



# Strategic Health & Wellbeing Plan 2009-2012 Part 1

**Revised June 2011**



# ISEPICH Strategic Health & Wellbeing Plan 2009-2012

## Revised 2011

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## Chair's Foreword

***“We are on the verge of creating a qualitatively better and more truly sociable society for all”***

(Wilkinson and Pickett, *The Spirit Level* 2009:265)

Wilkinson and Pickett, in *The Spirit Level: Why More Equal Societies Almost Always Do Better*<sup>1</sup> present compelling evidence connecting eleven different health & social indicators of physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage births, and child well-being to levels of disparity between the rich and the poor.

These differences do not only affect the most disadvantaged in society. While poorer groups are the most severely affected, people at all levels in less equal societies tend to have reduced health and wellbeing compared with people in more equal societies.

The inner south east is an area of marked inequality, with rich and poor living in close proximity. There are pockets of people on low incomes, many from culturally and linguistically diverse backgrounds and many of whom also have disabilities or complex health and social conditions, living in the midst of a generally wealthy area. There is a higher rate of mental health, drug and alcohol issues than the statewide average, and above average rates of people living alone and at risk of isolation.

For 2009-12 ISEPICH has adopted the following strategic priorities, responding to the needs and issues outlined above:

- Social inclusion and inclusive communities
- Better access to services
- Sustainable and affordable living and environments
- Care for people experiencing chronic disease (including diabetes and mental illness)

In responding to these issues, we also express the hope and optimism shown in the quote above. We have knowledge and the will to address health inequalities. We have knowledge and the will to work towards a fairer, more inclusive, more sustainable community for all, where everyone will benefit. We have capacity to ensure better access to services and to promote health and prevent avoidable illness.

We are on a journey together, towards ‘better health for all’, building on the strengths and capacities of our partnership and our community.



**Robbi Chaplin**

Chair ISEPICH Executive and CEO Inner South Community Health Service  
November 2009

### **June 2011 Update:**

A review of the Plan was undertaken during April-June 2011. It was determined the Plan was still relevant without need for major change. Some policy context and health data has been updated, and the order of some sections has changed. The *Integrated Health Promotion Plan* has been updated as a separate but complementary document to the *Strategic Health and Well Being Plan*. It is hoped ISEPICH members will find the revised Plan a useful reference.

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<sup>1</sup> R Wilkinson & K Pickett *The Spirit Level: Why More Equal Societies Almost Always Do Better* 2009

## Acknowledgements

ISEPICH is a partnership of health and community care agencies, and community members, and without the willing participation of members it could not continue to develop and prosper. The *ISEPICH Strategic Health and Wellbeing Plan 2009-2012* is the outcome of dedicated planning, consultation and research.

The Health Promotion Planning Group, convened by Val Kay, ISEPICH Health Promotion Coordinator, worked together from November 2008 to gather local demographic data and evidence on health and wellbeing, and organised the ISEPICH strategic planning forum in March 2009. Members of the planning group include:

- **Anna Thomas**, Community member
- **Annette Forde, Sandra Christie** (until February 2009) and **Rebecca Robson**, Corporate and Community Planning representatives, City of Stonnington
- **Erika Soto**, Community and Health Development Officer, City of Port Phillip
- **Jackie Gleeson**, Bentleigh Bayside Community Health Service
- **Linda Williamson**, Health Promotion Coordinator, Inner South Community Health Service
- **Nikki McGrath**, Health Promotion Coordinator, Caulfield Community Health Service
- **Rebecca Colcott**, Health and Community Development Officer, Glen Eira Council
- **Sonia Middleton** and other members of the Education Team, Baker IDI Heart and Diabetes Institute
- **Val Johnstone**, Community member
- **Val Kay**, ISEPICH Health Promotion Coordinator

Particular acknowledgement is due to Linda Williamson and Nikki McGrath for their work in gathering and presenting evidence.

**Anne Jungwirth**, ISEPICH Executive Officer, and the members of the **ISEPICH Executive Committee** have given their time and expertise to the planning process and fully supported the ongoing development, planning and implementation of ISEPICH goals and objectives. In particular, **Robbi Chaplin**, Chair of the ISEPICH Executive Committee and CEO of Inner South Community Health, has been a major champion of the planning process.

**Margaret Sinnott** through a contractual arrangement with the Kingston Bayside PCP contributed to the planning process regarding service coordination and chronic disease management.

**Jackie Beckmann** had a key role in completion and compilation of the 2009 document, of which much was adapted from the *Integrated Health Promotion Plan* prepared by Val Kay and the Health Promotion Planning Group.

The following ISEPICH Advisory Groups were involved in and supported the planning process:

- **Health Promotion Steering Committee;**
- **Service Coordination & Integrated Chronic Disease Management Advisory Group**, and
- **Community Advisory Group**, comprising community member representatives from across the 3 LGA catchments: the Cities of Glen Eira; Port Phillip and Stonnington. *(It should also be noted other community members have also had input to the Executive, Advisory and Steering Committees and other forums.)*

## About ISEPICH

The Inner South East Partnership in Community and Health (ISEPICH) is a Primary Care Partnership (PCP) that covers the three Melbourne local government areas of Glen Eira, Port Phillip and Stonnington. Established in 2000, ISEPICH now has 53 member health and community support organisations. The estimated total population in the ISEPICH catchment in 2011 is over 330,000.

There are 29 Primary Care Partnerships in Victoria. The Victorian PCP program has two key aims:

- To improve the experience and outcomes for people who use primary health care services;
- To reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.

PCPs are funded by the Victorian Department of Health (DH) and have four key program deliverables:

1. Partnerships
2. Integrated Health Promotion
3. Service Coordination
4. Integrated Chronic Disease Management

### The ISEPICH Vision:

*To improve the health and wellbeing of the inner south east community through working in partnerships, with a commitment to equity and inclusion.*

### ISEPICH principles and values<sup>2</sup>

ISEPICH aims to achieve its vision through:

- Building strong and effective partnerships through relationships that are built on trust and mutual respect;
- Addressing the social determinants of health, acknowledging that social factors, including inequality and exclusion, are contributors to ill health and poor wellbeing;
- Leading, influencing and advocating for best practice service planning and service provision;
- Integrated population health planning and health promotion;
- Building the capacity of the Partnership to respond to community needs;
- Improving the coordination and integration of services;
- Improving support, treatment and care for people with chronic conditions;
- Facilitating the active participation of consumers, carers and community members;
- Cultural sensitivity;
- Valuing of diversity in all its forms;
- Ongoing and open evaluation, monitoring and reporting on what we do; and
- Dissemination and use of evidence including evidence of effectiveness (what has worked and what has not, both in this community and in others).

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<sup>2</sup> ISEPICH Partnership Agreement 2010, available at:  
[http://www.portphillip.vic.gov.au/ISEPICH\\_Partnership\\_Agreement\\_Rev\\_May\\_2010.pdf](http://www.portphillip.vic.gov.au/ISEPICH_Partnership_Agreement_Rev_May_2010.pdf)

ISEPICH is guided by the Social Model of Health that recognises the impact of social, economic, cultural and political factors and conditions on health and wellbeing. It is a conceptual framework for improving health outcomes, aimed at preventing and reducing illness and addressing inequalities and disadvantage that exist within the community.

ISEPICH maintains a strong focus on reducing health inequalities. The recent work of Wilkinson and Pickett (2009) shows that greater inequality in society is associated with adverse impacts on health and wellbeing, including physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage births, and child well-being.<sup>3</sup> The findings highlight the importance and the benefits of promoting equity and social inclusion at all levels of society. Most importantly, low income community members who participate in our partnership and planning, confirm that inequality has a direct impact on their lives and wellbeing.

Primary care and community service agencies that provide services in the ISEPICH catchment are eligible to become members of ISEPICH. Member agencies are signatories to a Partnership Agreement and make a commitment to the ISEPICH vision, aims, principles and plans.

ISEPICH is governed by an Executive Committee, drawn from member agencies and community members. The Executive has a leadership role and is responsible for the overall governance of ISEPICH and the partnership's performance.

The *ISEPICH Strategic Health and Wellbeing Plan 2009-2012* sets out health and wellbeing strategic priorities, goals and objectives. The Plan provides a framework for action and for performance measurement.

Refer to Appendix 1 for an outline of the ISEPICH Organisational Structure and Appendix 2 for a list of current ISEPICH Member organisations (as at June 2011).

## **Review of the Strategic Plan**

This Strategic Plan was reviewed in April-June 2011. A progress report on the plan was provided to all member agencies and comments were invited. The ISEPICH Executive Committee then reviewed the plan at its meeting in May 2011. Key recommendations of the Executive were:

- The Plan is still relevant and does not require major change
- The Strategic Priorities were confirmed
- The policy context and population health data be updated
- The revised plan to include an IHP evaluation plan (2011-2012) in line with DH requirements and ISEPICH's aim to be accountable
- Timelines and targets in the operational plans will be clarified and tightened where necessary

The order of some sections of the revised June 2011 Plan have been changed from the original document to make information more accessible. Much of the content is the same, with the exception of the updated '*Policy context and reform environment*' and '*Data and Evidence*' sections.

The *Integrated Health Promotion Plan* has been updated as a separate but complementary document to the *Strategic Health and Well Being Plan*. The Service Co-ordination and ICDM Operational Plan 2011-2012 is also being revised as a complementary document.

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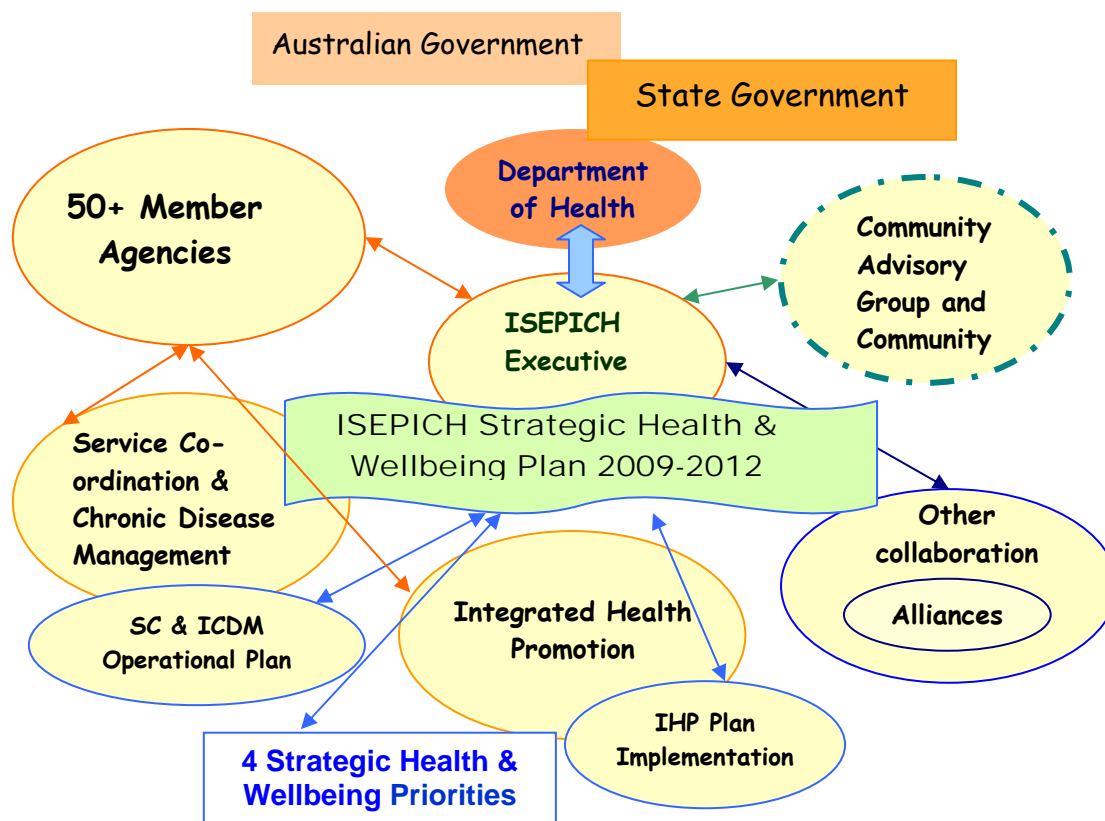
<sup>3</sup> R Wilkinson & K Pickett *The Spirit Level* 2009

# Overview - Strategic Health and Wellbeing Plan

## THE ISEPICH VISION

*To improve the health and wellbeing of the inner south east community through working in partnerships, with a commitment to equity and inclusion.*

### Planning and Policy Framework 2009-2012



#### 1. Social Inclusion and Inclusive Communities

The inner south east is an area of marked inequality with pockets of people experience significant disadvantage.

ISEPICH is committed to:

- reducing health inequalities;
- increasing social inclusion, and
- strengthening community capacity to address social determinants of health.

#### 2. Better Access to Services

ISEPICH partners work together to enable community members to achieve improved health outcomes via:

Person-centred:

- needs identification;
- information and referral pathways
- co-ordinated care planning and service delivery;
- high quality service standards and good practice.

#### 3. Sustainable & Affordable Living & Environments

Secure and affordable housing, food, and physical activity are key determinants of health.

ISEPICH partners are working together to address these determinants for people experiencing disadvantage and to facilitate supportive environments and more sustainable everyday living.

#### 4. Care for People Experiencing Chronic Disease

ISEPICH is committed to improving the health and wellbeing of people experiencing chronic illness.

During 2009-2012 there will be a focus on improving care pathways and access to services for people with:

- diabetes;
- mental illness

# Strategic Health and Wellbeing Plan 2009-12

## Purpose

The ISEPICH Strategic Health and Wellbeing Plan 2009-2012 reflects an integrated approach to identifying and addressing local priority health and wellbeing issues. A one-page overview of the Plan is provided on the previous page.

Detailed implementation planning and actions are outlined in greater detail in the *Integrated Health Promotion Plan* and the *Service Coordination and ICDM Operational Plan*. These plans are available on request from ISEPICH and revised plans are available on the ISEPICH website from mid-2011.

## Strategic priorities

Four ISEPICH Strategic Health and Wellbeing Priorities have been identified:

1. Social inclusion and inclusive communities
2. Better access to services
3. Sustainable and affordable living and environments
4. Care for people experiencing chronic disease - including diabetes and mental illness

A brief description of each priority is provided below.

### **Social inclusion and inclusive communities**

ISEPICH operates within the framework of a social model of health that recognises the profound impact that social, economic, cultural and political factors and conditions have on health and wellbeing. It is a conceptual framework for improving health outcomes, aimed at preventing and reducing illness and addressing inequalities and disadvantage that exist within the community.

The inner south east is an area of marked inequality, with rich and poor people living in close proximity. Income inequality is steadily rising in Australia and increasingly the inner south east is becoming a wealthy population and pockets of highly disadvantaged people.

There is increasing evidence (Wilkinson and Pickett 2009) that more equal societies do better and that fairness should be the concern of policy makers. An unacceptable range of inequality restricts people's choices, opportunities and their ability to contribute to society. ISEPICH promotes evidence based action to reduce poverty and build the capacity for all people to participate in their communities and in employment.

## **Better Access to Services**

Service Coordination within the PCP framework aims at:

- placing consumers at the centre of service delivery to gain access to the services they need through improved needs identification, assessment and care coordination; and
- re-orientation of the service system to towards better health outcomes through enhanced early intervention and health promotion.

After identification of *Better Access to Services* as a strategic priority at the March 2009 ISEPICH Planning Forum, members of the ISEPICH Service Co-ordination & Integrated Chronic Disease Management (SCIDM) Advisory Group affirmed the importance for ISEPICH to:

- develop a common understanding of what “person/client-centred” means;
- enable a *No Wrong Door* approach for people seeking access to services;
- facilitate consistency and good practice standards within and between ISEPICH member organisations, regarding needs identification, assessment, referral and coordinated care planning, with support for the uptake of the *Victorian Service Coordination Practice Manual 2009*;
- clarify issues around consent and privacy for consumers, carers and the general community

## **Sustainable and Affordable Living and Environments**

Environmental degradation and climate change pose major risks to health, for example through increased risk of heatwaves, natural disasters, vector-borne diseases and gastro-enteritis (McMichael 2009).

It is well established that housing, food/nutrition and physical activity are key determinants of people’s health and wellbeing. Marginalised groups living in poverty are most at risk from lack of access to these protective factors.

ISEPICH views safe, secure and affordable housing as the foundation for individual, family and community wellbeing. Homelessness is a term used to describe the experience or situation of not being able to access safe, secure or affordable housing. People experiencing homelessness are at risk of suffering further harm from a range of factors related to diet, general health, mental health, substance abuse and violence<sup>4</sup>. The structural, fiscal and personal factors contributing to homelessness are diverse, complex and often interdependent. The increasing shortage of affordable housing is one of the most significant structural causes of homelessness.

ISEPICH recognise people’s right to food security “*the state in which all persons obtain a nutritionally adequate, culturally acceptable diet at all times through local non-emergency sources*” (Community Food Security Coalition 1995).

Physical activity is a critical life style factor and contributor to good health.

Actions to improve housing and promote food security and physical activity also have the potential to promote environmental sustainability, mitigation and adaptation to climate change.

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<sup>4</sup> C Talbot *Homeless and At Risk Young People: Sexuality, Abuse and Vulnerability* 2007

## Care for People Experiencing Chronic Disease - including diabetes and mental health conditions

Chronic disease management is an important component of Victoria's PCP strategy supporting:

- planned and proactive care intended on keeping people as well as possible rather than responding to an illness
- empowering, systematic and coordinated care that includes regular screening, support for self management, assistance to make lifestyle and behaviour changes
- care that is provided by a range of health services and practitioners (e.g. GPs, podiatrist, physiotherapist, counsellor, dietician, nurse, specialist, dentist)
- care that is provided over time through the stages of disease progression

ISEPICH also supports use of the *Expanded Chronic Care Model*<sup>5</sup> for an integrated approach with health promotion and prevention effort, recognition of the social determinants of health and enhanced community participation.

The incidence of chronic conditions is increasing and currently represents approximately 70% of Australia's overall burden of disease. Diabetes and mental illness are among the most prevalent chronic diseases in the inner south east.

During 2009-2012 ISEPICH will work with its membership and through two sub-regional Alliances to attain better health outcomes for people in the ISEPICH catchment experiencing:

1. Diabetes: to increase access to services and to improve the care continuum - via the *South East Bayside Diabetes Alliance (SEBDA)* project; #
2. Mental illness: to improve care co-ordination and primary health support for people with complex needs and serious health inequalities - via ISEMHA\* and relevant local project initiatives.

# The *South East Bayside Diabetes Alliance (SEBDA)* comprises twelve key agencies involved in diabetes management across the combined ISEPICH and Kingston Bayside PCP catchments. The SEBDA project commenced in 2009 focused on developing and reviewing the local service system as it relates to people with diabetes. It aims to address access to service issues and strengthen the continuum of care.

\* ISEPICH is a member of and actively works with the *Inner South East Mental Health Alliance (ISEMHA)*, comprising sub-acute, community health and specialist mental health, homelessness and drug & alcohol services. Many members of ISEMHA are also members of ISEPICH. ISEMHA members are committed to working in partnership to ensure that:

- people living with a mental illness in the inner south east of Melbourne receive appropriate clinical and psychosocial support services when and where they need them; and that
- communities and community services are engaged in creating a sense of connectedness and supporting opportunities for meaningful consumer participation.

<sup>5</sup> Barr V et al 'The Expanded Chronic Care Model' *Hospital Quarterly* 7(1) 2003, pp 73-82

## Goals, Outcomes and Objectives

Detailed information on action/implementation strategies and strategic indicators are provided in complementary documents: the *Integrated Health Promotion (IHP) Plan* and *Service Co-ordination and Integrated Chronic Disease (SCIDM) Operational Plan*. These Plans are more detailed components of the overall PCP Strategic Health and Wellbeing Plan and are integrated with the ISEPICH strategic priorities.

The *IHP Plan* has been developed using an action research framework, allowing progressive stages of the plan to build on learning from previous stages. Yearly action plans are developed based on the outcomes of previous work. The IHP plan is available as Part 2 of the Strategic Plan on the ISEPICH website.

The *SCIDM Operational Plan* was developed in collaboration with the ISEPICH SCIDM Advisory Group (2009-2010) and is available on request. The *SCIDM 2011-2012 Operational Plan* is also available on request.

The goals, outcomes and objectives that support the strategic priorities are outlined in the tables below.

**Domains:** *IHP* - Integrated Health Promotion, *SC* - Service Coordination, *P* - Partnerships, *ICDM* - Integrated Chronic Disease Management

Strategic Health and Wellbeing Priority <b>1. Social inclusion and inclusive communities</b>	Domain
<b>Goal 1.1</b> Reduce health inequalities in the ISEPICH catchment by increasing social inclusion and community capacity to address the social determinants of health.	IHP
<b>Outcome: Inclusive communities that enhance health and wellbeing</b>	
Objective 1.1.1 Identify and implement new or enhanced strategies to reduce health inequalities in the inner south east.	IHP, P
Objective 1.1.2 Maintain and enhance opportunities for social connection and social inclusion in ISEPICH communities.	IHP

<b>Strategic Health and Wellbeing Priority</b> <b>2. Better Access to Services</b>		
<b>Goal 2.1</b> Promote consistent practice standards within and between agencies, across acute, sub-acute and primary care settings.		SC
<b>Outcome: Better planned and coordinated care for consumers</b>		
Objective 2.1.1 Increase electronic referral and the implementation of the State-wide Practices outlined in the Victorian SC Practice Manual 2009. ISEPICH staff will facilitate agency uptake of the VSCPM including supporting agencies to complete the State-wide surveys and to implement e-referral and monitor electronic referrals.		SC
Objective 2.1.2 Facilitate the exchange of demonstrated good practice in ISEPICH, including for General Practitioners. We are seeking to establish a partnership mechanism, such as a working group, to identify good practice, including in relation to referral and feedback practices, and promote the exchange of this information between ISEPICH agencies.		SC
Objective 2.1.3 Promote client-centred approaches to the key elements of service coordination (Initial contact, initial needs identification, assessment and care planning. Referral, consent and feedback are aspects of these elements) particularly for vulnerable groups. Member agencies will be encouraged to train and support staff to adopt client centred approaches		SC, IHP
Objective 2.1.4 Clarify issues around consent and privacy for consumers, carers and the general community and promote a shared understanding between agencies. We plan to form a Task Group to clarify issues around consent and privacy for consumers, carers and the general community and disseminate a shared understanding between ISEPICH agencies.		SC, P IHP
<b>Goal 2.2</b> Connect people to the right services		SC
<b>Outcome: Improved access and outcomes for consumers</b>		
Objective 2.2.1 Increase the knowledge consumers and providers about services in the ISEPICH catchment and how to access them, especially in relation to services for vulnerable groups. We plan to work with service providers and the Divisions of General Practice to develop and/or better utilise ways to increase the knowledge of consumers and providers about services available to clients and how to access them.		SC, P
Objective 2.2.2 Encourage the exchange of information between intake services and the development of shared practices and protocols, and plan a forum to facilitate the exchange of information between intake services and referral agencies in the inner south east.		SC
Objective 2.2.3 Promote the integration of illness prevention and health promotion services with clinical treatment, especially for vulnerable groups. Working with the Health Promotion Physical Activity Working Group to ensure that information about physical activity programs within the ISEPICH catchment is promoted to General Practitioners as well as other service providers.		SC, IHP

Strategic Health and Wellbeing Priority <b>3. Sustainable and Affordable Living and Environments</b>		
<b>Goal 3.1</b> Create a supportive environment that enhances sustainable and affordable living in the inner south east		<b>IHP</b>
<b>Outcome: Improved health and wellbeing for the local population, particularly marginalised or disadvantaged groups</b>		
Objective 3.1.1 Identify and implement new or enhanced strategies to reduce barriers to healthy eating and increase <b>food security</b> in the inner south east.		IHP, P
Objective 3.1.2 Identify and implement new or enhanced strategies to increase the affordability and sustainability of <b>housing</b> in the inner south east.		IHP, P
Objective 3.1.3 Identify and implement new or enhanced strategies to increase <b>active transport and physical activity</b> in the inner south east.		IHP, P, SC

Strategic Health and Wellbeing Priority <b>4. Care for people experiencing chronic disease</b> - including diabetes and mental health conditions		
<b>Goal 4.1</b> Create better client pathways and encourage integrated care		<b>ICDM</b>
<b>Outcome: Improved care for clients</b>		
Objective 4.1.1 Improve care pathways for people with diabetes through the South East Bayside Diabetes Alliance (SEBDA). This project aims to improve care pathways for people with or at risk of, diabetes through the development of a catchment wide, co-ordinated model of care.		SC, IHP, ICDM, P
Objective 4.1.2 Strengthen partnerships with Divisions of General Practice to improve care coordination for people with diabetes and other chronic diseases. This includes continuing to collaborate with Southcity GP Services and Monash Division of GPs to improve General Practice care coordination for people with diabetes and other chronic diseases in the south east.		SC, IHP, ICDM, P
Objective 4.1.3 Improve access to services and care pathways for people who may be experiencing mental illness including those who have complex needs. This includes collaborating with the Inner South Community Health Service (ISCHS) on the Health Matters project to improve access to primary care services for people with serious mental illness and participating in the Inner South East Mental Health Alliance (ISEMHA) complex care demonstration project.		SC, IHP, ICDM, P

# About the Planning Process

## ISEPICH Planning Role

Since the beginning of the PCP strategy, PCPs have facilitated planning across their various catchments. ISEPICH's early work included Integrated Service Plans (based on a population health planning approach), Integrated Health Promotion Plans and Community Health Plans. There has been an emphasis on identifying shared priorities and addressing unmet needs in the community. Over the past decade several planning forums have been held and information resources such as "*Not the Rich List*"<sup>6</sup> prepared to give member agencies better access to demographic and service data in relation to disadvantaged population groups.

## Planning Framework

The Department of Health *Planning and Reporting Guidelines for PCPs* highlight:

- An evidence based approach;
- Selection of priorities addressing issues of local health and wellbeing, one of which has a focus on chronic disease management;
- Integration with Health Promotion Planning by individual agencies, by the partnership and state-wide, and
- An interface between partnership, service coordination, health promotion and chronic disease management.

The *ISEPICH Strategic Health and Wellbeing Plan 2009-2012* focuses on local health and wellbeing issues, taking an evidence-based planning approach across the catchment of our three local government areas. Governance aspects of ISEPICH are set out in the *ISEPICH Partnership Agreement*.<sup>7</sup> Further information about membership and partnership development, capacity building and community participation may be found on the ISEPICH website at [www.isepich.org](http://www.isepich.org).

The *Integrated Health Promotion Plan* is a more detailed component of the *Strategic Health and Wellbeing Plan*. In Victoria, the term 'integrated health promotion' refers to agencies and organisations from a wide range of sectors and communities working in a collaborative manner to address priority health and wellbeing issues. The Department of Health (DH) has developed an Integrated Health Promotion Framework which guides this work.<sup>8</sup> The key features are: effective partnerships, a mix of interventions and the involvement of a range of sectors and community members underpinned by the Social Model of Health.

ISEPICH has also produced a *Service Coordination & Integrated Chronic Disease Management (ICDM) Operational Plan* and an *Integrated Health Promotion Action Plan* to provide greater detail of the implementation strategies.

## Planning Process

Ongoing planning processes are integral to the work of ISEPICH and are closely inter-related with consumer engagement, community consultation and collaboration with member agencies. Data is drawn from a range of quantitative and qualitative sources

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<sup>6</sup> Inner South East Partnership in Community and Health (ISEPICH) *Not the rich list: a profile of risk factors affecting the health of our community* 2004

<sup>7</sup> Inner South East Partnership in Community and Health (ISEPICH) *Partnership Agreement* 2010

<sup>8</sup> Victorian Government, Department of Human Services (Health) *Integrated Health Promotion: A practice guide for service providers* 2008 available at [http://www.health.vic.gov.au/healthpromotion/evidence\\_res/integrated.htm](http://www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm) (accessed 30/11/09)

and a diverse range of planning approaches are employed. ISEPICH highly values community participation and engagement in all phases of its work - planning, decision making, implementation and evaluation

**Two ISEPICH planning forums** contributed to development of the strategic priorities:

An **initial ISEPICH Planning forum** for 2009-12 was held at the Baker-IDI Heart and Diabetes Institute, Caulfield, on **26 March 2009**. Professor Helen Keleher of Monash University facilitated the forum.

Fifty-five people participated in the forum, including 29 representatives from 17 ISEPICH member agencies, 16 community members, five people from other community organisations, one representative from Department of Human Services, three ISEPICH staff members and the facilitator.

Following presentations on population health and wellbeing data and the policy context, participants worked in groups to identify strategic priorities for ISEPICH for 2009-2012 and developed draft goals for Integrated Health Promotion, Service Coordination and Integrated Chronic Disease Management. Three priorities were identified:

- Social inclusion and inclusive communities
- Better access to services, and
- Sustainable living and environment.

**The second planning day was held on 17 September 2009** and attended by over 35 members of ISEPICH Committees including the ISEPICH Executive, the Service Co-ordination and Integrated Chronic Disease Management (SCIDM) Advisory Group and the Health Promotion Steering Committee (HPSC). Several community members who are representatives on the ISEPICH committees were in attendance at the Planning Day. Participants considered the Department's strategic plan requirements, reviewed action on strategic priorities and discussed implementation strategies.

### ***Survey of Member Agencies***

After the initial planning forum in March, a one page survey was conducted to ascertain members' views regarding the three Strategic Priorities identified at the March Planning Forum. Thirty eight (38) of the then 49 member agencies responded. Findings include:

- Social inclusion and inclusive communities: 79% stated that they were very interested in working in partnership with other ISEPICH agencies to address this issue, 13% were somewhat interested and eight per cent not interested;
- Better access to services: 76% very interested and 24% somewhat interested;
- Sustainable living and environment: 34% very interested, 55% somewhat interested, and 11% not interested.

### ***Individual Agency Strategic Priorities***

The survey also gathered information on individual member agencies' strategic priorities. Thirty-two (32) of 38 organisations reported their strategic priorities. Nearly 75% of the agencies identified 1 to 4 priorities. Agency priorities reflected organisational goals as well as local health and wellbeing priorities.

The top priorities reported by agencies focused on:

- Staff/workforce development/training/best practice (14)
- Expansion of services/growth/promotion/meeting community needs (12)
- **Better access to services (10)**
- Safe, effective/quality care (10)
- **Social inclusion/mental health and social connection (8)**

Other issues addressed by agencies' priorities that are consistent with ISEPICH strategic priorities related to:

▪ Empowering people/promoting independence	5
▪ Information technology	3
▪ Community building/community engagement	3
▪ Environmental sustainability/climate change	3
▪ Services for the homeless including those with a mental illness	3
▪ The health of Indigenous Australians	2
▪ Affordable housing	2
▪ Integration of services	2
▪ Community linkages	1
▪ Early intervention	1
▪ Public health /health protection	1

Eight agencies had strategies specifically targeting vulnerable population groups including school students, disadvantaged, carers, frail aged, and people living with disability, complex needs, domestic violence and poor sexual health.

### ***ISEPICH Advisory Groups and Committees***

The ***Health Promotion Steering Committee*** holds overall responsibility for the development, implementation and evaluation of the Integrated Health Promotion Plan. The committee includes representatives of the three local Councils and three community health services in ISEPICH, plus representatives of Baker-IDI Heart and Diabetes Institute and when available, Women's Health in the South East (WHISE). The Committee also has places for two invited members. Currently these are held by representatives of Port Phillip Community Group (Chair) and Gamblers Help Southern. The Committee also includes the ISEPICH Health Promotion Coordinator and two community members. The Committee is supported by working groups set up to address specific objectives in the plan.

The ***Service Coordination and Integrated Disease Management (SCIDM) Advisory Group*** has responsibility for identifying strategic and operational issues relating to service coordination and integrated chronic disease management and providing advice on the development and implementation of the SC and ICDM elements of the Strategic Health and Wellbeing Plan. SCIDM members were well represented at both the March and September ISEPICH Strategic Planning Forums. Planning was also progressed through the regular bi-monthly meetings in May and July and an additional SCIDM Reference Group in June.

The ***Community Advisory Group (CAG)*** brought a community perspective to the planning process, helping to ensure the process was well grounded. The Community Advisory Group has a diversity of community members who reside in the three Local Government areas of the ISEPICH catchment, Glen Eira, Port Phillip and Stonnington. Members of the Community Advisory Group are represented on the ISEPICH Executive Committee, the Health Promotion Steering Committee (HPSC) and the Service Coordination and Integrated Chronic Disease Management Advisory Group (SCIDM).

### **Other Consumer, Carer and Community Involvement**

Community members, consumers and carers were represented at the ISEPICH Planning Day in March 2009. Sixteen (16) community members participated in the March Planning forum, just over a quarter of participants. Participants included people with experience of mental health issues, disability, homelessness, chronic illness and as carers. Several were residents of public housing and there was some representation of cultural diversity, with two participants being from a Russian speaking background and four from a Polish community organisation.

Six community members were residents of Port Phillip, five of Stonnington and four of Glen Eira (one not known). Six were members of the ISEPICH community advisory group or other ISEPICH working groups and several were volunteers or community/consumer representatives with ISEPICH member agencies.

### **Other Planning**

The planning process also included consideration of consultation previously undertaken by member agencies. Issues that emerged as important to community members from prior consultation include:

- Social inclusion, community strengthening, addressing disadvantage
- Food security, healthy eating, physical activity
- Financial counselling
- Community transport
- Environment and sustainability
- Affordable access to recreation, physical activity options, and neighbourhood facilities
- Opportunities for consumers to have input into service delivery from community and government departments
- More accountability, alignment and understanding from government departments

## Policy context and reform environment

Analysis of the policy context highlights the links between National, State and Local government policy. While funded by the Victorian Government, PCPs are linked to policy at all levels of government.

Primary Care Partnerships have evolved in line with Department of Health (Victoria) Program guidelines developed to address the health care needs of Victorians, and which also reflect national health care agendas. Primary Care Partnerships respond to the needs of the local population by identifying, planning and addressing strategic local health and wellbeing priorities.

Primary Care Partnerships are inclusive partnership structures responsive to community need, social justice and 'determinants of health' considerations.

The policy context for PCPs was originally outlined in '*Growing Victoria Together*'<sup>9</sup> and *A Fairer Victoria*<sup>10</sup>. These policies emphasised the importance of:

- High quality, accessible health and community services;
- Promoting rights and respecting diversity; and
- Reducing inequities and building social inclusion, especially for marginalised groups and individuals.

Other key policy challenges relevant to PCPs include:

- A growing burden of chronic disease;
- An ageing population;
- Health workforce pressures, and
- The increasing complexity and volume of care delivered and required in the community.

The role of public health and wellbeing planning has undergone significant development in recent years through the *Victorian Public Health and Wellbeing Act (2008)*. The Act positions prevention as a high priority of the Government, and expects that public health and wellbeing is the responsibility of all government departments and levels of government in Victoria. There is an enhanced role for local Government in population health planning and in developing and implementing their Municipal Public Health Plans in collaboration with their communities and other sectors of government, and through PCPs.

The current Victorian government in 2011 has identified seven priorities for the future of the health system

- Developing a system that is responsive to people's needs
- Improving every Victorian's health status and experiences
- Expanding service, workforce and system capacity
- Increasing the system's financial sustainability and productivity
- Implementing continuous improvements and innovation
- Increasing accountability and transparency
- Utilising e-health and communications technology.<sup>11</sup>

The government has also committed to produce a Victorian Health and Wellbeing Plan 2011-2015 and a Victorian General Practice and Primary Health Plan, which will be developed in consultation with the Commonwealth government. The Victorian

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<sup>9</sup> Victorian Government *Growing Victoria Together: A vision for Victoria to 2010 and Beyond*. 2001

<sup>10</sup> Victorian Government *A Fairer Victoria. Update. Strong People, Strong Communities* May 2008

<sup>11</sup> Victorian Government *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan* June 2011

government has also stated that it will also undertake joint planning with the Commonwealth government, “particularly on the Medicare Locals initiative to better connect primary care with other community-based services.” The Victorian government also supports closer coordination between public, not-for-profit and private health services.

The Australian Government has initiated a fundamental health reform agenda with the following aims:

- Improving hospitals
- A greater focus on primary health care
- Training more doctors, nurses and allied health professionals
- Supporting aged care
- Investing in prevention
- Helping those with mental illness
- Modernising the health system<sup>12</sup>

As part of the strengthened focus on primary health care, the government is establishing Medicare Locals. Medicare Locals will be locally run, independent non-government organisation responsible for providing better coordinated care in local communities. Medicare Locals will initially be responsible for coordination of Commonwealth funded medical and allied health services and for developing close between these services and state government funded services currently coordinated through PCPs. Over time there may be closer integration of the Medicare Locals and the PCPs. The Medicare Local in the inner south east area is expected to cover the area covered by ISEPICH and Kingston Bayside PCPs: the municipalities of Port Phillip, Stonnington, Glen Eira, Kingston and Bayside.

The National Partnership Agreement on Preventive Health (NPAPH) was announced by the Council of Australian Government (COAG) on 29 November 2008 and has committed \$872.1 million over six years from 2009-10 through eleven preventative health initiatives, including *Health Communities*.<sup>13</sup> This particular initiative is being rolled out through local government to support targeted community-based healthy lifestyle programs that facilitate increased access to physical activity, healthy eating and healthy weight activities for disadvantaged groups and those not predominately in the paid workforce.

The Australian National Preventive Health Agency commenced operation on 1 January 2011 as a permanent statutory body. The Agency will support the Council of Australian Government (COAG) and the Australian Health Ministers’ Conference (AHMC) in grappling with the increasingly complex challenges associated with preventing chronic disease.<sup>14</sup>

*Closing the Gap* between the health of indigenous people and the rest of society is a major priority of both the Australian and the Victorian governments. In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Indigenous communities to achieve the target of *Closing the Gap* in Indigenous disadvantage<sup>15</sup>.

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<sup>12</sup> Australian Government *National Health Reform: Delivering a Better Deal for Patients* at <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/home> accessed June 2011

<sup>13</sup> Link: <http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-prevention-np#communities>

<sup>14</sup> Link: <http://www.health.gov.au/internet/main/publishing.nsf/content/phd-anpha>

<sup>15</sup> Link: <http://www.healthinfonet.ecu.edu.au/closing-the-gap>

Since 2010 ISEPICH has been represented on the Department of Health Southern Metropolitan Region's *Closing the Gap* Steering Committee<sup>16</sup> and the Urban South Reference Group (St Kilda is a notable gathering place).

The objectives of the Urban South Reference Group are to:

1. Recommend priorities and strategies for implementation in the four focus areas of the *SMR Closing the Gap on Aboriginal Health regional plan* in the St Kilda/Urban South area, as follows:
  - Tackling Smoking
  - Transition to Adulthood
  - Health Care Pathways
  - Gathering Places
2. Raise the profile of both Aboriginal Community Controlled services and mainstream health services in meeting the health needs of Aboriginal communities.
3. Integrate the SMR regional Closing the Gap implementation with Commonwealth Closing the Gap initiatives in General Practice
4. Promote collaborative approaches to local area service delivery

### **Other relevant policy platforms**

Defining and addressing gaps to equitable access and inclusiveness is a key strategy to improve community health and wellbeing. The following policies contribute to or have relevance to the *ISEPICH Strategic Health and Wellbeing Plan*. The items are a selection and not a comprehensive listing of all relevant policy and legislation. Some are very recent or in the process of review or revision.

*Because mental health matters – Victorian mental health reform strategy 2009-19* is a whole of Victorian government ten-year plan for mental health. Key to implementation of the strategy in the Southern Metropolitan Region is the *Community Mental Health Planning and Service Co-ordination Initiative* (CMHP&SCI). This 4 year initiative aims to improve local mental health planning and service co-ordination across all parts of the mental health system with an emphasis on the needs of the most disadvantaged population groups. During 2011 the project has been gathering evidence and from mid 2011 will be developing recommendations for service system improvement and reform, in consultation with stakeholders.

*Disability Discrimination and Other Human Rights Legislation Amendment Act 2009*<sup>17</sup> Significant amendments to the Commonwealth *Disability Discrimination Act 1992* (DDA) came into effect on 5 August 2009. It represents a significant improvement in the protection of the rights of people with disability.

The Victorian *Disability Act 2006* (commenced July 2007) provides the framework to enable people with a disability to more actively participate in the community. The Act is guided by the principles of human rights and citizenship. It requires each public sector body to develop a *Disability Action Plan* to reduce barriers for people with a disability as community members and aims to make it easier for people with a disability to use services available to all Victorians. The Cities of Glen Eira, Port Phillip and Stonnington each have a *Disability Action Plan*, refer to their websites.

The *Equal Opportunity Act 1995* (Victoria) aims to promote recognition and acceptance of everyone's right to equality of opportunity and to eliminate, as far as possible, discrimination against people. The *Equal Opportunity Act 2010* is due to take effect in

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<sup>16</sup> *Southern Metropolitan Closing the Health Gap Plan 2009-2013*, Victoria Department of Health June 2010

<sup>17</sup> Link: <http://www.comlaw.gov.au/Details/C2009A00070>

August 2011. At the time of writing the *Equal Opportunity Amendment Bill 2011* was passed in the Victorian Parliament (15 June 2011).

Victoria introduced a *Charter of Human Rights and Responsibilities Act 2006* that came into full effect on 1 January 2008 and aims to build a fairer, more inclusive community by giving specific legal protection to 20 fundamental rights. It has been used to inform and uphold rights of women, Indigenous self-determination, rights of people with disabilities, and economic, social and cultural rights. In April 2011 the new Victorian Government commenced a review of the Charter.<sup>18</sup>

*A Right to Safety and Justice, the Strategic Framework to Guide Continuing Family Violence Reform in Victoria 2010-2020* (June 2010) provides a ten year whole-of-government framework for promoting respectful relationships and gender equity. Formulated by the former Victorian Government, there may be developments in policy and implementation. (The Office of Women's Policy transferred to the Department of Human Services on 1 January 2011).

Since December 2007 the Australian Government has been developing *Social Inclusion* as a whole-of-government agenda<sup>19</sup>. The goal is to achieve better outcomes for the most disadvantaged in our community and to improve social inclusion in society as a whole. Strategies include supporting children and families at greatest risk of long term disadvantage, focusing on locations of greatest disadvantage by tailoring place-based approaches in partnership with the community; addressing the incidence of homelessness, and *Closing the Gap* for Indigenous disadvantage.

The Australian Government asked the Productivity Commission to undertake a public inquiry into a long-term disability care and support scheme, with the Final Report being due 31 July 2011. The Commission was asked to examine the feasibility, costs and benefits of replacing the current system of disability services with a new arrangement that provides essential care and support for all Australians in the event of significant disability<sup>20</sup>.

The Victorian Competition and Efficiency Commission (VCEC) *Inquiry into Liveability* (2009)<sup>21</sup> found that the main drivers of liveability are: Communities; Economic strength and markets; Governments and decision making; and Human Rights. The Commission also identified a number of features of strong communities:

- community connectedness, engagement and wellbeing
- cultural diversity
- local amenity
- access to services, in particular transport and ICT
- housing affordability.

The VCEC emphasised the value of strong social networks where people feel confident about contributing to their community's social infrastructure and decision making as an important factor that generates stronger, more liveable communities and fosters economic growth and civic involvement.

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<sup>18</sup> Link: [humanrightscommission.vic.gov.au/charterreview](http://humanrightscommission.vic.gov.au/charterreview)

<sup>19</sup> Link: <http://www.socialinclusion.gov.au/Pages/default.aspx>

<sup>20</sup> Australian Government productivity Commission, Disability Care and Support: <http://www.pc.gov.au/projects/inquiry/disability-support>

<sup>21</sup> Victorian Competition and Efficiency Commission (VCEC) October 2009. *A State of Liveability: An Inquiry into Enhancing Victoria's Liveability, Final Report*

## Data and Evidence

### Population profiles

The estimated total population in the ISEPICH catchment in 2011 is over 330,000. The population estimates are: Port Phillip 97,429; Stonnington 100,351; Glen Eira 137,712.<sup>22</sup> Since the 2006 census the population is estimated to have increased by 12% in Port Phillip and Glen Eira and 11% in Stonnington.<sup>23</sup>

ISEPICH and member agencies collected a large amount of relevant data from primary sources such as the ABS Census and also utilised both service utilisation and qualitative data collected by member agencies. In particular, as part of the Integrated Health Promotion planning Caulfield Community Health Service and the Inner South Community Health Service developed comprehensive 'databooks' containing demographic and health profiles of the catchment population/s. A snapshot of the catchment population by age and country of birth is given below.

### Age profile

The population age distribution of Glen Eira is relatively similar to the metropolitan average. However the population age distribution of the inner city areas of Port Phillip and to a lesser extent Stonnington show significant differences. This trend is likely to continue and is closely linked to housing, particularly the density and development of inner city locations.

Melbourne Statistical Division (MSD)<sup>24</sup>

Age structure age group (yrs)	2006						
	City of Port Phillip		City of Stonnington		City of Glen Eira		Melbourne Statistical Division %
Enumerated data	Number	%	Number	%	Number	%	
0 to 4	3,822	4.5	4,315	4.8	7,657	6.3	6.3
5 to 11	3,309	3.9	5,308	6.0	9,835	8.1	8.8
12 to 17	2,474	2.9	4,657	5.2	8,156	6.7	7.8
18 to 24	8,282	9.7	10,516	11.8	11,267	9.2	10.2
25 to 34	23,878	28.1	18,033	20.3	18,064	14.8	14.9
35 to 49	21,642	25.5	18,812	21.1	28,038	23.0	22.7
50 to 59	9,422	11.1	10,661	12.0	15,076	12.4	12.2
60 to 69	5,889	6.9	7,542	8.5	8,994	7.4	7.9
70 to 84	5,023	5.9	7,181	8.1	11,660	9.6	7.5
85 and over	1,270	1.5	1,951	2.2	3,322	2.7	1.6
Total	85,011	100.0	88,976	100.0	122,069	100.0	100.0
Total ISEPICH catchment population 2006 Census <b>296,056</b>							

<sup>22</sup> Estimates courtesy Haydn Brown, Social Planner, City of Greater Dandenong (based on Australian Bureau of Statistics data)

<sup>23</sup> Australian Bureau of Statistics *Population Estimates 2006*.

<sup>24</sup> Melbourne Statistical Division (ABS 2005) Covers metropolitan Melbourne, surrounding urban fringe and rural areas, including the Dandenong Ranges, Yarra Valley and Mornington Peninsula., with about 3.5 million people representing over 70 percent of Victoria's population.

Difference in Age Group Population Proportions between the three ISEPICH LGAs  
and the Metropolitan Statistical Division.

Age group	%	Diff	%	Diff	%	Diff	MSD
0 to 4	4.5	-1.8	4.8	-1.5	6.3	0.0	6.3
5 to 11	3.9	-4.9	6	-2.8	8.1	-0.7	8.8
12 to 17	2.9	-4.9	5.2	-2.6	6.7	-1.1	7.8
18 to 24	9.7	-0.5	11.8	1.6	9.2	-1.0	10.2
25 to 34	28.1	13.2	20.3	5.4	14.8	-0.1	14.9
35 to 49	25.5	2.8	21.1	-1.6	23	0.3	22.7
50 to 59	11.1	-1.1	12	-0.2	12.4	0.2	12.2
60 to 69	6.9	-1.0	8.5	0.6	7.4	-0.5	7.9
70 to 84	5.9	-1.6	8.1	0.6	9.6	2.1	7.5
85 and over	1.5	-0.1	2.2	0.6	2.7	1.1	1.6
Total	100	0.0	100	0	100	0.0	100

Source: ISEPICH analysis; profile.id Census data

Compared to the proportions of people in various age groups in the metropolitan area, the most significant difference is the greater concentration of people in the 25 to 34 year age group in Port Phillip (a difference of 13.2%) and secondly in Stonnington (a difference of 5.4%). Port Phillip is also substantially under represented in the 5 to 17 year age group (a difference of 4.9%), and also Stonnington but to a lesser extent (a difference of 2.6 to 2.8%).

Glen Eira has a higher proportion of people in the 70-84 years of age group compared to the MSD (9.6% to 7.5%), and also in the 85+ years group (2.7% to 1.6%). Stonnington has more people in the 60 to 69 year age group compared to the metropolitan average (8.5% to 7.9%).

In light of the differences across the three LGAs in the proportion of the population in the different age groups, the changes in migration 2001 to 2006 were examined. It is clear that the changing age distribution is linked to the influx of young people into the inner city areas and people in the 35 to 54 years age group leaving.

### Country of birth

The number of people who migrated from other countries is similar in the three LGAs: Glen Eira 8,681 people, Port Phillip 8,765 people and in Stonnington, 8,216 migrated from overseas countries (2001-2006).<sup>25</sup>

Stonnington and Glen Eira both have higher proportions of overseas born people from Non-English speaking backgrounds. In contrast, people born overseas that moved into Port Phillip were predominantly from the United Kingdom and New Zealand.

There were no major differences between the City of Port Phillip or the City of Stonnington and the Melbourne Statistical Division's country of birth data in 2006.

Analysis of the country of birth of the population in the City of **Glen Eira** in 2006 compared to the Melbourne Statistical Division shows that there was a larger proportion of people born overseas as well as a larger proportion of people from a non-English speaking background. The dominant non-English speaking country of birth in the City of Glen Eira was China, where 2.3% of the population, or 2,787 people, were born. The major difference between the countries of birth of the population in the City of **Glen Eira** and the Melbourne Statistical Division was a *larger* percentage of people born in South Africa (2.1% compared to 0.5%).

<sup>25</sup> Census 2006 accessed via profile.id

The largest changes in the countries of birth of the population in Port Phillip between 2001 and 2006 were for those born in:

- India (+412 persons);
- United Kingdom (+336 persons);
- New Zealand (+212 persons).

The largest changes in the countries of birth of the population in Stonnington between 2001 and 2006 were for those born in:

- China (+840 persons);
- India (+789 persons);
- Indonesia (-293 persons).

The largest changes in the countries of birth of the population in Glen Eira between 2001 and 2006 were for those born in:

- India (+1,225 persons);
- China (+1,183 persons);
- South Africa (+547 persons).

The proportion of people born in non-English speaking countries continues to be significantly **higher in older age groups** than in younger age groups across the whole catchment, particularly in Port Phillip. Similarly, the **total change in the number of people born overseas is relatively small** compared to the total overseas born population (ranging from 3.4% to 5.3% of the total overseas born population).

## Evidence of needs

Integral to the planning process is the gathering and analysis of data. In addition to quantitative demographic and service utilisation data collection, an exhaustive process of planning forums and consultations yielded valuable qualitative information from service providers as well as from consumers and community members.

The evidence of local needs included an analysis of reports on community consultation, both published and unpublished. Information was provided by the cities of Port Phillip, Stonnington and Glen Eira and by Caulfield Community Health Service. Port Phillip in particular conducted and supported consultation on a wide range of issues. Information from previous ISEPICH reports was also reviewed, including results from the 2003 and 2006 Rooming House consultations.

Snapshots of the available evidence, as it relates to the ISEPICH Strategic Priorities, are provided below. Links are provided to websites and other sources of more detailed information at the end of this section.

### Social inclusion and inclusive communities

#### *Unequal incomes*

The inner south east is an area of increasing gentrification and marked inequality, with rich and poor people living in close proximity. There is widespread evidence<sup>26</sup> in Australia and internationally that health status is linked to income, with wealthier people

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<sup>26</sup> I McAuley (University of Canberra and Fellow, Centre for Policy Development) 'Poverty – an economic blight' Paper to accompany presentation to Port Phillip Community Group forum "An unequal society is an unhealthy society", October 2009

generally enjoying better health than those on lower incomes.<sup>27</sup> Local surveys have substantiated these findings. In 2009 for example, overall 89% of Stonnington survey group residents reported that they were in good-excellent health, however just 64% of the residents with a low socio-economic status reported this degree of good health.<sup>28</sup>

There is a significant number of Rooming Houses and pension level Supported Residential Services (SRSs) in the ISEPICH catchment. Residents of Rooming Houses and SRSs experience a high level of mental health and psycho-social issues and chronic illnesses.

Analysis by Wilkinson and Pickett in *The Spirit Level* (2009) indicates that in developed societies, the most important factor contributing to better or worse health (and a range of other social indicators) is the extent of inequality or equality in a society.<sup>29</sup> That is, in societies that are more unequal in distribution of income and wealth, there are generally more health and social problems. This is true across all income groups, though the poorest and most disadvantaged are affected most.

This is particularly relevant to the inner south east because the area is becoming more unequal. Rising housing costs mean people on low incomes are unable to find housing in the area. There is evidence that a significant number of residents who have rented here for a long time are under housing stress and being forced to leave because of rent increases. While the statistical associations found by Wilkinson and Pickett (2009) for nations and large cities cannot be directly applied to smaller areas such as the ISEPICH catchment, the increasing extent of inequality in this area is an example and a result of increasing inequality in Australia more broadly.

People on low incomes who still live in the area, for example residents of public or social housing and older people on low incomes who purchased their homes in previous eras, are increasingly concentrated in 'pockets' of disadvantage within a generally wealthy population. This disparity can create additional stress, as the cost of living, stigmatization and social exclusion of poorer people may increase.

Intervention is required at all levels from the downstream focus on the individual through to an upstream focus on factors such as social change, policy and environments. It is essential to address the fundamental causes of health inequality – the social determinants – otherwise, no matter how good our strategies are, we are at risk of simply trying to make the poor “more sensible”, as Wilkinson and Pickett put it, without addressing the underlying causes of their problems.<sup>30</sup>

### *Indigenous Population*

According to the Australian Bureau of Statistics, at the time of the 2006 census there were 235 people identifying as Aboriginal or Torres Strait Islander in the City of Port Phillip, a decrease of 24 since 2001. St Kilda area is a traditional gathering ground for Indigenous people and these population figures may underestimate the total number of Indigenous people who regularly visit or have ties to the area.

In the City of Stonnington, there were 167 people identifying as Aboriginal or Torres Strait Islander, an increase of 20 from 2001. In the City of Glen Eira, there were 167

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<sup>27</sup> VicHealth (the Victorian Health Promotion Foundation) Research Summary: Burden of disease due to health inequalities VicHealth 2008 available at <http://www.vichealth.vic.gov.au/en/Resource-Centre/Publications-and-Resources/Health-Inequalities/Research-Summary-Burden-of-disease-due-to-health-inequalities.aspx> (accessed 4/6/09)

<sup>28</sup> City of Stonnington *Municipal Public Health Plan 2009-13* p 52.

<sup>29</sup> R Wilkinson & K Pickett *The Spirit Level* (op cit) 2009

<sup>30</sup> Ibid p 234

people identifying as Aboriginal or Torres Strait Islander, a decrease of 29 from 2001. Both Stonnington and Glen Eira have a lower representation of Indigenous residents compared to the Melbourne Statistical Division.

The Indigenous population of the area has a lower proportion of people in older age groups than the non-Indigenous population, and on average have a lower household and individual income than non-Indigenous people.

There is a large body of evidence of the poor health and poverty experienced by indigenous people. *Closing the Gap* between the health of indigenous people and the rest of society is a major priority of both the Australian and the Victorian governments.

### *Cultural Diversity*

In Port Phillip and Stonnington, the proportion of people born in non-English speaking countries in 2006 was slightly lower than the average for Melbourne (about 17% and 19% respectively compared with the Melbourne average of 22%). In Glen Eira the proportion born overseas (24%) was slightly higher. The most marked changes across the catchment since the 2001 census were increases in the number of people born in China and India, and declines in the number born in Poland and Greece.

People born in non-English speaking countries are much more likely to live in public or social housing than the remainder of the catchment population, which suggests they are also more likely to have lower incomes and higher rates of disability.

The most commonly spoken languages across the catchment are Greek, Russian, Italian, and Chinese languages (Mandarin and Cantonese) with Hebrew also significant in Glen Eira. The language groups with the largest number of people who have limited proficiency in English (that is, who speak English not well or not at all) are Greek, Russian, Mandarin and Cantonese.

Significant numbers of students, including international students, live in the ISEPICH catchment due to proximity to tertiary education (eg Swinburne (Prahran), Monash (Caulfield), and to the CBD and other locations accessible by public transport. Living conditions for students can be difficult due to high costs of living and a lack of affordable rental accommodation. Incidents of severe overcrowding have been reported in local newspapers, such as in excess of 20 people (mainly students) living in accommodation suitable for less than 8 residents.

During 2009-2010 ISEPICH undertook a research project - the *Health and Wellbeing of International Students in the Inner South*<sup>31</sup>. Key themes which emerged from the focus groups included concern over discrimination and racism; difficulties in finding affordable and appropriate housing; difficulties associated with work and employment; homesickness, isolation and difficulties in adapting; limited access to health services, food and nutrition, including the cost of food.

### *People living with a disability*

The Survey of Disability, Ageing and Carers (SDAC)<sup>32</sup> data indicates that close to one in five Australians has one or more disabilities and this proportion increases with age.

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<sup>31</sup> *Health and Wellbeing of International Students in the Inner South East Report July 2010* – see website: [www.isepich.org](http://www.isepich.org)

<sup>32</sup> Survey of Disability, Ageing and Carers (SDAC), Australian Bureau of Statistics 2009  
<http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0>

Almost nine in ten people aged 90 and over (88%) have a disability, compared with 3.4% of those aged four years and under.

*“Disability can result from accident, illness, be congenital or a genetic disorder. There are many different kinds of disability—physical, intellectual or mental health related.....*

*.....A disability may be visible or hidden, may be permanent or temporary and may have a minimal or substantial impact on a person’s abilities. A disability may affect mobility, ability to learn, or ability to communicate easily. ....*

*The key issue in planning for inclusion of all people within our community is acknowledging that a significant number of us will be a person with a disability and/or provide care for a person with a disability at some point in our lifespan”.<sup>33</sup>*

Compared to Victoria overall, there is a lower proportion of people needing assistance for core activities in Port Phillip and Stonnington while the proportion in Glen Eira is above average. Glen Eira and Stonnington both have a higher number of people needing assistance for core activities in the 75 years and over age group. The Australian Bureau of Statistics (ABS) 2006 indicates 4,942 people in Glen Eira have a core activity need for assistance,<sup>34</sup> 2,553 people in Port Phillip and 2,789 people in Stonnington.

Approximately 16,118 of Glen Eira residents aged between 0-64 years have a disability<sup>35</sup> (15% of the total population). Glen Eira has a higher than average number of carers of people with disabilities. In Glen Eira 10,702 people provided unpaid care to family members because of a disability, long-term illness or problems related to old age, compared to 5991 people in Port Phillip and 7,351 people in Stonnington.

An estimated 11,020 people in **Port Phillip** between the ages of 0 and 64 years have a disability<sup>36</sup> (15% of the total population). The majority of people with a disability living in Port Phillip are aged between 25-64 years. There is a significant difference in the rates from 15-24 years to 25-34. A few factors that may contribute to this rate include disability acquired through injury and illness and fewer young people living in Port Phillip aged 15-24 years compared to the 25-34 years age group.

In the City of **Stonnington** an estimated 11,948 people are aged 0 - 64 years have a disability<sup>37</sup>. There are an increasing number of people with a disability in each ten year age cohort, with almost a third of the people with a disability being aged between 55 and 64 years.

### *Sexual orientation*

The inner south east has traditionally had above average rates of people who are gay, lesbian, bisexual, transgender or intersexual (GLBTI) in their sexual orientation. People of GLBTI orientation may experience discrimination and violence. Same sex attracted young people may be particularly at risk of self-harm and depression if they have been

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<sup>33</sup> Extract from the *City of Stonnington Access and Inclusion Plan, 2010-2013*, p2

<sup>34</sup> Core activity need for assistance is used to measure the number of persons with a profound or severe disability. People with a profound or severe disability are defined as people needing help or assistance in one or more of the three core activity areas of self-care; mobility and communication because of a disability, long-term health condition (lasting six months or more), or old age.

<sup>35</sup> *Disability Counts 2006: A statistical profile of children and young adults with a disability living in Victoria* Southern Metro Association for Children with a Disability  
<http://www.acd.org.au/advocacy/Southern%20Metro%20DC%202006.pdf>

<sup>36</sup> *ibid*

<sup>37</sup> *ibid*

subjected to discrimination or bullying. Increased support, particularly in the school environment, and through social support groups, can improve this situation.<sup>38 39</sup>

The Cities of Port Phillip and Stonnington are proactive in their support of people with a GLBTI orientation and provide information on their websites.

The City of Port Phillip provides a range of services and advice to assist the GLBTI community. The City of Port Phillip has a stated commitment to the promotion of a fair, just, tolerant and inclusive community - City of Port Phillip Statement of Commitment - GLBTI. The GLBTI forum is made up of members of the GLBTI communities living within the City of Port Phillip. It advises council on the development of policies and strategies to promote inclusiveness of GLBTI people in all areas of council activity.

In 2008 the City of Stonnington estimated there was over 2000 people aged 55 and over<sup>40</sup> who identify as GLBTI. In June/July 2011 Stonnington's Aged Services is participating in a program conducted by Gay and Lesbian Health Victoria, and the Also Foundation, to help Council strengthen its service delivery to GLBTI residents aged 55 years and over.

### *Problem Gambling*

Problem gambling has serious consequences for individuals, families and communities and is most prevalent among people with low socio-economic status.

Excluding the Electronic Gaming Machines (EGMs commonly called poker machines) at Crown Casino, in 2009-10:

- Glen Eira had 7.2 EGMs per 1000 adult population. The EGM rate of losses was \$698 per adult (metropolitan average \$641);
- Port Phillip had 4.5 EGMs per 1000 adult population and the rate of losses per adult was \$333; and
- Stonnington had 3.5 EGMs per 1000 adult population and the rate of losses per adult was \$268.<sup>41</sup>

While the rates of EGM gambling in Glen Eira appear to be higher than in the other two LGAs, the losses from an additional 2500 EGMs at Crown Casino are not included in these figures. These machines are readily accessible to residents of the Port Phillip and Stonnington, particularly to people living in Port Melbourne and South Melbourne where there are high concentrations of public and community housing.

Gambler's Help Southern provides services to the southern metropolitan region, including the inner south east. Problem gambling counselling and financial counselling are among the services provided. Gambler's Help estimates at least 80-85% of clients have EGM problems.

### *Family violence*

Family violence is the leading contributor to death, disability and illness in women aged 15 to 44. The *Victorian Family Violence Database Volume 4 2009* provides an evidence-based analysis and tracking of trends from 1999–2008,<sup>42</sup> During this period Victorian Police had an increased focus on risk assessment which led to an increase

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<sup>38</sup> L Hillier, A Turner & A Mitchell *Writing themselves in again: 6 years on* La Trobe University, 2009.

<sup>39</sup> L Hillier *This group gave me a family* La Trobe University, Melbourne 2009

<sup>40</sup> City of Stonnington Older person's Strategy 2008-2012 (September 2008).

<sup>41</sup> Victorian Commission for Gambling Regulation 2011

<sup>42</sup> The Victorian Family Violence Database Volume 4: Nine Year Trend Analysis (2009) State of Victoria, Department of Justice

in police-initiated family violence intervention orders and a steady increase in the number of children that police have recorded as aggrieved family members.

#### *Local Family violence incidents*

The following incidents were reported to police in 2006/07:

- 374 incidents in Stonnington (down from 516 in 2002/03);
- 522 incidents in Glen Eira (up from 484 in 2002/03); and
- 436 incidents Port Phillip (down from 508 in 2002/03)

Source: Melbourne Access Point, Southern Metropolitan Region (based on Victoria Police data, 2002-07)

*Who to contact in a family violence situation*<sup>43</sup> is an up to date listing of services and who to go to contacts, developed and maintained by the Southern Metropolitan Region Integrated Family Violence Reform Partnership - available online.

#### *Consultation*

A range of consultations by member agencies<sup>44</sup> with marginalised groups has identified the following priorities:

- Support for employment and education programs;
- More after hour services and activities;
- Cultural community development projects that provide opportunities to foster increased understanding;
- More opportunities to contribute to and be accepted by the community;
- Homelessness and mental illness;
- Access to services for physical health for Rooming House Residents; and
- Quality of housing, open space and green space.

### **Better access to services**

The need to improve access to services and support navigation of the service system has been an ongoing important issue for consumers and community members who have participated in ISEPICH consultations, committees, working groups and planning forums. They regularly raise instances of difficulties experienced by themselves and other community members in accessing services and particularly regarding communication and cultural issues for people from a CALD background.

Because the service system is complex and constantly evolving, improving access to services is an ongoing need. Its' importance was strongly reinforced by the consumers and community members involved in the March 2009 ISEPICH Planning Forum.

*There is increasing evidence from effectiveness studies that consumer and community participation can improve health outcomes, lead to more responsive care, facilitate people's involvement in treatment decisions and improve quality and safety. In addition to better health outcomes, consumer and community participation can help to reduce political risk, hold professionals and bureaucrats accountable, encourage clinical accountability, identify workforce issues and foster more responsive and equitable services.*

Doing it with us not for us' Department of Human Services 2006

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<sup>43</sup> Southern Metropolitan Region Integrated Family Violence Reform Partnership, *Who to contact in a family violence situation*: see link: <http://www.tellsomeone.org.au/FVCardIM2010.pdf>

<sup>44</sup> See Inner South East Partnership in Community and Health (ISEPICH) *Integrated Health Promotion Plan 2009-12 working draft* 2009 for further information

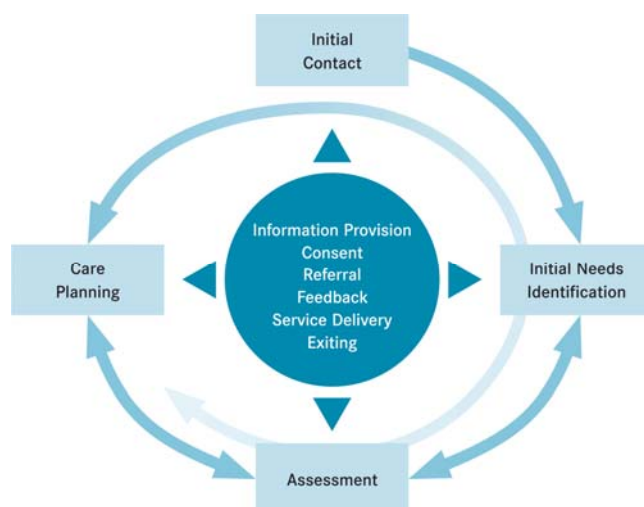
Since its establishment in 2000, ISEPICH has actively sought input from carers, consumers and community members and promoted participation in decision making. At an ISEPICH Community Participation Forum in October 2010 initiated by the Community Advisory Group, participants affirmed the value of community participation in member agencies and its contribution to developing accessible, person-centred and responsive services.

The following were identified as some enablers for effective community participation in health and community support organisations:<sup>45</sup>

- The Individual is at the centre of decision making and client focus is a priority
- Processes are in place to 'enable' individuals to be supported and understood
- Active communication including information that is available and accessible
- Organisation is culturally sensitive and responsive and able to link to appropriate services and resources
- Commitment to developing organisation wide understanding, policies and active encouragement that supports community participation
- Understanding of the social determinants of health and importance of involving community in problem solving and change
- Peer support and education programs
- Membership based organisations
- Prepared to take the time to learn and in turn teach others
- Opportunities for education, growth and support of staff and community members
- Robust and effective partnerships between organisations
- Understanding of change management processes and how to develop responsive change

The *Better Access to Services (BATS) Policy* and Operational Framework, including the first Service Coordination Tools and Templates (the SCTT), were developed in 2001 in response to the need to ensure consistent quality of processes and reduce duplication in the collection of health care information. Revised regularly by the Department of Health and the sector to reflect best practice in the identification and service responses to the needs of consumers, the SCTT has recently been upgraded. Implementing the use of the SCTT 2009 occurs within the context of broader service system developments and quality improvement processes.

### Operational Elements of Service Coordination



Source: DHS SC Training 2009

<sup>45</sup> Reflections from the ISEPICH Community Advisory Group Forum on October 2010 –see website: [www.isepich.org](http://www.isepich.org)

ISEPICH is committed to strengthening service co-ordination by member organisations throughout 2009-2012 to achieve better health outcomes for consumers, particularly for people experiencing serious health inequality.

## **Sustainable and affordable living and environments**

### *Housing Affordability*

Key emerging trends across ISEPICH in housing, between the 2001 and 2006 Censuses, were increases in:

- high density housing;
- the proportion of people renting, and
- the number of lone person households for all municipalities.

In Port Phillip, about 41% of households are sole person households, in Stonnington about 35% and in Glen Eira about 30%, compared with an overall average for Melbourne of 24%.<sup>46</sup>

There is a marked shortage of affordable housing in the ISEPICH catchment and high levels of housing stress. Over 50% of household loan repayments made in the three municipalities exceed \$1,600 per month.

Housing workers in Port Phillip report ongoing problems with people whose rent is increasing and who are unable to continue living in the area. An increasing proportion of these people are older residents.

### *Public Housing*

There are comparatively high levels of public or social housing in Port Phillip and Stonnington compared to Melbourne overall, with about 5.9% of all households being public or social rentals in Port Phillip, and about 4.0% in Stonnington, compared to an average 3.3% for the Melbourne Statistical District.<sup>47</sup> Glen Eira has low levels of public housing, being only about 1.4% of households. The Council provides some affordable rental housing for residents, including Independent Living Units for older residents in financial difficulty.

The age grouping of people living in public housing estates within the ISEPICH area is shown in the table below. The data is derived from the Office of Housing demographic data for the housing estates in the inner and middle south east as at 31 August 2009. More than one third of tenants (37.7%) are over 70 years of age and 53.5% are over 60 years of age.

Approximately one third (28.0%) of tenants in ISEPICH were born in Australia. Twenty-five (25.0%) were born either in the Russian Federation, Ukraine or former USSR, 4.7% in Vietnam, 2.6% Poland and 2.0% England. For 8.7% of tenants the country of birth was not stated and tenants were from over 89 countries of origin.

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<sup>46</sup> Data from the 2006 Census, accessed via profile.id

<sup>47</sup> Data derived from Melbourne Affordable Housing Website <http://www.imrhai.com.au/Default.aspx> accessed 30/11/09)

Source: Port Phillip Community Group 2009

Age and Number of Public Housing Tenants in the ISEPICH Catchment September 2009		
0 to 4	97	2.5%
5 to 9	141	3.6%
10 to 19	273	6.9%
20 to 29	189	4.8%
30 to 39	250	6.4%
40 to 49	368	9.4%
50 to 59	516	13.1%
60 to 69	623	15.8%
70 to 79	883	22.4%
80 to 89	548	13.9%
90 and over	55	1.4%
	<b>4783</b>	<b>100%</b>

Over the last decade the amount of public housing has not kept pace with population growth. It is now grossly inadequate to meet the demand. There are over 10,000 people on public housing wait lists in the Southern Metropolitan Region in September 2009, including 1,890 registered with the South Melbourne/Prahran Office.<sup>48</sup>

#### Homelessness

The factors contributing to homelessness are complex and often interdependent<sup>49</sup> and include:

- **structural** factors such as unemployment, poverty, inadequate income support, and lack of affordable housing;
- **government fiscal and social policy** such as welfare expenditure, health services and housing assistance;
- **personal** issues such as mental illness, family breakdown, domestic violence, alcohol and drug use, gambling, conflict with friends and family and sexual abuse.

Lack of affordable housing is one of the most significant structural causes of homelessness. The growing difficulties experienced in accessing affordable housing are placing mounting pressure on communities across Melbourne. The pathways into homelessness are diverse and it is experienced by people from all walks of life.

Homelessness is a term used to describe the experience or situation of not being able to access safe, secure or affordable housing. People experiencing homelessness are at risk of suffering further harm from a range of factors related to diet, general health, mental health, substance abuse and violence.<sup>50</sup>

People experiencing homelessness often endure exclusion from mainstream society, social isolation, discrimination, unemployment, little or no family support or networks, and financial hardship.

<sup>48</sup> Victoria, Department of Human Services, Office of Housing *Public Housing Waiting and Transfer List* September 2009, available at <http://www.housing.vic.gov.au/applying-for-housing/waiting-times> (accessed 30/11/09)

<sup>49</sup> City of Port Phillip *Homelessness Action Plan 2009-13* 2009

<sup>50</sup> C Talbot. *Homeless and At Risk Young People: Sexuality, Abuse and Vulnerability* 2007

In 2005-2006, within the broader Southern Metropolitan Region, nearly 40% of the over 31,000 people who presented for urgent housing assistance were women, many accompanied by children. Children who experience homelessness have a higher risk of experiencing homelessness in later adulthood. Thirty eight per cent (38%) of people using Homeless services are aged 15-24 years.<sup>51</sup>

### *Food security*

The Community Indicators Victoria Wellbeing Report 2007<sup>52</sup> measured food insecurity by the number of people who say that at least once in the past year they ran out of money and were unable to buy food. Glen Eira had a higher rate (7.2%) of food insecurity than the Victorian average (6.0%) and the SMR average (6.9%). Port Phillip was closer with 5.5% and Stonnington recorded only 2.8% of people surveyed having experienced food insecurity.

### *Behavioural risk factors*<sup>53</sup>

The national **dietary** guidelines for adults recommend that people consume at least five serves of vegetables and two serves of fruit per day.

- 6.9% of females and 4.3% of males in Glen Eira met the guidelines for vegetable consumption, while 56.7% of females and 39.9% of males met the guidelines for fruit consumption
- 9.2% of females and 5.7% of males in Port Phillip met the guidelines for vegetable consumption while 57.3% of females and 40.4% of males met the guidelines for fruit consumption,
- 11.0% of females and 4.6% of males in Stonnington met the guidelines for vegetable consumption, while 61.1% of females and 44.3% of males met the guidelines for fruit consumption
- The average rates meeting the guidelines for vegetable consumption in Victoria are 10.7% for females and 5.0% for males, and the average rates meeting the guidelines for fruit consumption are 53.5% for females and 41.0% for males.

The national **physical activity** guidelines for adults recommend at least half an hour of moderate to vigorous exercise on most days of the week.

- In 2008 67.7% of males and 68.7% of females in the City of Stonnington, 71.5% of males and 69.1% of females in the City of Port Phillip, and 65.4% of males and 61.6% of females in the City of Glen Eira, met the guidelines;
- The average rates meeting the physical activity guidelines in Victoria are 61.0% for males and 59.7% for females

In 2008, the rates of people assessed as **overweight or obese** in ISEPICH were:

- 38.4% of males and 24.3% of females in the City of Glen Eira were overweight, whilst 16.3% of males and 9.1% of females were obese
- 39.3% of males and 18.3% of females in the City of Port Phillip were overweight, while 10.2% of males and 8.7% of females were obese
- 47.0% of males and 16.7% of females in the City of Stonnington were overweight, while 7.0% of males and 9.2% of females were obese
- The average rates of overweight for Victoria are 39.9% for males and 24.2% for females. Average rates for obesity are 17.3% for males and 16.1% for females

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<sup>51</sup> City of Port Phillip *Homelessness Action Strategy 2008-2013*

<sup>52</sup> McCaughey Centre, University of Melbourne 'Community Indicators Victoria Wellbeing Reports' at [http://www.communityindicators.net.au/wellbeing\\_reports](http://www.communityindicators.net.au/wellbeing_reports) (accessed 30/11/09)

<sup>53</sup> All data in this section is from the *Victorian Population Health Survey 2008* at [http://www.health.vic.gov.au/healthstatus/vphs\\_current.htm](http://www.health.vic.gov.au/healthstatus/vphs_current.htm) (accessed 14 June 2011)

The proportions who are current **smokers** in 2008 were:

- 18.3% of males and 11.5% of females in Glen Eira, 9.8% of males and 17.4% of females in Port Phillip, and 14.6% of males and 10.7% of females in Stonnington
- The proportions in Victoria were 21.4% males and 16.9% of females.

In 2008 rates of likely short term harm to health from **drinking alcohol** at least weekly were 14.9% in Port Phillip, 10.1% in Stonnington and 6.3% in Glen Eira, compared with a metropolitan average of 10%, Males are more likely than females to drink at risky levels.

### *Transport*

The Inner South East is comparatively well served by public transport including trains, trams and buses. In addition the Cities of Glen Eira, Port Phillip and Stonnington provide some levels of community transport within their communities. The Councils have each developed sustainable transport and walking strategies, refer to their respective websites for details.

Notwithstanding that the area is relatively well-served by public transport, in community consultation transport problems are commonly reported as a barrier to participation and access to services.

Census data<sup>54</sup> indicates that while car travel is the single most common mode of transport to work in all three municipalities, 'active travel' (walking and cycling as a means of transport rather than recreation, and public transport use) is growing at a faster rate than private auto travel. Car travel as a means of transport to work decreased in all three municipalities between the 2001 and 2006 censuses. Residents in all three municipalities are more likely to use public transport in order to travel to work, social activities and special events or for personal business and shopping, than the state average.

Data from the Department of Transport<sup>55</sup> indicates that the car is not the dominant mode of transport to work or for shopping and personal business in Port Phillip, as other means of transport (mainly public transport, walking and cycling) in combination account for more trips than private cars.

## **Care for people experiencing chronic disease**

Care for people with chronic diseases usually involves multiple health care providers in multiple settings. To provide this care within an integrated system, health care providers must work collaboratively to coordinate and plan care and services. This requires a commitment to working together to achieve shared goals. People with chronic disease need a responsive person-centred and effective system of care.

From 2006–07, all PCPs received recurrent funding for integrated chronic disease management (ICDM), and mapping of self management programs, to build on their established role in facilitating service system integration. Service coordination provides an essential platform for ICDM. PCPs have an important role in bringing agencies together to facilitate a coordinated approach to planning and delivery of services for clients with chronic disease.

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<sup>54</sup> 2006 Census data accessed via profile.id

<sup>55</sup> Victorian Government, Department of Transport 'Victorian Transport Statistics Portal' (accessed 30/11/09), <http://www1.transport.vic.gov.au/VTSP/homepage.html?id=1> plus unpublished data

## Chronic Disease local snapshot <sup>56</sup>

- The most prevalent chronic diseases in our catchment area are diabetes, obesity, cardiovascular disease and cancer
- Diabetes accounts for the of majority of Ambulatory Care Sensitive Conditions (ACSCs)
- Dental conditions are the second highest cause of ACSCs in Stonnington and the third highest in Port Phillip
- From age 55, Diabetes Mellitus (NIDDM) is the third most prevalent disease among males and the fifth most prevalent among women

### Diabetes

In 2001, approximately one million Australians had type 2 diabetes, with projections indicating this figure will increase to 3.3 million by 2031. In 2001, it was estimated that 7.2% of Victorians had type 2 diabetes and up to half are undiagnosed.<sup>57</sup>

Aboriginal and Torres Strait Islander people have one of the highest rates of type 2 diabetes in the world and the prevalence amongst culturally and linguistically diverse groups is also higher than average. The risk of developing type 2 diabetes is higher for people from lower socioeconomic groups and diabetes-related mortality in disadvantaged areas is recorded as 82% higher than in the most advantaged areas.

Type 2 diabetes is a largely preventable lifestyle disease, with key risk factors such as overweight and obesity, poor diet, and a lack of physical activity. The failure to prevent type 2 diabetes, and delays in diagnosis, can lead to severe complications such as amputation, blindness and kidney failure, and in the extreme, death from heart attacks and strokes. These complications have enormous impact on both the person suffering from the disease and their family, as well as putting pressure on health systems.

Diabetes complications represent the highest number of preventable hospitalisations in Victoria, accounting for 36% of the top ten avoidable hospital admissions.<sup>58</sup>

Ambulatory care sensitive conditions (ACSCs) are those for which hospitalisation is thought to be avoidable if preventive care and early disease management are applied, usually in an ambulatory setting. The most common ACSC for hospital admission across Glen Eira, Port Phillip and Stonnington is diabetes complications.<sup>59</sup> From age 55, diabetes is the third most prevalent disease among males and the fifth most prevalent among women.

Across the ISEPICH catchment, ACSCs in both 65+ males and females of non-English speaking background (NES) are higher than for those of English speaking background, but particularly so for males.

According to the *Victorian Population Health Survey report 2008*<sup>60</sup>, the estimated prevalence of Type 2 diabetes in the 3 LGAs in our catchment is close to the Victorian average of 4.8 % of the population: Glen Eira averages 4.0 %; Port Phillip 3.1 %; and Stonnington 3.5 %. The prevalence of the disease ranged from 1.6 % in the Melbourne LGA to 9.3 % in Melton. In Victoria although the average prevalence of type 2 diabetes

<sup>56</sup> <http://www.ischs.org.au/Home/TheLocalArea/tabid/77/Default.aspx> accessed June 2011

<sup>57</sup> Baker-IDI Heart and Diabetes Institute 'AusDiab' (database) at [http://www.diabetes.com.au/research.php?regionID=181&page=ausdiab\\_home](http://www.diabetes.com.au/research.php?regionID=181&page=ausdiab_home) (accessed 30/11/09)

<sup>58</sup> Victorian Government Department of Health 'Health Status of Victorian' (database) available at <http://www.health.vic.gov.au/healthstatus/index.htm> (accessed 30/11/09)

<sup>59</sup> Ibid

<sup>60</sup> *Victorian Population Health Survey 2008* at [http://www.health.vic.gov.au/healthstatus/vphs\\_current.htm](http://www.health.vic.gov.au/healthstatus/vphs_current.htm) (accessed 14 June 2011)

did not change for females between 2005 and 2008 (3.8%), the prevalence of type 2 diabetes increased for males from 3.9 per cent in 2005 to 5.8 per cent in 2008

Alfred Health held a **regional Diabetes Forum on 30 October 2008** to present findings to stakeholders in ISEPICH and KBPCP catchments about the Alfred Health ambulatory diabetes services review conducted in 2007. A goal of the Forum was to explore opportunities to improve integration of diabetes care across the catchment.

Alfred Health statistics provided at this Forum included:

- 25% of inpatients have diabetes with 80% of these admitted with other medical problems
- Of those admitted for diabetes, 40% were emergency admissions
- Length of stay is higher for emergency diabetes admissions (8.56) compared to non emergency admissions (2.90).
- Over 60% of all people admitted for diabetes related conditions reside in the local government areas (LGAs) of Port Phillip, Glen Eira, Bayside, Stonnington and Kingston

As an outcome of the Alfred Health Regional Diabetes Forum, a working group was formed to explore how integrated diabetes care could be developed across the catchment. Ultimately the **South East Bayside Diabetes Alliance (SEBDA)** was formed in early 2009. Thirteen key agencies responsible for diabetes services or service co-ordination, across the ISEPICH and KBPCP catchments, have agreed to work in partnership to improve care continuums and collaboration across health care settings for the management of diabetes.

ISEPICH thus identified diabetes as a key ICDM priority for its 2009-2012 Strategic Health and Wellbeing Plan and committed funds towards employment of the SEBDA Project co-ordinator in 2009-2010, and in 2010-2011. Over half the 13 organisations on the SEBDA Steering Committee are ISEPICH members. ISEPICH Executive members and the ISEPICH EO are represented on the SEBDA Steering Committee and the Project Advisory Group.

SEBDA is seeking funding to support a third year of the project in 2011-2012. Details of the SEBDA project are available on-line<sup>61</sup>.

### ***Mental Health and Wellbeing***

There are a number of specialist services located in the ISEPICH catchment, including mental health services and support services, and the HIV/AIDs clinic at the Alfred Hospital. The area also has a range of welfare services and accommodation options for people with mental health and other conditions, including pension-only Supported Residential Services, community residential units and Rooming Houses. Attracted by these services, a significant number of people with mental health and chronic conditions live in the area.

Hospital admissions for alcohol and related drug conditions were higher in Stonnington and Port Phillip than Victoria overall. Very high prevalence of alcohol abuse/dependence is evident among 15-54 year old males (particularly in the 25-44 age bracket) and among females aged 15-44 years. Port Phillip and Stonnington have, respectively, 13 and 5 times more alcohol and drug clients than the average rate for Victoria.<sup>62</sup> "Mental diseases and disorders" as a category were higher in all three municipalities. Port Phillip has a significant number of mental health services clients.

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<sup>61</sup> See Alliances at [www.isepich.org](http://www.isepich.org) and <http://www.kingstonbaysidepcp.org.au/ssd/cdm.html>

<sup>62</sup> Data sources available in the Inner South Community Health Service *Databook* 2009, available at <http://www.ischs.org.au/Home/TheLocalarea/tabid/77/Default.aspx>

In Port Phillip and Stonnington there is:

- High incidence and prevalence of depression across the lifespan
- Particularly high depression among females aged 35-54
- High rates of generalised anxiety disorder for females aged 34-64
- Numerous cases of schizophrenia, trauma and social phobia (particularly among younger age groups).

According to the *Victorian Population Health Survey 2008*<sup>63</sup> residents in Glen Eira, Port Phillip and Stonnington do not differ greatly in levels of psychological distress compared to the Victorian average, except that:

- 69.2% of Stonnington females had a low level of psychological distress compared to 59.7% of Victorian females;
- 72.2% of Glen Eira males had a low level of psychological distress compared to 65.3% of Victorian males.

The proportion of people across the ISEPICH catchment who sought professional help for a mental health problem within the previous 12 months was similar to the Victorian average (11.4%) although a slightly higher proportion of people in Stonnington (13.0%) sought help.

In Glen Eira and Stonnington there is a higher incidence than the Victorian average of people with dementia. In the Southern metropolitan region, Glen Eira has the 2<sup>nd</sup> highest number of clients using the Child Adolescent Mental Health Service and the 4<sup>th</sup> highest number of clients and contacts for the Aged Mental Health Service.

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<sup>63</sup> *Victorian Population Health Survey 2008* at [http://www.health.vic.gov.au/healthstatus/vphs\\_current.htm](http://www.health.vic.gov.au/healthstatus/vphs_current.htm) (accessed 14 June 2011)

## Further Information

**For more information about ISEPICH** please visit the website at [www.isepich.org](http://www.isepich.org)  
Demographic and health status information is available on the “About ISEPICH” page

A full report of the ISEPICH planning forum in March 2009 is available from ISEPICH on (03) 9209 6455 or [isepich@portphillip.vic.gov.au](mailto:isepich@portphillip.vic.gov.au)

### **Health & Wellbeing Status Evidence:**

The Inner South Community Health Service databook may be downloaded from <http://www.ischs.org.au/Home/TheLocalArea/tabid/77/Default.aspx>

The Caulfield Community Health Service databook may be accessed from Caulfield Community Health - see <http://www.alfred.org.au/cchs/>

*Victorian Population Health Survey 2008* at [http://www.health.vic.gov.au/healthstatus/vphs\\_current.htm](http://www.health.vic.gov.au/healthstatus/vphs_current.htm)

**More information about health promotion** can be found at <http://www.health.vic.gov.au/pcps/hp/index.htm>

**For more information about the PCP strategy** please see <http://www.health.vic.gov.au/pcps/>. Including

- *Primary Care Partnerships Planning and Reporting Guidelines 2009-2012, July 2009*
- *Primary Care Partnerships Revised Program Logic, July 2009*
- *Primary Health Branch Funded organisation requirements 2009-10 to 2011-12*
- *Primary Care Partnerships National State Policy Context for Primary Care Partnerships Information Resource May 2009*

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- Australian Bureau of Statistics 'Survey of Disability, Ageing and Carers (SDAC)' 2009 <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0> (accessed June 2011)
- Australian Bureau of Statistics *Census 2006* 2008 (note that some census material cited in this document is accessed via "profile.id" which provides community profiles on the websites of the cities of Glen Eira, Port Phillip and Stonnington)
- Australian Government *National Health Reform: Delivering a Better Deal for Patients* at <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/home> (accessed June 2011)
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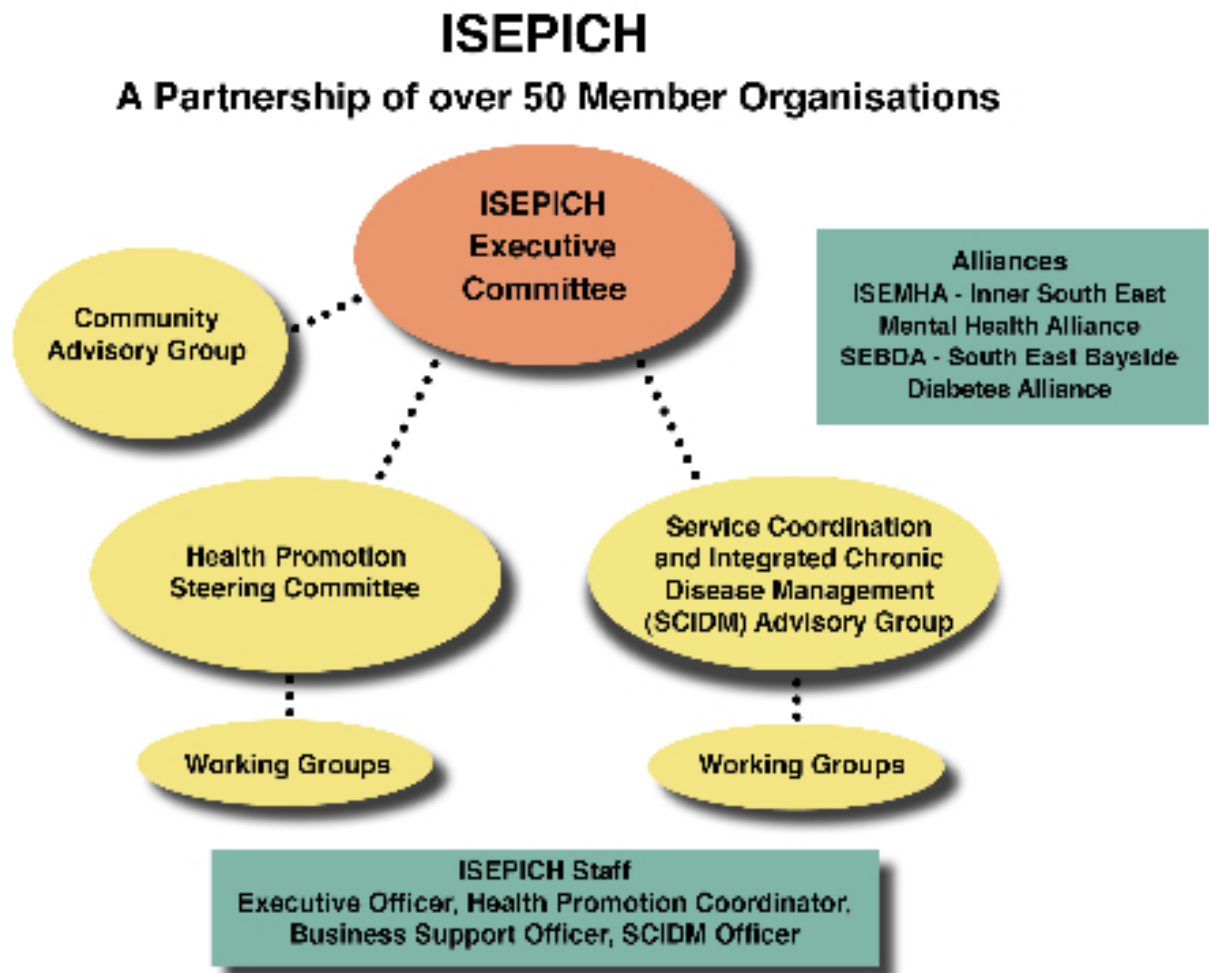
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# Appendix One: ISEPICH Organisational Structure



## Appendix 2: ISEPICH Member organisations

Inner South East Partnership in Community and Health (ISEPICH) Member Organisations - at June 2011	
Access Care Southern	Access Health Salvation Army
Arthritis Foundation of Victoria	Australian Multicultural Community Services Inc
Alfred Health, including Caulfield Hospital and Caulfield Community Health	Baker IDI Heart and Diabetes Institute
Bentleigh Bayside Community Health	Better Hearing Australia
Calvary Health Care, Bethlehem	Caulfield South Community House
Centre Against Sexual Assault	Christ Church Mission
City of Glen Eira	City of Port Phillip
City of Stonnington	Community Information Inc Glen Eira
Connections	Froniditha Care Inc
Gamblers Help Southern	Hanover Welfare Services
Inclusion Melbourne	HomeGround Services
Inner South Communication Service	Inner South Community Health Service
Jewish Care	John Macrae Centre, Uniting Church of Australia
Kosher Meals on Wheels Association	Marillac House
MECWA Community Care	Mental Illness Fellowship Victoria Ltd
MIND	MOIRA
Monash Division of General Practice	Napier Street Aged Care Services
New Hope Foundation	Polish Community Council
Port Melbourne Neighbourhood House	Port Phillip Community Group Ltd
Prahran Mission	Royal District Nursing Service – Caulfield
Russian Ethnic Representative Council of Victoria	Sacred Heart Mission
South Port Uniting Care	School Focused Youth Services (C/o Stonnington )
Southcity GP Services	South Port Day Links
St Kilda Uniting Care Drop In Centre	St Kilda Gatehouse
Salvation Army Bridge Program	Taskforce Community Agency Inc
Vision Australia	Wesley Do Care
Women's Health in the South East	

## Member Organisations



ISEPICH is governed by an Executive Committee drawn from member organisations and community members. For details see [http://www.portphilip.vic.gov.au/about\\_isepich.htm](http://www.portphilip.vic.gov.au/about_isepich.htm)

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