93	13.66	1.52
50-59	3.99	21.07	0.34	7.78	16.12	15.25	1.72
60-69	8.01	37.87	0.72	13.00	25.70	17.40 (3)	2.07
70-79	14.04 (3)	54.62 (3)	1.87 (3)	17.59 (2)	38.81 (3)	19.83 (2)	3.14 (3)
80-89	17.50 (1)	66.18 (1)	3.67 (2)	19.89 (1)	48.36 (2)	20.48 (1)	5.65 (2)
90-99	15.38 (2)	65.27 (2)	4.53 (1)	15.68 (3)	49.88 (1)	16.78	7.13 (1)
South east Melbourne	3.60	15.74	0.49	5.52	2.40	12.95	13.61

Note: Highlighted cells denote the highest 3 rates of chronic conditions across all age groups.

Patients aged 70 and older had the highest prevalence of all chronic diseases, excluding musculoskeletal. The proportion of patients with a diagnosis in any of the 7 reported chronic diseases categories typically increased from the youngest age group (0-9) through to the oldest (90-99) (Table 9.5). This is indicative of the increasing health needs for individuals as they age, attributable to an increased susceptibility to chronic health issues. Substantial increases in chronic disease prevalence were observed between individuals aged 50 or younger and those 60 or older, particularly for cardiovascular conditions, disability and cancer.

The proportion of patients with multiple comorbid chronic disease diagnoses varied by LGA. Patients with multiple (2+) comorbidities typically had escalated/complex health needs and may have required additional primary care services to monitor their conditions. Table 9.6 illustrates the proportion of patients with one, 2, 3, 4 and 5 or more chronic disease diagnoses by LGA.

Table 9.6 Number of comorbid chronic disease diagnoses among patients by LGA, July 2024

LGA	Number of chronic disease diagnoses				
	1	2	3	4	5+
Mornington Peninsula	26.65 (1)	15.49 (1)	7.80 (1)	2.95 (1)	1.05 (1)
Frankston	26.16 (2)	14.18 (2)	6.65 (2)	2.65 (2)	0.93 (2)
Kingston	24.52	11.98 (3)	5.08	1.85	0.63
Bayside	24.80	11.81	5.10	1.83	0.64
Cardinia	24.19	11.39	5.09	1.94	0.72
Casey	22.76	11.01	5.00	1.92	0.69
Glen Eira	23.80	10.85	4.62	1.69	0.64
Port Phillip	24.59	10.74	4.54	1.73	0.65
Stonnington	25.48 (3)	10.42	4.11	1.55	0.60
Greater Dandenong	20.64	10.39	5.11 (3)	2.04 (3)	0.79 (3)
South east Melbourne	24.09	11.87	5.40	2.05	0.74

Note: Highlighted cells denote the highest 3 rates of across all LGAs and number of chronic conditions.

Mornington Peninsula and Frankston had the first and second highest proportion of patients with any number (1,2,3,4,5+) of comorbid chronic disease respectively, representing over one in 2 patients. High prevalence of comorbid chronic disease is indicative of the population health needs in these localities and may be related to the higher distribution of residents aged 65+ in comparison with other LGAs in the SEMPHN catchment.

Greater Dandenong had the third highest proportion of patients with diagnoses across 3 or more chronic disease categories. Stonnington had the third highest proportion of patients with a single chronic disease diagnosis. This is likely attributable to the high prevalence of MH diagnoses in the SEMPHN region.

In situations where patients have multiple comorbid[35] chronic disease diagnoses, these may be related across broad groupings (e.g. diabetes and cardiovascular conditions) due to the many factors contributing to overall health. To better illustrate these relationships, the 3 most common comorbidities for patients with 2 or more chronic disease diagnoses are presented in Table 9.7.

[35] The condition of having two or more diseases at the same time.

Table 9.7 Top 3 chronic disease comorbidities for patients with 2+ chronic disease diagnoses in SEMPHN catchment, July 2024

Rank	Cancer	Cardiovascular	CKD	Diabetes	Disability	Musculoskeletal	Respiratory
1st	Cardiovascular	Diabetes	Cardiovascular	Cardiovascular	MH	MH	Musculoskeletal
2nd	MH	MH	Diabetes	MH	Respiratory	Respiratory	MH
3rd	Musculoskeletal	Musculoskeletal	Musculoskeletal	Musculoskeletal	Musculoskeletal	Cardiovascular	Cardiovascular

Note: Each chronic disease diagnosis is highlighted by a separate colour.

Due to the relatively high prevalence of MH conditions across the SEMPHN catchment (approximately one in 6 patients), MH-related conditions are among the top 3 comorbidities for all chronic disease groupings, other than CKD. Both disability and musculoskeletal conditions are most commonly comorbid with MH conditions (Table 9.7).

Cardiovascular and diabetes conditions frequently co-occurred, aligning with current knowledge of shared risk factors influencing their development and diagnosis. Musculoskeletal conditions rank as the third most common comorbidity across all chronic disease groupings, except for respiratory conditions.

General Practice Service utilisation

General practice service utilisation by patients varied by age, LGA and the health profile of the individual. The type of chronic disease diagnosis (if any) a patient has may contribute to the number of GP consultations they attend and the time between those consultations (due to emerging health issues or ongoing treatment/medication).

Table 9.8 Median number of GP consultations in last 2 years by chronic disease, July 2024

Chronic disease	Median number of GP consultations in last 2 years	Number of patients
No chronic disease	4	877,613
CKD	18	7,608
Respiratory	11	209,787
Disability	11	85,063
Cardiovascular	13	242,542
Musculoskeletal	14	199,545
Cancer	14	55,487
Diabetes	15	85,063

Chronic disease	Median number of GP consultations in last 2 years	Number of patients
SEMPHN average	6	1,541,157

Note: Highlighted cells denote the 3 highest median number of consultations across all chronic conditions.

Among all SEMPHN patients, both those with and without a chronic disease diagnosis, general practices recorded a median of 6 GP consultations per patient over 2 years (Table 9.8). Patients with no chronic disease diagnoses attended a median of 2 consultations per year (4 in 2 years), which was substantially lower than for those with at least one chronic condition who attended a median of 11-to-19 consultations over the last 2 years. Patients with CKD had the highest median number of consultations at 19, followed by diabetes (15) and cancer (14). These 3 conditions are typically associated with ongoing monitoring of health status, medical testing and treatment.

Understanding the relationship between an individual's health status and their frequency of primary care visits is crucial, especially for chronic conditions that may require specialist care. This knowledge can better inform decision-making to enhance the availability and variety of services within a PHN region, addressing the broader health needs of the local population (e.g. diabetes-related services in high-prevalence areas like Casey and Greater Dandenong).

Tertiary care insights

ED PRESENTATIONS

Table 9.9 ED presentations (per 1,000 ERP) by LGA, FY2022-23 (ABS, 20230

LGA	ERP 2023	Number of ED presentations	Rate per 1,000 population
Bayside	104,272	21,806	209
Cardinia	126,960	34,785	274
Casey	392,110	101,486	259
Frankston	142,826	43,579	305
Glen Eira	156,837	27,497	175
Greater Dandenong	163,792	42,227	258
Kingston	163,724	37,136	227
Mornington Peninsula	170,243	46,618	274
Port Phillip	109,515	30,024	274
Stonnington	111,335	18,024	162
South east Melbourne	1,641,614	403,182	246
Victoria	6,815,441	1,894,732	278

Note: Highlighted cells denote the highest estimated population, number and rate of ED presentations across all LGAs. ERP=estimated resident population.

Casey residents made up the largest amount of ED presentations in SEMPHN at just over 100,000 (n=101,486), representing approximately one in 4 ED presentations by SEMPHN residents. This is attributable to the locality's large population, followed by Mornington Peninsula (n=46,618) and Frankston (n=43,579). However, when analysed by the rate of ED presentations per 1,000 population (as of June 2023), Frankston had the highest rate at 305, followed by Cardinia, Mornington Peninsula and Port Phillip all at approximately 274 presentations (Table 9.9).

ED PRESENTATIONS BY PRIMARY DIAGNOSIS

ED presentations across SEMPHN contain a primary diagnosis recorded by the ICD-10 code associated with the patient's primary reason for attending.

Table 9.10 ED presentations per 1,000 resident population by top 10 principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Proportion of ED presentations	Rate per 1,000 population
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	28.5%	70.0
Injury, poisoning and certain other consequences of external causes	20.4%	50.0
No recorded diagnosis	6.8%	16.6
Diseases of the respiratory system	6.2%	15.2
Certain infectious and parasitic diseases	5.1%	12.6
Diseases of the musculoskeletal system and connective tissue	4.4%	10.7
Diseases of the digestive system	4.3%	10.6
Diseases of the circulatory system	4.1%	10.0
Diseases of the genitourinary system	3.6%	8.9
Mental and behavioural disorders	3.3%	8.2
Diseases of the skin and subcutaneous tissue	2.6%	6.4

Note: Highlighted cells denote the highest proportions and rates of ED presentations, respectively, across all principal diagnoses.

Excluding broad category groupings such as 'symptoms, signs and abnormal clinical findings', the top primary broad ICD-10 category diagnoses for ED presentations across SEMPHN were (Table 9.10):

- injury, poisoning and certain other consequences of external causes
- diseases of the respiratory system (respiratory conditions)
- certain infectious and parasitic diseases (infectious disease)

- diseases of the musculoskeletal system and connective tissue
- diseases of the digestive system.

The top 5 primary diagnosis categories for ED presentations varied by LGA and are presented in Table 9.11.

Table 9.11 Top 5 principal diagnosis categories for ED presentations by LGA, FY2022-23

LGA	1st	2nd	3rd	4th	5th
Bayside	Injury & poisoning	Respiratory conditions	Infectious and parasitic disease	Circulatory conditions	Musculoskeletal conditions
Cardinia	Injury & poisoning	Respiratory conditions	Infectious and parasitic disease	Digestive conditions	Musculoskeletal conditions
Casey	Injury & poisoning	Respiratory conditions	Infectious and parasitic disease	Digestive conditions	Musculoskeletal conditions
Frankston	Injury & poisoning	Respiratory conditions	Infectious and parasitic disease	Digestive conditions	Musculoskeletal conditions
Glen Eira	Injury & poisoning	Respiratory conditions	Infectious and parasitic disease	Musculoskeletal conditions	Circulatory conditions
Greater Dandenong	Injury & poisoning	Infectious and parasitic disease	Respiratory conditions	Musculoskeletal conditions	Digestive conditions
Kingston	Injury & poisoning	Respiratory conditions	Infectious and parasitic disease	Circulatory conditions	Digestive conditions
Mornington Peninsula	Injury & poisoning	Respiratory conditions	Circulatory conditions	Musculoskeletal conditions	Digestive conditions
Port Phillip	Injury & poisoning	Mental and behavioural	Respiratory conditions	Musculoskeletal conditions	Infectious and parasitic disease
Stonnington	Injury & poisoning	Respiratory conditions	Mental and behavioural	Musculoskeletal conditions	Infectious and parasitic disease
South east Melbourne	Injury & poisoning	Respiratory conditions	Infectious and parasitic disease	Musculoskeletal conditions	Digestive conditions

Injury and poisoning was the most common broad category primary diagnosis for ED presentations across all SEMPHN LGAs. The top specific diagnoses related to injury and poisoning ED presentations were:

- injuries to the wrist and hand
- injuries to the head
- injuries to ankle and foot.

Port Phillip and Stonnington were the only LGAs to record mental and behavioural disorders within the top 5 diagnosis categories, at 2nd and 3rd most frequently cited respectively. LGAs with a higher proportion of older residents (aged 65+), such as Mornington Peninsula, Kingston and Bayside, recorded circulatory conditions as either the 3rd or 4th most frequent primary diagnosis of ED presentations, consistent with the prevalence of cardiovascular conditions in primary care patients across those LGAs.

Differences were observed based on the age of the patient based on 3 age groupings: children and adolescents (0-19 years old), adults (20-64 years old), and older adults (65 years or older). Three noteworthy differences were observed in terms of the most frequent primary diagnoses assigned to ED presentations by age:

- Skin and subcutaneous conditions were disproportionately prevalent for children aged 0-10 years.
- Mental and behavioural related presentations were most frequent (2nd or 3rd most frequent) for adolescents and young adults aged 15-40 years.
- Presentations for diagnoses related to the circulatory system were most common in older adults aged 65 years and over.

WAIT TIMES BY DIAGNOSIS

ED wait times can depend on a multitude of factors, such as the purpose of the visit, the allocated triage priority, the time of day and patient demand by location. The relationship between patient wait time and primary diagnosis may provide insight into ED presentations that are typically lower urgency. In line with this, peak times of day make up a substantial proportion of ED demand and may be health areas that could be improved through access to appropriate general practice or more specialised services. The average wait time for ED presentations by the top 10 broad category diagnoses are highlighted in Table 9.12.

Table 9.12 Average wait time for ED presentations across SEMPHN by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Average time to treatment (minutes)
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	33.0
Injury, poisoning and certain other consequences of external causes	37.5
No recorded diagnosis	46.9
Diseases of the respiratory system	34.2
Certain infectious and parasitic diseases	41.0
Diseases of the musculoskeletal system and connective tissue	40.8
Diseases of the digestive system	35.6
Diseases of the circulatory system	26.3
Diseases of the genitourinary system	31.9
Mental and behavioural disorders	33.0

Category (by principal diagnosis)	Average time to treatment (minutes)
Diseases of the skin and subcutaneous tissue	48.0

Note: Highlighted cells denote the top 3 average wait times based on principal diagnoses.

ED presentations related to the circulatory system had the lowest average wait time in FY2022-23 across SEMPHN, at just over 26 minutes, followed by genitourinary presentations (32 minutes), and mental and behavioural presentations (33 minutes). Skin and subcutaneous tissue conditions, ED presentations most frequent among young children, had the highest time to treatment of all broad category primary diagnoses at 48 minutes, indicative of lower-urgency triaging.

Triage category by LGA

Presentations by SEMPHN residents to the ED were triaged and assigned one of 5 prioritisation categories: non-urgent, semi-urgent, urgent, emergency and resuscitation. The 2 priority categories of non-urgent and semi-urgent are representative of lower-urgency care, which in some situations (but not always, given the complex context of an individual's health situation) indicate presentations to the ED that may be more effectively managed by a general practice. Table 9.13 highlights the proportion of ED presentations classified as urgent, semi-urgent and non-urgent by LGA.

Table 9.13 ED presentation triage categories by LGA, FY2022-23

LGA	Resuscitation, emergency, urgent	Semi-urgent, non-urgent	Number of presentations
Bayside (Vic.)	57.9%	42.1%	21,806
Cardinia	65.7%	34.3%	34,785
Casey	67.8%	32.2%	101,486
Frankston	71.9%	28.1%	43,579
Glen Eira	60.3%	39.7%	27,497
Greater Dandenong	68.1%	31.9%	42,227
Kingston (Vic.)	65.2%	34.8%	37,136
Mornington Peninsula	68.0%	32.0%	46,618
Port Phillip	53.0%	47.0%	30,024
Stonnington	57.6%	42.4%	18,024
South east Melbourne	65.2%	34.8%	403,182

Note: Highlighted cells denote the top 3 proportion of ED presentation triage categories across all LGAs.

Across SEMPHN during FY2022-23, just under two-thirds (65%) of ED presentations were categorised as resuscitations, emergency or urgent (triage category 1, 2, or, 3), and the remaining third (35%) were categorised as lower urgency care – semi-urgent or non-urgent (triage category 4 or 5) (Table 9.13). Port Phillip had the highest proportion of ED presentations classified as lower urgency at 47% (just under one in 2

presentations), which was 12% higher than the SEMPHN catchment. This was followed by Stonnington and Bayside at 42%. Frankston had the lowest proportion of lower-urgency classifications at 28%, which was 6% lower than the SEMPHN catchment with just under three-quarters of ED presentations being classified as urgent or higher.

Hospital admissions

Hospital admissions, whether through the emergency department (ED) or directly, offer valuable insights into the health needs of the community served by the SEMPHN. These admissions highlight areas with high rates of moderate-to-complex chronic diseases that may not be as apparent in the primary care patient population within the region. The total amount of hospital admissions per 1,000 ERP (ABS, 2023) by LGA in FY2022/23 is provided in Table 9.14.

Table 9.14 Hospital admissions by LGA, FY2022-23

LGA	ERP 2023	Number of admissions	Rate per 1,000 population
Bayside (Vic.)	104,272	20,456	196
Cardinia	126,960	34,581	272
Casey	392,110	110,374	281
Frankston	142,826	46,146	323
Glen Eira	156,837	31,849	203
Greater Dandenong	163,792	56,047	342
Kingston (Vic.)	163,724	42,177	258
Mornington Peninsula	170,243	50,311	296
Port Phillip	109,515	26,159	239
Stonnington	111,335	17,241	155
South east Melbourne	1,641,614	435,341	265
Victoria	6,815,441	1,967,677	289

Note: Highlighted cells denote the top 3 number of admissions and rate per 1,000 population, respectively, across all LGAs. ERP=estimated resident population.

Casey residents made up the largest amount of SEMPHN hospitalisations at just over 110,000 (n=110,374), approximately one in 4 SEMPHN hospitalisations, which is attributable to its large population size. This is followed by Greater Dandenong (n=56,047) and Mornington Peninsula (n=50,311). Although when analysed by the rate of hospitalisations per 1,000 population (estimated as of June 2023), Greater Dandenong had the highest rate at 342 hospitalisations per 1,000 residents, followed by Frankston (323) and the Mornington Peninsula (296).

Table 9.15 Hospital admissions per 1,000 resident population by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Percentage of hospital admissions	Rate per 1,000 population
Factors influencing health status and contact with health services	28.5	75.6
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	10.3	27.3
Injury, poisoning and certain other consequences of external causes	8.8	23.3
Diseases of the digestive system	7.1	18.7
Diseases of the circulatory system	5.0	13.2
Neoplasms	4.9	12.9
Diseases of the respiratory system	4.5	11.8
Pregnancy, childbirth and the puerperium	4.2	11.1
Diseases of the genitourinary system	4.1	11.0
Diseases of the nervous system	3.5	9.3

Note: Highlighted cells denote the top 5 percentage of hospital admissions and rate per 1,000 population across all principal diagnoses.

Excluding broad ICD-10 category groupings of 'factors influencing health status and contact with health services' and 'symptoms, signs and abnormal clinical and laboratory findings', the highest proportion of hospital admissions across the SEMPHN region were for the following conditions (Table 9.15):

- injury, poisoning and certain other consequences of external causes
- diseases of the digestive system
- diseases of the circulatory system
- neoplasms (cancer)
- diseases of the respiratory system.

The top 5 primary diagnosis categories for hospital admissions by LGA are presented in Table 9.16.

Table 9.16 Top 5 principal diagnosis categories for hospital admissions by LGA, FY2022-23

LGA	1st	2nd	3rd	4th	5th
Bayside (Vic.)	Injury & poisoning	Digestive conditions	Circulatory conditions	Neoplasms	Respiratory conditions
Cardinia	Injury & poisoning	Digestive conditions	Pregnancy, childbirth, and peurperium	Respiratory conditions	Circulatory conditions

LGA	1st	2nd	3rd	4th	5th
Casey	Injury & poisoning	Digestive conditions	Pregnancy, childbirth, and peurperium	Respiratory conditions	Genitourinary conditions
Frankston	Injury & poisoning	Digestive conditions	Circulatory conditions	Neoplasms	Pregnancy, childbirth, and peurperium
Glen Eira	Injury & poisoning	Digestive conditions	Circulatory conditions	Neoplasms	Respiratory conditions
Greater Dandenong	Injury & poisoning	Digestive conditions	Neoplasms	Respiratory conditions	Genitourinary conditions
Kingston (Vic.)	Injury & poisoning	Digestive conditions	Neoplasms	Circulatory conditions	Respiratory conditions
Mornington Peninsula	Injury & poisoning	Digestive conditions	Circulatory conditions	Neoplasms	Musculoskeletal conditions
Port Phillip	Injury & poisoning	Digestive conditions	Mental and behavioural	Neoplasms	Circulatory conditions
Stonnington	Injury & poisoning	Digestive conditions	Neoplasms	Respiratory conditions	Mental and behavioural
South east Melbourne	Injury & poisoning	Digestive conditions	Circulatory conditions	Neoplasms	Respiratory conditions

Injury and poisoning were the most frequently diagnosed reason for hospitalisation across all LGAs which is comparable to what was observed in ED presentations during the same period. This was followed by digestive conditions (e.g. appendicitis) and circulatory conditions. The top specific diagnoses related to injury and poisoning admissions were:

- injuries to the head
- complications of surgical and medical care
- injuries to the wrist and hand.

Casey and Cardinia had large proportions of young families where pregnancy, childbirth and the puerperium was the third most frequent primary diagnosis. Like what was observed in ED presentations, Port Phillip and Stonnington were the only 2 LGAs to report mental and behavioural disorders in their top 5 primary diagnoses for hospital admissions.

The following differences were observed based on 3 age groupings: children and adolescents (0-19 years old), adults (20-64 years old) and older adults (65 years or older):

- The most frequent diagnoses for hospital admissions among young adults (aged 25-40) related to pregnancy, childbirth and the puerperium, followed by injuries and poisoning, and digestive disorders.
- The proportion of hospital admissions relating to neoplasms (e.g. cancer) increased with age and was the most frequent primary diagnosis for those aged 65 to 75.
- Hospitals admissions relating to mental and behavioural diagnoses were most frequent among adolescents and young adults aged 15-40 years.

LENGTH OF STAY BY DIAGNOSIS

Hospitals record length of stay for each hospitalisation regardless of whether it is same day stay, overnight or multiple days. Factors that influence the amount of time an individual needs to be hospitalised include age, health-status, current risk factors and the primary diagnosis (e.g. attending hospital for a clinical test compared to a surgery). The average length of stay based on principal diagnosis, measured in days, is provided in Table 9.17.

Table 9.17 Average length of hospital stays by principal diagnosis category, FY2022-23

Category (by principal diagnosis)	Length of stay (days)	Length of stay – same-day (%)	Length of stay – overnight or multi-day (%)
Factors influencing health status and contact with health services	1.1	91.5%	8.5%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	2.2	60.2%	39.8%
Injury, poisoning and certain other consequences of external causes	4.1	42.9%	57.1%
Diseases of the digestive system	2.8	50.9%	49.1
Diseases of the circulatory system	5.6	30.8%	69.2%
Neoplasms	4.0	51.8%	48.2%
Diseases of the respiratory system	3.7	31.9%	68.1%
Pregnancy, childbirth and the puerperium	2.4	19.2%	80.8%
Diseases of the genitourinary system	2.3	57.6%	42.4%
Diseases of the nervous system	3.1	55.7%	44.3%

Note: Highlighted cells denote the top 3 length of stay categories across all principal diagnoses.

References

Abouzeid M, Philpot B, Janus ED, Coates MJ and Dunbar JA (2013) 'Type 2 diabetes prevalence varies by socio-economic status within and between migrant groups: analysis and implications for Australia', *BMC Public Health*, 13(1):1-9.

Australian Bureau of Statistics (2018a) *Chronic conditions and multimorbidity*, Australian Bureau of Statistics, https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity

——— (2018b) *Modelled estimates of indicators from the 2018 Survey of Disability, Ageing and Carers for Local Government Areas* [data set], https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/2018/44300do002_2018.xls.

——— (2020) *National Aboriginal and Torres Strait Islander Health Survey*, Australian Bureau of Statistics,, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release.

——— (2022) *Asthma*, https://www.abs.gov.au/statistics/health/health-conditions-and-risks/asthma/latest-release.

Australian Institute of Health and Welfare (2018) Australian Burden of Disease Study: Impact and causes of illness and death in Australia

——— (2020a) *Arthritis,* , https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/arthritis/contents/about.

——— (2020b) *Chronic muskuloskeletal conditions - arthritis*, Australian Institute of Health and Welfare,, https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/arthritis/data.

——— (2020c) *Chronic obstructive pulmonary disease (COPD)*, https://www.aihw.gov.au/reports/chronic-respiratory-conditions/copd/contents/copd.

——— (2021) Mortality Over Regions and Time (MORT) books by PHN, [data set].

——— (2021) *Heart, stroke and vascular disease—Australian facts*, https://www.aihw.gov.au/reports/heart-stroke-vascular-diseases/hsvd-facts/contents/about.

——— (2022a) *Chronic conditions and multimorbidity*, (Australian Institute of Health and Welfare, chairman).

——— (2022b) *Diabetes: Australian facts*, https://www.aihw.gov.au/reports/diabetes/diabetes/contents/summary.

——— (2022c) *Long-term health conditions,*, https://www.abs.gov.au/articles/long-term-health-conditions.

Cancer Australia (2020) *Cancer in Australia statistics* https://www.canceraustralia.gov.au/impacted-cancer/what-cancer/cancer-australia-statistics.

Cancer Council (2021) *Facts and figures: Cancer statistics in Australia*, https://www.cancer.org.au/cancer-information/what-is-cancer/facts-and-figures.

Department of Health (2021) National Preventive Health Strategy.

Diabetes Australia (2021) *What is diabetes*, https://www.diabetesaustralia.com.au/about-diabetes/what-is-diabetes/.

Tewari S and Lin SS (2019) 'Managing diabetes in CALD communities'.

Chapter 10 Health workforce

- **General Practices:** 497 general practices as at 31 July 2024, with highest number in Casey (84) and Greater Dandenong (80) and lowest in Bayside (27) and Frankston (34). Casey has the greatest number of small (2-5 GPs) (52) and large practices (6+ GPs) (20), while Greater Dandenong has the most solo practices (32).

- **RACGP Accreditation:** lowest in Greater Dandenong (62.3%) and Stonnington (67.3%), and highest in Casey (84.4%).

- **Bulk Billing Practices:** most common in areas of higher socioeconomic disadvantage like Casey (61.1%), Greater Dandenong (63.6%) and Cardinia (51.5%).

- **General Practitioners (GP):** 2,813 GPs, with highest number in Casey and Stonnington (617 and 396, respectively). Half LGAs have a higher ratio of GPs FTE per 100,000 population compared to Victoria (116.3 FTE per 100,000), with Stonnington the highest (143.0 GP FTE per 100,000).

- **After Hours Services:** most prevalent use in Greater Dandenong 8.5%), Casey (7.2%) and Cardinia (6.0%), and least prevalent in Stonnington (2.8%), Mornington Peninsula (2.4%), and Bayside (2.3%).

- **Chronic Disease and MH-related Care:** highest chronic disease care in Port Phillip (9.4%), Greater Dandenong (9.3%), and Frankston (8.7%). Highest MH-related care in Stonnington at 6.4%, Port Phillip at 6.1%, and Bayside at 4.5%.

- **First Nations Workforce**: 2 ACCHS within the SEMPHN catchment.

Australia's Primary Health Care 10 Year Plan 2020-2023 has identified the need for a highly skilled primary care workforce (Department of Health 2022a). Primary care is delivered in general practices, community health services (CHS) and allied health practices by GPs, nurses, nurse practitioners, allied health professionals[36], midwives, pharmacists, dentists and Aboriginal and Torres Strait Islander health practitioners (Australian Institute of Health and Welfare 2016). While the number of primary healthcare professionals is increasing, this does not reflect current or projected demand. In 2020, for example, there were more than 642,000 health professionals working in registered medical professions across Australia. From 2015 to 2020, the number of registered practitioners increased by 20.8% and 11.3 FTE per 100,000 population. In this time period, the number of medical practitioners increased by 19.7% (7.0 FTE per 100,000), nurses and midwives increased by 14.1% (13.1 FTE per 100,000), and allied health practitioners increased by 40.2% (32.9 FTE per 100,000) (Australian Institute of Health and Welfare 2022).

General practices

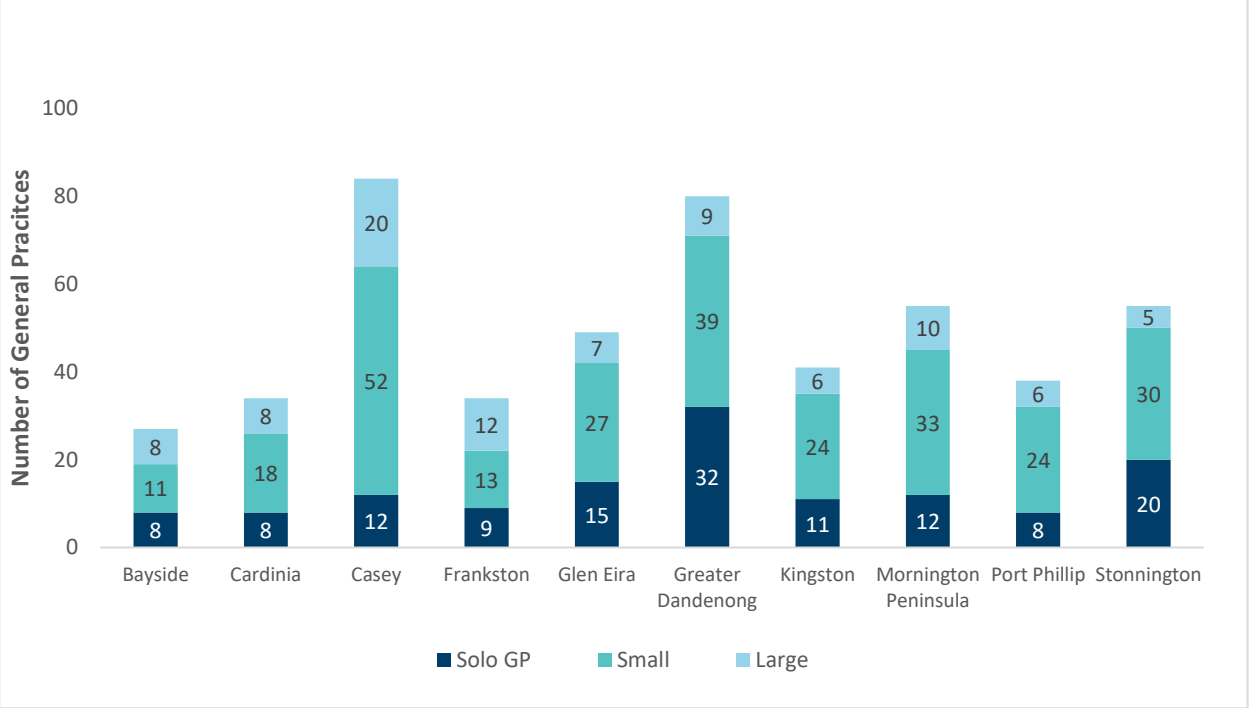
As at 31 July 2024, there were 497[37] general practices in the SEMPHN catchment. General practices vary in size according to the number of GPs employed at the practice, which indicates the existing capacity to service surrounding areas. Figure 10.1 shows that Casey (n=84) and Greater Dandenong (n=80) had the highest amounts of general practices, while Bayside (n=27) and Frankston (n=34) had the lowest. Casey also had the

[36] Allied health professions include Aboriginal and Torres Strait Islander health practitioners, chiropractors, Chinese medicine practitioners, medical radiation practitioners, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, psychologists and paramedicine practitioners. In 2019, paramedicine practitioners emerged as a new career path of registered health professionals in Australia.

[37] This includes 4 GP practices located in the City of Monash region that falls withing the SEMPHN catchment.

highest amount of both small practices (defined as 2 to 5 GPs) (n=52) and large practices (defined as 6 or more GPs) (n=20). Greater Dandenong had the highest number of solo practices (n=32) in the region.

Figure 10.1 Number and size of general practices by LGA, 2024



Source: CRM Data, SEMPHN 2024, Table: Account advanced find view, extracted 14 August 2024.

RACGP ACCREDITATION

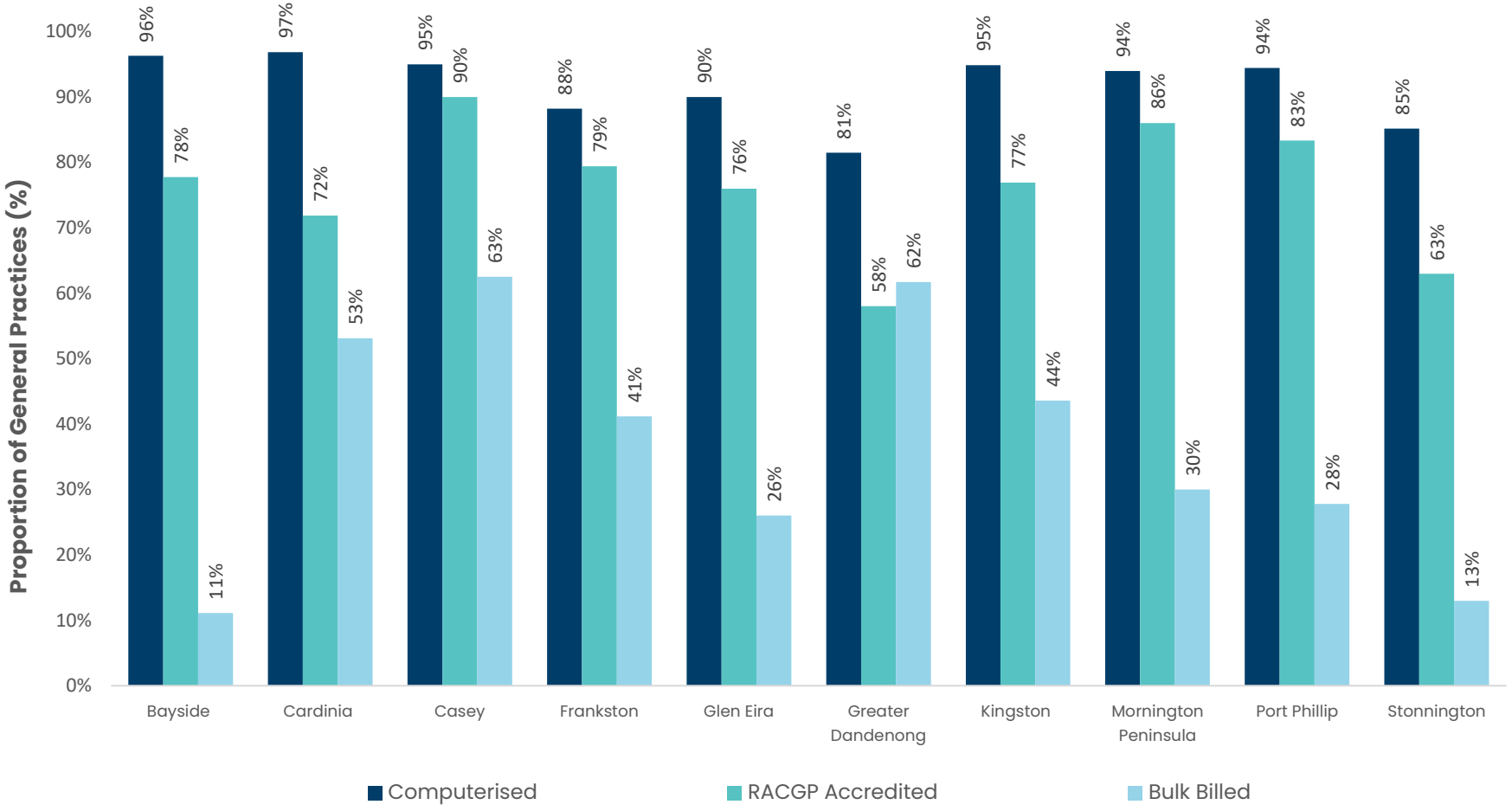
General practices can undertake assessment to gain accreditation to ensure safety, quality and continuous improvement standards. If a general practice is accredited, they meet the standards set by the Royal Australian College of General Practitioners (RACGP). Greater Dandenong (62.3%) and Stonnington (67.3%) had the lowest proportion of accredited practices, while Casey had the highest proportion (84.4%).

BULK-BILLING PRACTICES

Bulk-billing is a payment option so that the consumer does not incur the cost of the service delivered by the health professional (Services Australia 2022). When a service is bulk-billed, the medical professional accepts the Medicare benefit as payment for the service by the Federal Government. If there is a lack of bulk-billing options available, this creates a cost barrier to consumers accessing healthcare. SEMPHN run community consultations have identified a lack of bulk-billing options across the catchment as one of the leading barriers to healthcare for residents.

In 2020-2021, 68.3% of patients in Victoria were bulk-billed for all their general practice services and did not incur any out-of-pocket costs (Productivity Commission 2022). As of July 2024, while most general practices offered bulk-billing for patients (no out-of-pocket expense) in higher socioeconomic disadvantaged LGAs (e.g. Casey at 61.1%, Greater Dandenong at 63.6% and Cardinia at 51.5%), one-third or more practices across south east Melbourne did not offer bulk-billing (Figure 10.2).

Figure 10.2 Proportion of computerised, RACGP-accredited and bulk-billed general practice services by LGA, 2023



Source: CRM data, SEMPHN 2023, Table: Account advanced find view, extracted 14 August 2023.

General practitioners (GPs)

In 2023, 2,813 GPs provided primary healthcare services across south east Melbourne (Table 10.1). Casey and Stonnington had the highest number of GPs (n=617 and n=396, respectively). Half of the LGAs in the catchment had a higher ratio of GPs FTE per 100,000 residents compared with Victoria (116.3 FTE per 100,000). Stonnington had the highest GP FTE 143.0 GP FTE per 100,000). Conversely, Glen Eira had the lowest ratio (100.2 GP FTE per 100,00), followed by Bayside (111.0 GP FTE per 100,00).

Table 10.1 Number of GPs by LGA, 2023

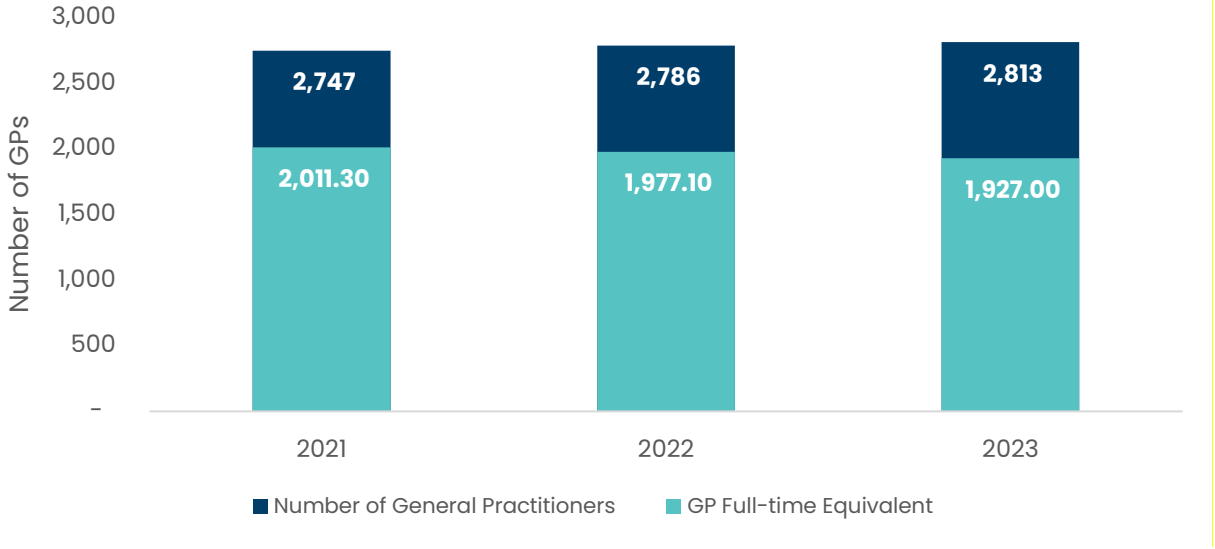
LGA	Number of GPs (n)	GP FTE	GP FTE per 100,000 residents
Bayside	310	113.4	111.0
Cardinia	189	139.6	113.4
Casey	617	466.8	123.2
Frankston	312	173.1	122.7
Glen Eira	340	152	100.2
Greater Dandenong	338	232.3	145.9
Kingston	336	176.6	110.4
Mornington Peninsula	351	209.2	123.3
Port Phillip	288	107.6	103.5
Stonnington	396	152.1	143.0
South east Melbourne	2,813	1,927.0	120.1
Victoria	10,122	7,709.2	116.3

Source: Commonwealth Department of Health and Aged Care, HeaDS UPP Tool, Needs Assessment Workforce Planning Product, extracted 13/08/2024 for the purpose of needs assessments. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Between 2021 and 2023, a small year-on-year increase (1.0%) has been observed in the number of GPs providing services in the SEMPHN catchment. Although this increase was below expected growth in the SEMPHN catchment population (2.4%) during this period. Despite GP numbers rising during this period, the proportional GP FTEs decreased by 2.5%. This decrease indicates a reduction in the average weekly hours worked by GPs in the catchment, reinforced by a GP FTE to GP ratio of 0.7-to-1 (

Figure 10.3).

Figure 10.3 Number of GPs in SEMPHN catchment, 2021-2023



Source: Commonwealth Department of Health and Aged Care, HeaDS UPP Tool, Needs Assessment Workforce Planning Product, extracted 13/08/2024 for the purpose of needs assessments. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Services provision and utilisation

In 2023, GPs in the SEMPHN catchment delivered over 11,300,000 primary care services to approximately 1,570,000 patients. The number of GP patients in south east Melbourne exceeded the 2023 ERP (n=1,541,157) by approximately 30,000 patients, indicating temporary residents accessing SEMPHN primary care services. Variation was observed in the number of GP services provided per capita across LGAs. Greater Dandenong had the highest rate of primary healthcare services per capita (8.7), followed by Stonnington at 8.1, and Casey and Mornington Peninsula at 7.4 services per capita. This suggests these LGAs have a higher need for primary healthcare services compared with Glen Eira and Port Phillip, which reported the lowest number of services per capita in the catchment at 5.8 (DoH – HeaDS UPP Tool, 2023c).

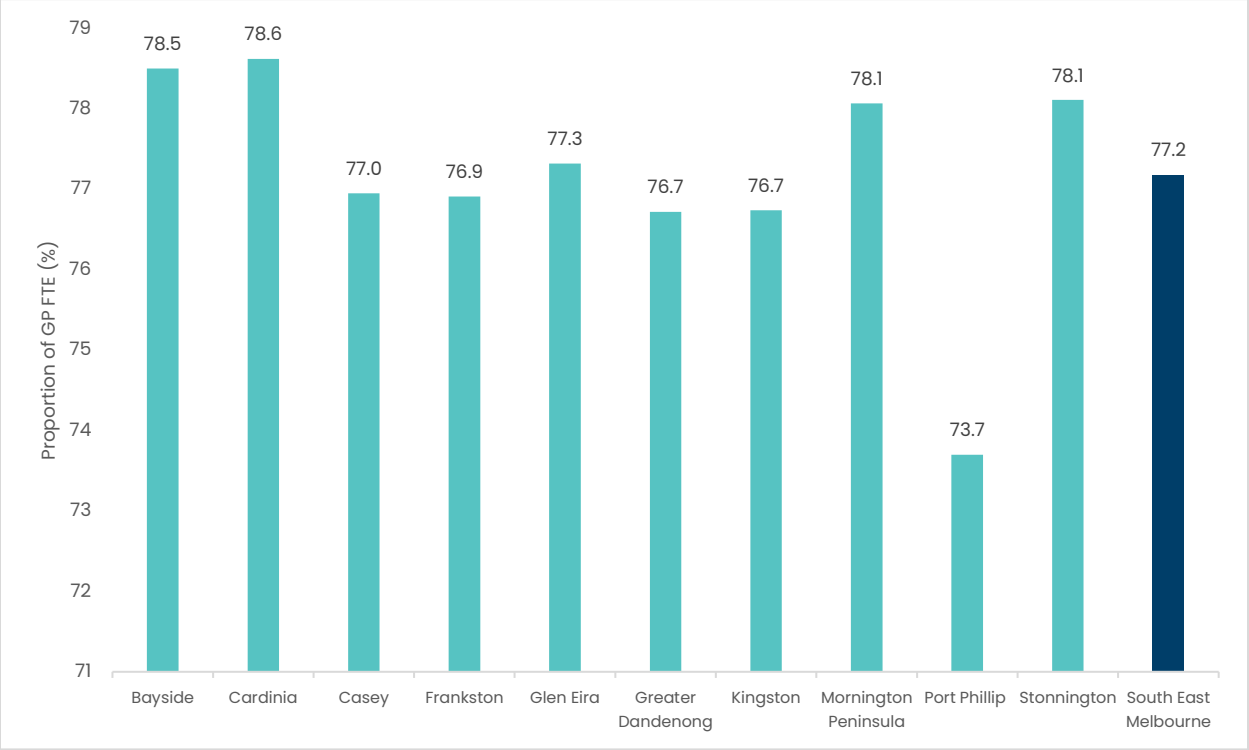
To accurately determine GP service needs across south east Melbourne, 14 GP catchments were identified. In 2023, GPs across all 14 SEMPHN GP catchments offered a diverse range of primary care services, reflected by varying proportions of their respective GP FTEs across 12 high-level reporting groups. These high-level reporting groups encompassed a wide range of service types including standard and long consultations, after-hours care, MH-related care, and chronic disease/complex care management.

Non-specific GP consultations

GPs in each GP catchment across south east Melbourne recorded approximately the same proportion of their respective FTE utilised for non-specific GP consultations of varying lengths (e.g. brief, standard, long and prolonged appointments). Cardinia utilised the highest proportion (78.6%) of their FTE on GP services and Port Phillip utilised the lowest (73.7%) (

Figure 10.4).

Figure 10.4 Proportion of GP FTE provided on consultations by LGA, 2023

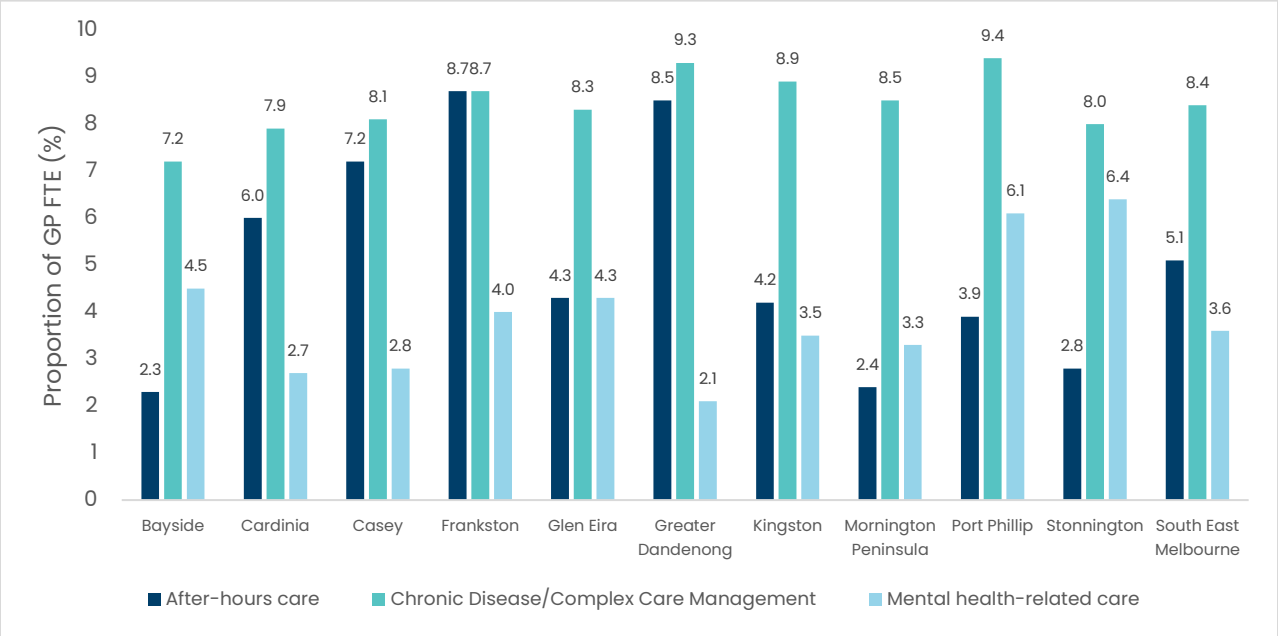


Source: Commonwealth Department of Health and Aged Care, HeaDS UPP Tool, Needs Assessment Workforce Planning Product, extracted 13/08/2024 for the purpose of needs assessments. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Noticeable differences were observed among LGAs in terms of the proportion of GP FTE utilised for 3 specific primary care services for after-hours care, MH-related care and chronic disease/complex care management. This potentially reflects the health needs and service provision capabilities of their respective communities (

Figure 10.5).

Figure 10.5 Proportion of GP FTE provided for after-hours care, MH-related care and chronic disease/complex care management by LGA, 2023



Source: Commonwealth Department of Health and Aged Care, HeaDS UPP Tool, Needs Assessment Workforce Planning Product, extracted 13/08/2024 for the purpose of needs assessments. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

AFTER-HOURS SERVICES

As shown in

Figure 10.5, Greater Dandenong recorded the highest proportion of GP FTE utilised for after-hours care (8.5%), followed by Casey at 7.2% and Cardinia at 6.0%. These results highlight population demand and utilisation of primary healthcare outside of regular practice hours, and indicate a lack of after-hours service capacity in corresponding LGAs with low after-hours service provision/utilisation such as Stonnington (2.8%), Mornington Peninsula (2.4%) and Bayside (2.3%).

Chronic disease/complex care management

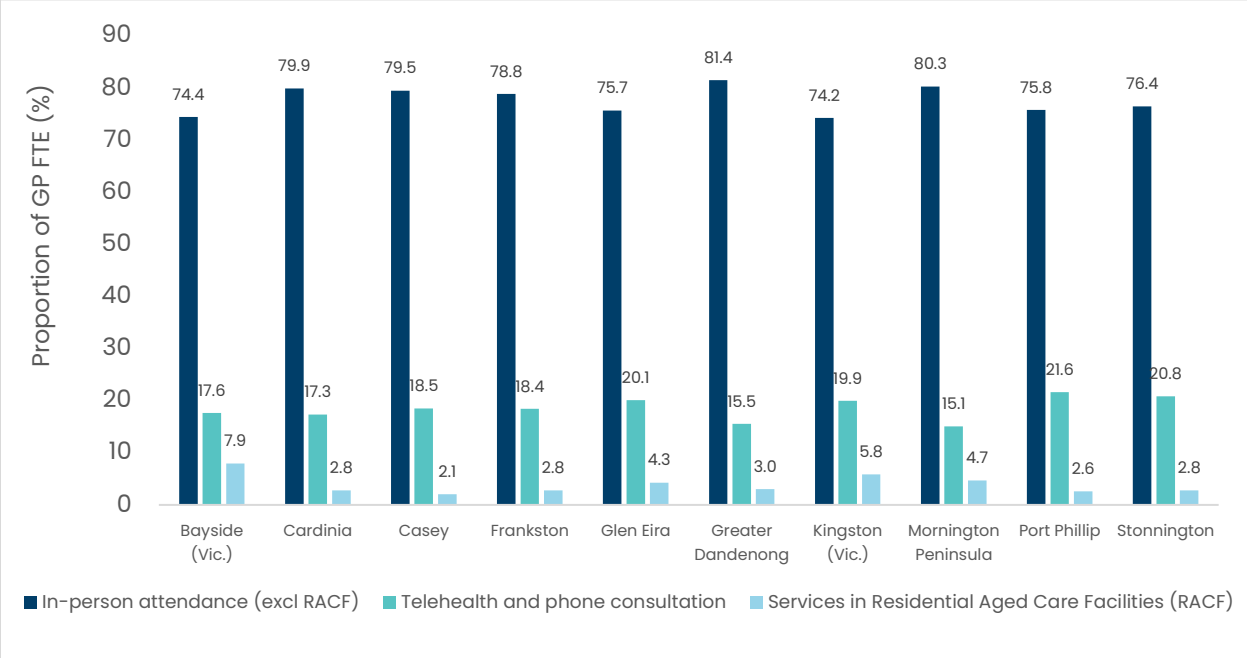
Port Phillip had the highest proportion of GP FTE utilised on chronic disease/complex care management services (9.4%), followed by Greater Dandenong (9.3%) and Frankston (8.7%).

MH-RELATED CARE

Stonnington had the highest proportion of GP FTE dedicated to MH-related care at 6.4%, followed by Port Phillip at 6.1% and Bayside at 4.5%. These findings highlight the growing population demand for MH care within the SEMPHN catchment. They emphasise the need for accessible MH services and support, while verifying the regular position of GPs as the first point of contact for MH-related concerns.

The method of delivery for GP services varied by LGA between in-person attendance, telehealth/phone consultation, and services provided in a residential aged care facility. Across SEMPHN, 78.2% of all GP FTE was utilised for in-person consultations, followed by 18.2% for telehealth consultations, and the remaining 3.6% for residential aged care facilities. Telehealth service provision, as a proportion of total GP FTE, was highest in Port Phillip (21.6% of GP FTE), followed by Stonnington (20.8%) and Glen Eira (20.1%). Services in residential aged care facilities were most prevalent in Bayside (7.9%), Kingston (5.8%) and Mornington Peninsula (4.7%), which are LGAs with a higher proportion of residents aged 65 or older (Figure 10.6).

Figure 10.6 Proportion of GP FTE by delivery type and LGA, 2023



Source: Commonwealth Department of Health and Aged Care, HeaDS UPP Tool, Needs Assessment Workforce Planning Product, extracted 13/08/2024 for the purpose of needs assessments. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

Nurses and midwives

As at 2019, there were around 470,000 nurses and midwives in Australia, accounting for the largest segment in the healthcare workforce (Department of Health and Aged Care 2020). The Australian Primary Health Care Nurses Association (APNA) describes general practice nursing as the fastest growing area within the healthcare sector (Australian Primary Healthcare Nurses Association 2021).

In the SEMPHN catchment, 75.8% of practices (n=374) had at least one nurse employed in their care team (South Eastern Melbourne Primary Health Network 2023), compared with 63.5% nationally (APNA, 2021). Table 10.2 depicts the distribution of nursing and midwifery workforces across varying healthcare settings by LGA. Average hours worked by SEMPHN catchment nurses and midwives was consistent with the overall Victorian average. Additionally, nurse and midwife FTE employed in hospital settings significantly varied across the SEMPHN catchment, reflective of where most medium-to-large hospitals were located (e.g. Stonnington, Frankston and Greater Dandenong).

Table 10.2 Distribution of nurses and midwives by LGA 2023

LGA	Primary and community settings			Hospitals			Aged care residential facilities			Midwifery		
	Number of nurses	FTE of nurses	Average weekly hours	Number of nurses	FTE of nurses	Average weekly hours	Number of nurses	FTE of nurses	Average weekly hours	Number of midwives	FTE of midwives	Average weekly hours
Bayside	252	198.9	29	600	490.3	31	267	238.8	33	23	13.9	23
Cardinia	191	142	28	109	97.2	33	239	223.2	35	33	16.6	19
Casey	667	556.7	31	1,844	1,653.8	34	630	573.6	34	60	31	19
Frankston	583	483.1	31	NP	2,255.3	NP	314	278.6	33	41	22.8	21
Glen Eira	442	367.7	31	NP	848	NP	410	387.6	35	23	14.6	24
Greater Dandenong	483	425.7	33	NP	1,514.8	NP	386	366	36	35	19	20
Kingston	372	299.8	30	893	809.7	34	373	357.1	36	25	9	13
Mornington Peninsula	475	374.3	29	NP	632.2	NP	495	440.6	33	40	21.3	20
Port Phillip	208	172.3	31	170	161.1	36	107	102.9	36	16	8.4	19
Stonnington	420	342.2	30	2,171	1,998.7	34	256	239.7	35	22	11.6	19
South east Melbourne	4,096	3,365	31	11,693	10,464.9	34	3,490	3,217.8	35	318	168.2	20
Victoria	19,779	16,058.8	30	64,038	56,919.8	33	17,112	15,562.4	34	1,623	867.2	20

Source: Commonwealth Department of Health and Aged Care, HeaDS UPP Tool, Needs Assessment Workforce Planning Product, extracted 13/08/2024 for the purpose of needs assessments. Please note Monash LGA is excluded due to the small proportion of the LGA falling within the SEMPHN catchment (4%).

First Nations workforce

First Nations people are underrepresented in the Australian healthcare workforce despite being employed in healthcare more than any other industry (Department of Health 2022b). In 2021, First Nations people represented 1.7% (n=16,659) of the total health workforce in Australia, despite representing 3.2% of the working population in Australia in 2021 (Department of Health 2022b). In 2022, 5,037 nurses and midwives identified as Aboriginal or Torres Strait Islander, representing approximately 1.5% of all enrolled and registered nurses and midwives (Australian Institute of Health and Welfare - National Indigenous Australian Agency 2020). An estimated 0.5% of all employed medical practitioners identified as Aboriginal or Torres Strait Islander.

While there was an increase in the number of First Nations people in the health workforce between 2013 and 2021, the overall proportion of the First Nations workforce remains low. Increasing the representation of First Nations people in the health workforce can improve access to culturally appropriate health services for First Nations Australians (Australian Institute of Health and Welfare - National Indigenous Australian Agency 2020).

Aboriginal community controlled health services (ACCHS)

ACCHS have been providing a wide range of health, social and emotional well-being services for the past 50 years. The ACCHS within the SEMPHN catchment are:

- DDACL was established by First Nations families in the local area who saw the need to provide support for the growing First Nations community in the region (Dandenong and District Aborigines Co-operative Ltd 2022). The DDACL Aged and Disability team services Greater Dandenong, Casey, Knox, Cardinia, Frankston and the Mornington Peninsula LGAs. Some of the support services provided include domestic assistance, personal care, 1:1 support and social support groups for Elders, carers and disability clients (Dandenong and District Aborigines Co-operative Ltd 2022).
- Ngwala Willumbong Aboriginal Cooperation delivers services to meet the needs of Aboriginal and Torres Strait Islander peoples,[38] their families and communities. Services include AOD treatment, family violence, housing, and homelessness.
- First Peoples' Health and Well-being is a dynamic organisation aiming to improve access to affordable primary healthcare in urban Melbourne. The service was expanded to support unmet primary care needs in Frankston and Thomastown.[39] It delivers trauma-informed primary healthcare to First Nations people in the SEMPHN catchment (First Peoples' Health And Well-being 2020).

Cultural appropriateness training

Cultural awareness training aims to build a culturally responsive workforce. Literature has shown healthcare providers find cultural awareness training to be an invaluable entry point. Cultural education elevates the consumer experience and provides health professionals and service providers with an opportunity to improve their delivery of culturally safe care during common cross-cultural encounters (Kerrigan et al. 2020).

[38] Knox is a suburb of Melbourne, located within the City of Know LGA which is outside the SEMPHN catchment boundaries.

[39] Thomastown is a suburb of Melbourne, located within the City of Whittlesea LGA which is outside the SEMPHN catchment boundaries.

References

Australian Institute of Health and Welfare - National Indigenous Australian Agency (2020) *Aboriginal and Torres Strait Islander Health Performance Framework - summary report*, Australian Institute of Health and Welfare - National Indigenous Australian Agency,, https://www.indigenoushpf.gov.au/getattachment/65fbaaf3-100c-4df5-941c-a8455922693c/attachment.aspx.

Australian Institute of Health and Welfare (2016) *Primary health care in Australia*, https://www.aihw.gov.au/reports/primary-health-care/primary-health-care-in-australia/contents/about-primary-health-care.

——— (2022) *Health workforce*, https://www.aihw.gov.au/reports/workforce/health-workforce.

Australian Primary Healthcare Nurses Association (2021) *General practice nursing*, Australian Primary Healthcare Nurses Association (APNA),, https://www.apna.asn.au/profession/what-is-primary-health-care-nursing/general-practice-nursing.

Dandenong and District Aborigines Co-operative Ltd (2022) Dandenong and District Aborigines Co-operative Ltd (DDACL) Annual Report 2019/2020.

Department of Health (2022a) Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032.

——— (2022b) National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031, .

Department of Health and Aged Care (2020) *Nurses and midwives in Australia*, https://www.health.gov.au/health-topics/nurses-and-midwives/in-australia.

First Peoples' Health And Well-being (2020) First Peoples' Health And Well-being (FPHW) 2019–20 Annual Report.

Kerrigan V, Lewis N, Cass A, Hefler M and Ralph AP (2020) '"How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload', *BMC Medical Education*, 20(1):1-11.

Productivity Commission (2022) *Report on Government Services 2022*, https://www.pc.gov.au/ongoing/report-on-government-services/2022/health/primary-and-community-health.

Services Australia (2022) *Bulk Billing* https://www.servicesaustralia.gov.au/bulk-billing?context=60092.

South Eastern Melbourne Primary Health Network (2023) Microsoft Dynamics Customer Relationship Management (CRM) SEMPHN Dataset 2023 [data set].