Municipal Public Health
and Wellbeing Plan 2017-2021

Our Health and Wellbeing *BACKGROUND REPORT*

A review of health and wellbeing related legislation, research and data to provide context to the planning process

Contents

1. WHY?

CONTEXTUALISING HEALTH AND WELLBEING PLANNING

Contents

About this section

Local government plays a key role in creating the environment for communities to prosper and enjoy improved health and wellbeing. As the level of government closest to the people, Council's have a unique role in improving and maintaining the health and wellbeing of its community. Achieving strategic alignment is critical to achieving health and wellbeing outcomes in local communities.

The following section explores Council's role in health and wellbeing, including a review of legislative and policy influences, an investigation of conceptual models of health and ultimately answering the question of why Council's plan for the health and wellbeing of their community.

1.1. LOCAL GOVERNMENT IN HEALTH AND WELLBEING

Local government in Victoria has had a long-standing association with public health. It began during the gold rushes of the 1850s, with the rapid increase in population and concerns about insanitary conditions. The focus was on preventing the spread of epidemic diseases, primarily through action on sanitation and housing standards. [1]

This continued into the 20th century, with public health practitioners focused on threats to health in the immediate environment by dealing with sewage, the provision of clean water, sale of adulterated foods, and housing conditions. [2]

There is still an important role for local government to play in controlling these threats; however the leading causes of ill health are no longer infectious diseases, but chronic diseases such as cardiovascular disease, cancer, mental disorders, chronic respiratory conditions, and injuries.

The approach to addressing these diseases has included and still remains a focus on prevention, utilising health promotion and behaviour change methods; however consideration must also be given to the environment in which we live and the role that it plays in supporting our health and wellbeing.

1.1.1. VICTORIAN PUBLIC HEALTH AND WELLBEING ACT 2008

While the majority of Victorians experience good health and wellbeing, this is not shared by all. Inequalities in health can lead to, or result from, inequalities in various other areas of life – housing, education, employment and transport accessibility among others.

The link between poor health and poverty is clear: those with the least resources suffer more from avoidable illness and reduced life expectancy, often across generations. These inequalities are particularly evident for Aboriginal Victorians.[3]

Such concerns informed the development of the Victorian Public Health and Wellbeing Act 2008; which has as its primary objective the achievement of the highest attainable standard of public health and wellbeing for Victoria.

This objective is to be achieved by:

- protecting public health;
- preventing disease, illness, injury, disability and premature death;
- promoting conditions in which people can be healthy; and
- reducing inequalities in the state of public health and wellbeing.

In achieving the objectives of the Act regard should be given to the guiding principles set out in S. 5–11 of the Act. These include:

- evidence-based decision making,
- collaboration,
- the precautionary principle, and
- primacy of prevention.

In particular, the principle of collaboration asserts that public health and wellbeing can be enhanced through collaboration between all levels of government and industry, business, communities and individuals.

The Act recognises the social model of health and the social gradient in its objectives. S.4(1) of the Act explicitly recognises that health is not merely the absence of disease or infirmity and that intervention is necessary to reduce inequities.

Section 4(1): The Parliament recognises that-

- the State has a significant role in promoting and protecting the public health and wellbeing of persons in Victoria;
- public health and wellbeing includes the absence of disease, illness, injury, disability or premature death and the collective state of public health and wellbeing; and
- public health interventions are one of the ways in which the public health and wellbeing can be improved and inequalities reduced.

One of the major requirements of the Act is the preparation, every four years, of a state public health and wellbeing plan. Victoria's first plan was released on 1 September 2011.

Specific features of the Act relevant to municipal public health and wellbeing planning are summarised in the following section.

Section 24 - Function of Councils

The Act strengthens the role of local government as a major partner in the effort to protect public health and prevent disease, illness, injury, disability or premature death. The Act clarifies the respective roles and responsibilities of local and state government regarding public health and wellbeing planning and the functions of councils.

The Act also recognises that local government is a major partner to the state government in the effort to protect public health and wellbeing in Victoria.

The function of a Council under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by—

(a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;
(b) initiating, supporting and managing public health planning processes at the local government level;
(c) developing and implementing public health policies and programs within the municipal district;
(d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected;
(e) facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community;
(f) co-ordinating and providing immunisation services to children living or being educated within the municipal district;
(g) ensuring that the municipal district is maintained in a clean and sanitary condition.

Section 26 - Municipal public health and wellbeing plans

The Act requires councils to prepare a MPHWP within 12 months of each general election of the council.

The Act makes explicit the matters a MPHWP needs to address, such as the evidence behind the plan, community consultation practices and to specify how the council will work in partnership with the department and other agencies.

A municipal public health and wellbeing plan must:

(a) include an examination of data about health status and health determinants in the municipal district;
(b) identify goals and strategies based on available evidence for creating a local community in which people can achieve maximum health and wellbeing;
(c) provide for the involvement of people in the local community in the development, implementation and evaluation of the public health and wellbeing plan;
(d) specify how the Council will work in partnership with the Department and other agencies undertaking public health initiatives, projects and programs to accomplish the goals and strategies identified in the public health and wellbeing plan;
(e) be consistent with—
  (i) the Council Plan prepared under section 125 of the Local Government Act 1989; and
  (ii) the municipal strategic statement prepared under section 12A of the Planning and Environment Act 1987.
(f) In preparing a municipal public health and wellbeing plan, a Council must have regard to the State Public Health and Wellbeing Plan

In addition, the Climate Change Act 2010 requires Councils to consider climate change when preparing a municipal public health and wellbeing plan (MPHWP).

1.1.2. STATUTORY PUBLIC HEALTH FUNCTIONS

Local Government plays an important role in controlling public health threats by enforcing up-to-date public health standards and through fulfilling its statutory obligations such as those contained in the Victorian Health, Food and Environment Protection Acts, associated regulations and standards. Some of the functions include:

- *Food safety;* The Food Act 1984 requires Council to register and inspect food premises annually, investigate complaints relating to food safety and monitor the safety of food sold within.
- *Immunisation;* The Public Health and Wellbeing Act 2008 requires Council to co-ordinate and provide immunisation services to children living or educated within the municipality.
- *Tobacco control;* The Tobacco Act 1987 requires Council to enforce tobacco related laws regarding sale of cigarettes to minors, tobacco displays, advertising, and smoke free areas.
- *Control of infectious disease;* The Public Health and Wellbeing Act 2008 requires Council to register and inspect all: hairdressers, beauty therapists, tattooists, colonic irrigation, businesses performing body piercing and public swimming and spa pools.
- *Prescribed accommodation;* The Public Health and Wellbeing Act 2008 requires Council to register and inspect all accommodation premises where six or more residents are living.
- *Public health nuisances;* The Public Health and Wellbeing Act 2008 requires Council to investigate all complaints that are liable to impact upon the health of the community i.e. safe asbestos removal, sewage, odour and residential noise.
- *Public health emergencies;* The Emergency Management Act 1986 requires Council to respond to public health emergencies and assist community recovery and to develop and implement a Pandemic Flu Plan and a Heatwave Plan.

1.1.3. LOCAL HEALTH AND WELLBEING

While the statutory role in public health functions of local government is clear, the role of local government in community health and wellbeing is ever-expanding with changes in funding, service models and other factors heightening the need for local government action.

The importance of local government in leading local policies and developing programs and infrastructure that can influence the health of local community members is not only recognised in Victorian legislation and government policy, but also globally.[4]

Since 1997 the World Health Organization has championed the Healthy Cities movement. More recently, the successes of the EPODE program in Europe among others, reinforce the contribution that local government leadership, underpinned by strong community engagement and partnerships, can make to health improvement. In England, the Government is returning responsibility for health to local government based in part on their population focus, closeness to their communities and ability to influence social determinants of health.

Councils have been historically at the forefront of addressing social determinants of health through their roles in sanitation, public utilities and transport infrastructure. Over time, councils have taken on additional social and public health initiatives aimed at improving the overall health of their community e.g. health promotion programs, child and maternal health services, and aged care.

It can be argued that councils are at the centre of addressing the social determinants of health of their residents. Local governments are intimately involved in addressing many, if not all, social determinants of health, directly or indirectly. Successful local public health strategies lead to prevention and reduction of disease and disability, and to the creation of communities and environments in which people can lead productive and rewarding lives through focusing on improving the health of populations through personal, social and environmental change rather than individual treatment.

The role of local government is wide and varied, however the ultimate goal of improved health outcomes remains.

Health Outcomes; "A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status." (WHO Health Promotion Glossary).

1.2. UNDERSTANDING HEALTH

1.2.1. SOCIAL DETERMINANTS OF HEALTH

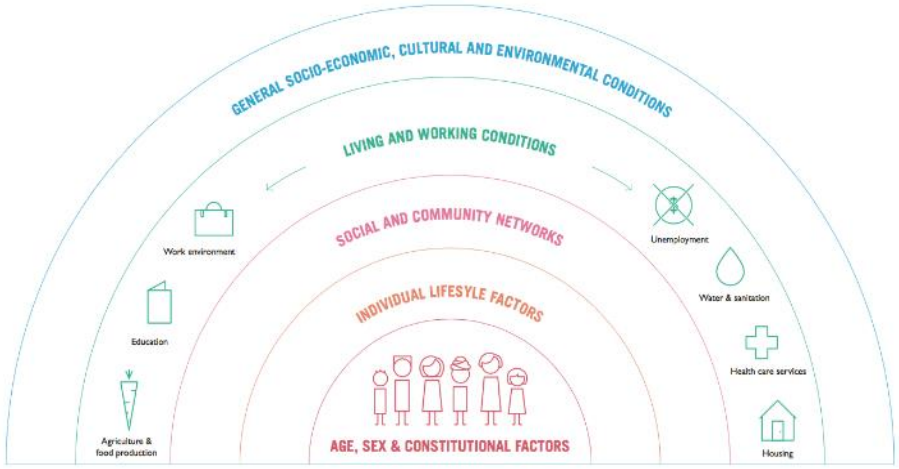
Differences in health outcomes between social groups are often defined according to socioeconomic status, or socioeconomic position, which is a composite measure of educational attainment, living conditions, income and occupational characteristics as well as the level of prestige, power, control or social standing associated with these. A graded relationship between social position and health exists, where health outcomes progressively improve with increasing social position, and is known as the social gradient in health[5].

However, differences in health outcomes are also influenced by a number of other factors, including race/ethnicity, disability, aboriginality, and characteristics of the area and neighbourhood in which people live (including rurality and access to key services).

Collectively, natural biological variation (sex, age and genetic make-up, for example) and the conditions in which people are born, grow, live, work, play and age are known as the social determinants of health.[6]

The famous Dahlgren and Whitehead[7] social model of health depicts the main determinants of health, thought of as a series of layers.

Figure 2: Social Model of Health



Individuals are at the centre with a set of fixed genes. Surrounding them are influences on health that can be modified:

1. The first layer is personal behaviour and ways of living that can promote or damage health. Individuals are affected by friendship patterns and the norms of their community.
2. The next layer is social and community influences, which provide mutual support for members of the community in unfavourable conditions. But they can also provide no support or have a negative effect.
3. The third layer includes the material and social conditions in which people live and work, determined by various sectors such as housing, education, health care, agriculture and so on.
4. And finally, overall there is the major structural environment including socioeconomic, cultural and environmental conditions.

1.2.2. OTTAWA CHARTER FOR HEALTH PROMOTION

The foundation document for Health Promotion, the World Health Organisation's Ottawa Charter asserts that there are fundamental prerequisites needed for health including;

- Peace,
- Shelter,
- Education,
- Food,
- Income,
- A stable eco-system,
- Sustainable resources, and
- Social justice and equity.

Though many of these are grounded in fundamental human rights and the Social Determinants of Health, it is crucial to recognise that without addressing these elements, work that is undertaken will have little sustained impact.

The action areas for health promotion identified in the charter are:

1. Building healthy public policy
2. Creating supportive environments
3. Strengthening community action
4. Developing personal skills

5. Re-orienting health care services toward prevention of illness and promotion of health
6. Moving into the future

The basic strategies for health promotion were prioritized as:

- Advocate: Health is a resource for social and developmental means, thus the dimensions that affect these factors must be changed to encourage health.
- Enable: Health equity must be reached where individuals must become empowered to control the determinants that affect their health, such that they are able to reach the highest attainable quality of life.
- Mediate: Health promotion cannot be achieved by the health sector alone; rather its success will depend on the collaboration of all sectors of government as well as independent organizations.

Figure 3: Ottawa Charter for Health Promotion

1.2.3. ENVIRONMENTS FOR HEALTH

The Environments for Health framework focuses on the determinants of health that lie within the **built, social, economic and natural environments**.

- The **Built environment**: encompasses access to housing, shops, playgrounds, sports facilities, roads, footpaths, community facilities and transport infrastructure.
- The **Social environment**: takes into account our connection to the community, education choices/pathways, sense of belonging and acceptance, community support services, feelings of safety, access to arts and cultural programs, quality of relationships, recreation and leisure choices.
- The **Economic environment**: includes secure employment, socio-economic status, income levels and ability to afford necessities like food and shelter.
- The **Natural environment**: includes access to open spaces including parks, reserves, bushland, gardens and creeks, clean air and water.

Local government has direct influence over some of the most powerful influences on health and wellbeing known, such as employment, social support, land-use planning, transport and access to cultural activities, so is ideally placed to have a profound impact on the quality of life of its citizens.

1.2.4. HEALTH EQUITY, SOCIAL JUSTICE AND HUMAN RIGHTS

The Victorian Charter of Human Rights recognises freedom, respect, equality and dignity. It obliges Local Governments to act consistently with these values.

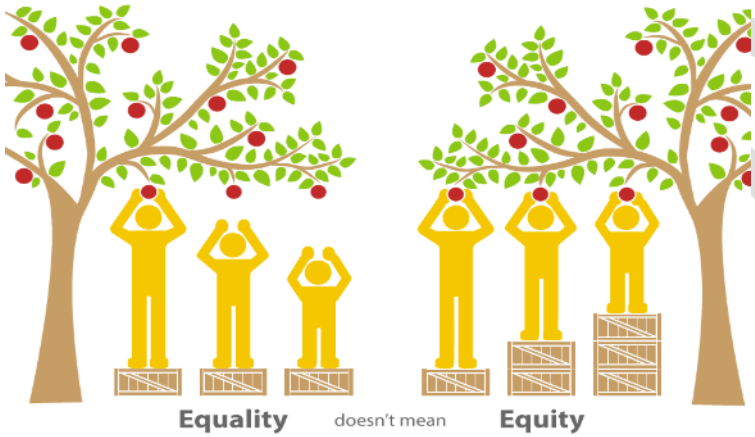
Equity is a concept based on the human-rights principles of social justice and fairness. It is an approach that addresses the unfair and avoidable differences among social groups with an aim of achieving more equal outcomes.[8]

Health equity refers to the absence of systematic or avoidable disparities in health between groups of people, whether these groups are defined socially, economically, geographically or demographically[9].

'Equity' is sometimes used interchangeably with the related term 'equality', although the two are not the same thing.

Equality is considered to exist when all individuals and groups of people are given equal treatment, regardless of need or outcome, whereas an equitable approach focuses on more equal outcomes, recognising that disadvantaged groups may need more support or resources in order to achieve the same health outcomes as more advantaged groups[10].

Figure 4: A visual depiction of the difference between equality and equity[11]



1.2.5. PREVENTION AND EARLY INTERVENTION ACROSS THE LIFECOURSE[12]

Prevention and early intervention helps to address and overcome a range of problems in development, health, learning, behaviour and wellbeing. As such, both have a capacity to reduce the factors that can have negative short- and long-term impacts.

Better outcomes are achieved when issues are identified and treated early and comprehensively.

It is now well established that preventive and supportive action taken early at each stage and transition point in the life course can provide multiple benefits.

Rather than a static view of health and disease, the life course approach recognises that both biological and social risks accumulate and interact over the life cycle.

Individual behaviours, the various environments in which people live and work, and the opportunities available throughout life, have cumulative impacts on health and wellbeing.

At each life stage there are critical periods of susceptibility and vulnerability, as well as opportunities to build resilience and capabilities. For example, investing in the early years establishes good health and resilience that will have benefits throughout life.

The life course perspective is also valuable in understanding the factors that best ensure good health into older age and provide vital input into understand best practice prevention and early intervention strategies.

1.3. LEGISLATIVE AND POLICY CONTEXT

In recognising the determinants of health are vast and incorporate a wide collection of sectors, the following section has been limited in its scope to:

- provide an overview of the many legislative requirements of local government;
- explore recent reform activity that impacts on our community's health and wellbeing;
- identify the specific health policy and strategy of the Australian and Victorian governments; and
- local policy positions

Recognition must be made of the many sectors and guiding principles not explored in this section such as the Victorian Government's Youth Policy, the National Quality Framework for Education and Care Services or Creative State: Victoria's first creative industries strategy.

The impact that they have on promoting good health and wellbeing across our community must not go unnoticed and will be considered in the broader context when defining actions and outcomes of the next Municipal Public Health and Wellbeing Plan.

1.3.1. FEDERAL

1.3.1.1. LEGISLATION

Federal Disability Discrimination Act 1992

The Federal Disability Discrimination Act (DDA) 1992 provides protection for everyone in Australia against discrimination based on disability.

Disability discrimination happens when people with disabilities are treated less fairly than people without disabilities. Disability discrimination also occurs when people are treated less fairly because they are relatives, friends, carers, co-workers or associates of a person with disability.

The DDA makes it against the law to discriminate against someone if they have disabilities in the following areas of life:

- Employment e.g. when trying to get a job, equal pay or promotion.
- Education e.g. when enrolling in a school, TAFE, university etc.
- Access to premises used by the public e.g. using libraries, places of worship, government offices, hospitals, restaurants, shops
- Provision of goods, services and facilities e.g. when a person wants goods or services from shops, pubs and places of entertainment, cafes, video shops, banks, lawyers, government departments, doctors, hospitals etc.
- Accommodation e.g. when renting or trying to rent a room in a boarding house, a flat, unit or house.
- Buying land e.g. buying a house, a place for a group of people, or drop-in centre.
- Activities of clubs and associations e.g. wanting to enter or join a registered club, (such as a sports club, RSL or fitness centre)
- Sport e.g. when wanting to play, or playing a sport.
- Administration of Commonwealth Government laws and programs e.g. when seeking information on government entitlements, trying to access government programs, wanting to use voting facilities.

1.3.1.2. REFORM

National Health Reform Agreement

Council of Australian Government (COAG) agreed, out-of-session in August 2011, to the National Health Reform Agreement, designed to deliver major reforms to the organisation, funding and delivery of health and aged care.

The Agreement sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.

The reforms are designed to achieve better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for our health system into the future through increased Commonwealth funding.

These arrangements aim to deliver a nationally unified and locally controlled health system through:

- Introducing a number of financial arrangements for the Commonwealth and states and territories in partnership
- Confirming state and territories' lead role in public health and as system managers for public hospital services
- Improving patient access to services and public hospital efficiency through the use of activity based funding (ABF) based on a national efficient price
- Ensuring the sustainability of funding for public hospitals by the Commonwealth and improving the transparency of public hospital funding through a National Health Funding Pool
- Improving local accountability and responsiveness to the needs of communities through the establishment of local hospital networks (LHNs) and Medicare locals
- New national performance standards and better outcomes for hospital patients.

This Agreement affirms that the following implementation principles should underpin National Health Reform:

- governments agree that an effective health system that meets the health needs of the community requires coordination between hospital, GP and primary health care and aged care to minimise service duplication and fragmentation;
- Australians should be able to access transparent and nationally comparable performance data and information on hospitals, GPs and primary health care, aged care services and other health services;
- governments should continue to support diversity and innovation in the health system as a crucial mechanism to achieve better outcomes;
- all Australians should have equitable access to high quality health care, including those living in regional and remote areas; and
- governments agree that Australia's health system should promote social inclusion and reduce disadvantage, especially for Indigenous Australians.

Health 2040: A discussion paper on the future

Our health system performs very well overall. Nationally, Australia has one of the highest life expectancies of any country in the world and our survival rates for cancer and cardiovascular disease are among the best in the world.

The health system is always evolving to meet changing needs; however, the changes of yesterday do not meet the demands of tomorrow. While much has been achieved over the past 10 to 20 years, change must happen to meet the challenges we now face including:

- an ageing population, together with new discoveries, new technology and new treatments which are creating growing demand
- lifestyle choices and behaviours that are contributing to higher levels of chronic disease
- disparities and inequalities in health outcomes for population groups
- people's changing needs and expectations
- unprecedented financial constraints that are unlikely to diminish.

In this discussion paper, the Victorian Government have selected six broad themes as starting points for further exploration of healthcare reform direction. At the heart of these themes is the idea that the healthcare system should be designed from the perspective of the people who use the system.

The six themes are:

1. A person-centred view of healthcare
2. Preventing and treating chronic disease
3. Improving people's health outcomes and experience
4. Improving the way the system works together
5. Better health for people in rural and regional areas
6. Valuing and supporting our workforce

Aged Care Reform[13]

Our aged care system is currently arguably world class[14]. However, people are living longer thanks to better health and better health care.

Moving towards consumer-directed care is a big part of the changes being made to the aged care system, with the aim that people will have greater choice, and care will be based on needs.

The traditional image of aged care is often associated with residential aged care, but most people want to stay independent, remain in their home and connected to family and community for much longer.

Aged care reforms are being progressively implemented in three phases over 10 years:

2012-13 and 2013-14

- new Home Care Packages and supplements introduced in home care and residential care
- My Aged Care including a national contact centre began operations
- the Australian Aged Care Quality Agency was established
- the Aged Care Pricing Commission was launched.

2014-15 and 2015-16

- implementing the national voluntary quality indicators for aged care
- introducing a national fee framework for the Commonwealth Home Support Programme.

2016-17 to 2021-22

While not yet fully developed, the Australian Government has noted that changes to be implemented in this phase will be developed in consultation with the aged care sector. This includes the development of a single quality framework that will increase the focus on quality outcomes for consumers.

By 2022, the vision is that Australia's aged care system will:

- be sustainable and affordable, long into the future
- offer greater choice and flexibility for consumers
- support people to stay at home, and part of their communities, for as long as possible

The Aged Care Legislated Review

As part of the changes to aged care announced in 2012, a comprehensive five year review was included in the Aged Care (Living Longer Living Better) Act 2013. When complete, the Aged Care Legislated Review (the Review) will look at the impact of the changes to date and where the system should be directed into the future.

My Aged Care

My Aged Care is a centralised service providing information and services to older people, their families and carers via a website and phone service.

It was introduced in July 2013 to simplify and streamline the process of accessing aged care for consumers, providing a single entry point.

In July 2015, My Aged Care commenced centralised client records, nationally consistent eligibility screening and assessment, and electronic referrals to assessors and service providers.

Commonwealth Home Support Programme

Of particular note in this reform are the changes in brings to the home care packages and the establishment of the Commonwealth Home Support Programme (CHSP) whereby all the current Home and Community Care (HACC) services provided by councils in Victoria will transition to the new CHSP model.

The CHSP is one consolidated programme providing entry-level home support for older people who need assistance to keep living independently.

To be eligible individuals must be:

- 65 years or older,
- 50 years or older and identify as an Aboriginal and/or Torres Strait Islander person,
- 50 years or older and on a low income, homeless or at risk of homelessness.

Those under the age of 65 years of age will shift to the NDIS service system (which is explained in further detail in the following section). Currently, 31% of CoPP HACC clients are under 65 years, and a proportion of these clients may not be eligible for NDIS which would leave them with potentially no funding stream.

Home Care Packages

The Home Care Packages Programme replaced the Community Aged Care Package Programme and provides higher-level support to assist people to remain in their own homes.

This allows consumers to decide what types of care and services they access, and how and by whom they are delivered. The reforms also expanded the number of Home Care Packages available.

National Disability Insurance Scheme[15]

The NDIS is a national program that will provide a new way of delivering services and support for people with permanent and significant disability in Australia.

Similar to the Aged Care and Mental Health Sector Reforms, with the NDIS people with disability can choose supports and services to meet their individual needs, rather than have to fit into a one-size-fits-all system.

It is proposed that the NDIS provides people with disability, their families and carers, with:

- More choice around the supports received.
- Increased control and flexibility around how and when those supports are provided.
- A lifetime approach to the delivery of disability support services, and a support plan that changes to reflect changes in personal circumstances over time.
- Greater opportunity for early intervention (support provided before the point of crisis, to reduce the impact of disability).

The scheme is available to Victorians who:

- are aged less than 65 when they first access the scheme
- have a permanent disability that significantly affects their ability to take part in everyday activities

The NDIS will be rolled out progressively in Victoria over a three-year period from 1 July 2016.

To support the transition to the NDIS, the Victorian Government will provide $10 million to support Victorians with disabilities, their families, service providers and staff. By 2019, Victoria will be investing $2.5 billion per year into the NDIS scheme.

By July 2019, it is estimated that 105,000 Victorians will have transitioned to the scheme. This includes 76,000 clients from the existing Victorian specialist disability and mainstream systems. With time, these systems will be replaced by the NDIS.

The staged roll out of the NDIS in Victoria is based on a range of factors including:

- The number and needs of adults and children with disabilities (existing Victorian disability clients) living in the area,
- The time to get the right support and services in place; and,
- National and local experience to date with NDIS trials.

The NDIS will become available in the Bayside Peninsula area (including Port Phillip) from 1 April 2018.

This means that all the current HACC services provided by councils in Victoria for those under the age of 65 years of age will shift to the NDIS service system. In Port Phillip it may also mean that the Fog Theatre's and JCAAA's funding sources will shift to the NDIS system.

The implementation of these reforms will significantly impact the way disability services are managed and delivered.

Some of the expected outcomes include;

- Increased participation in community life
- Increased employment and training opportunities
- Increased access to mainstream services
- Increased social and economic participation

Mental Health Sector Reform

In November 2015, the Turnbull Government released its response to the National Mental Health Commission's Review of Mental Health Programmes and Services -Contributing Lives, Thriving Communities

Similar to the Aged Care Reforms and National Disability Insurance Scheme, the response sets out a reform package that aims to put the individual needs of patients at the centre of the mental health system.

The reforms will be rolled out over a three year period between 2016 and 2019 and delivered within the existing funding envelope.

The reforms focus on a number of actions:

- Contestable mental health services will be commissioned, not delivered, through the recently established Primary Health Networks (PHNs);
- Stepped care model where individuals will receive varying levels of primary care treatment and support depending on their level of need as determined by a health professional;
- Coordinated packages of care will be created for people with severe and complex needs and flexible support for mild and moderate needs;
- A new Digital Mental Health Gateway will optimise the use of digital mental health services;
- A new approach to suicide prevention, co-ordinated by PHNs;
- An additional $85 million over three years to provide greater access to mental health services for Indigenous Australians;
- A new single school-based initiative covering early childhood through the end of secondary school will be rolled out from July 1 2016.

1.3.2. STATE

1.3.2.1. LEGISLATION

Local Government Act 1989

The principal legislation in Victoria governing the establishment and operation of councils is the Local Government Act 1989. This defines the purposes and functions of local government as well as providing the legal framework for establishing and administering Councils.

Within the Act, it is stated that *'it is the role of the Council to provide governance and leadership for the local community through advocacy, decision making and action.'*

While recognising that the Local Government Act in its entirety has broad intersections with health and wellbeing, the following section excerpts taken from the Act highlight the key components of the Local Government Act that pertain to Health and Wellbeing.

Section 3C. Objectives of a council

(1) The primary objective of a council is to endeavour to achieve the best outcomes for the local community having regard to the long term and cumulative effects of decisions.

(2) In seeking to achieve its primary objective, a council must have regard to the following facilitating objectives—

(a) to promote the social, economic and environmental viability and sustainability of the municipal district;

(c) to improve the overall quality of life of people in the local community;

(e) to ensure that services and facilities provided by the Council are accessible and equitable;

Section 3D. What is the role of a Council?

(2) The role of a Council includes—

(a) acting as a representative government by taking into account the diverse needs of the local community in decision making;

(b) providing leadership by establishing strategic objectives and monitoring their achievement;

(d) advocating the interests of the local community to other communities and governments;

(e) acting as a responsible partner in government by taking into account the needs of other communities;

(f) fostering community cohesion and encouraging active participation in civic life.

Section 3E. What are the functions of a council?

(1)The functions of a council include—

(a) advocating and promoting proposals which are in the best interests of the local community;

(b) planning for and providing services and facilities for the local community;

(c) providing and maintaining community infrastructure in the municipal district;

(d) undertaking strategic and land use planning for the municipal district;

(f) making and enforcing local laws;

Local Government Act Review

The Victorian Government is conducting the first comprehensive review of the Local Government Act 1989 in a quarter of a century.

The Victorian Government has noted *'the review will be far-reaching and comprehensive, examining issues from the role and functions of councillors and CEOs, to donation regulation and how complaints should be handled.'*

This review responds to calls from the local government sector for legislative reform after over 90 amending acts have resulted in hundreds of individual amendments to the Act in the past 25 years.

Outcomes of the review are still in development but a Directions Paper released in June 2016 indicates the following key areas of reform being proposed:

- A stronger role for mayors to lead councils
  - Mayors will have two-year terms and greater authority to lead council in making important decisions.

- Greater consistency in council structures (wards) to make elections fairer
  - Councillor numbers for each council will be determined by a formula.
  - Councillors will be elected on an unsubdivided basis (this means the entire local council area is considered one electorate) or through uniform multi-member wards.
- Simpler electoral rolls and voting rules
  - Voting rules will be aligned with state elections, for example, partial preferential voting in multi-member wards or unsubdivided municipalities.
  - A consistent voting method (attendance, postal or on-line) will apply for all council elections.
- Community engagement
  - Community engagement will become a core principle of the Act and a core councillor role.
  - The four-year council plan will be the principal policy document and will require deep engagement with local communities before adoption.
  - Mayors will lead development of the plan and be required to report back annually to the community on its progress.
- Accountable and high performing councils
  - The Minister for Local Government will have the power to suspend individual councillors who are contributing to, or causing, serious governance failures at a council.
  - All councils will have a public CEO remuneration policy and an independent advisory mechanism to guide recruitment, contractual arrangements and performance monitoring of CEOs.
  - All councils will have a formal customer complaints policy that includes an avenue for independent review of operational decisions.
- More autonomy for councils to cut unnecessary red tape
  - Removal of prescriptive council decision-making rules and replacing with high level principles requiring transparency and accountability.
  - Councils will have more financial autonomy provided they meet the principles of sound financial management.
- A consistent, modern rating system
  - Councils will be required to calculate rates using a single land-valuation method, modernise the process for rate exemptions and increase transparency in the levying of differential rates.

Victorian Climate Change Act 2010

Climate change will alter global and local climates. In Victoria, this means warmer average temperatures, more frequent and severe heatwaves, more very high fire danger days, reduced average and more variable rainfall, increased incidence and extent of drought, reduced snow cover, and sea level rise.

The Climate Change Act 2010 (the Act) recognises that Victoria's climate is changing and s. 14 of the Act introduces a duty that requires a number of key government decision-makers to take climate change into account when making specified decisions.

Local government is identified as one of the decision makers that must consider climate change when preparing a municipal public health and wellbeing plan (MPHWP).

The duty to have regard to climate change requires consideration of:

- biophysical impacts
- long- and short-term economic, environmental, health and other social impacts
- beneficial and detrimental impacts
- direct and indirect impacts
- cumulative impacts.

In relation to the decision or actions taken, the Act also requires consideration of:

- short- and long-term greenhouse gas emissions
- direct and indirect greenhouse gas emissions
- increases and decreases in greenhouse gas emissions
- cumulative impacts of greenhouse gas emissions.

Victorian Charter of Human Rights and Responsibilities Act 2006

The Charter of Human Rights and Responsibilities Act 2006 (the Charter) is a Victorian law that sets out the basic rights, freedoms and responsibilities of all people in Victoria.

The Charter requires the Victorian Government, public servants, local councils, Victoria Police and other public authorities to act compatibly with human rights, and to consider human rights when developing policies, making laws, delivering services and making decisions. So no matter which state or local government agency the community is dealing with, the same human rights apply.

The Victorian Charter of Human Rights and Responsibilities contains twenty basic rights that promote and protect the values of freedom, respect, equality and dignity. The Victorian Government, local councils and other public authorities must not knowingly be in breach of these rights, and must always consider them when they create laws, develop policies and deliver their services.

The twenty rights are:

1. Your right to recognition and equality before the law
2. Your right to life
3. Your right to protection from torture and cruel, inhuman or degrading treatment
4. Your right to freedom from forced work
5. Your right to freedom of movement
6. Your right to privacy and reputation
7. Your right to freedom of thought, conscience, religion and belief
8. Your right to freedom of expression
9. Your right to peaceful assembly and freedom of association
10. Your right to protection of families and children
11. Your right to taking part in public life
12. Cultural rights
13. Property rights
14. Your right to liberty and security of person
15. Your right to humane treatment when deprived of liberty
16. Rights of children in the criminal process
17. Your right to a fair hearing
18. Rights in criminal proceedings
19. Right not to be tried or punished more than once
20. Retrospective criminal laws

The Charter was reviewed in 2015 and subsequently in July 2016, the government released their response to the review. The government supported 45 of the 52 recommendations to strengthen human rights culture in Victoria and make the Charter more effective, accessible and practical. To date, no changes to the Act itself have been enacted.

Child Wellbeing and Safety Amendment (Child Safety Standards (CSS)) Act 2015

An amendment to the Child Wellbeing and Safety Act 2005 has recently been introduced to provide for the Minister to make standards in relation to child safety with which certain entities must comply.

The standards being introduced are known as the Child Safe Standards which are compulsory minimum standards that will apply to organisations that provide services for children to help protect children from all forms of abuse. The child safe standards form part of the Victorian Government's response to the Betrayal of Trust Inquiry.

The child safe standards became applicable to organisations that provide services for children that are government funded and/or regulated from 1 January 2016 – this includes local councils.

The child safe standards are as follows:

- Standard 1: Strategies to embed an organisational culture of child safety, including through effective leadership arrangements
- Standard 2: A child safe policy or statement of commitment to child safety
- Standard 3: A code of conduct that establishes clear expectations for appropriate behaviour with children
- Standard 4: Screening, supervision, training and other human resources practices that reduce the risk of child abuse by new and existing personnel
- Standard 5: Processes for responding to and reporting suspected child abuse
- Standard 6: Strategies to identify and reduce or remove risks of child abuse
- Standard 7: Strategies to promote the participation and empowerment of children.

The City of Port Phillip Council (CoPP) is required to comply with the new Victorian Government's compulsory Child Safe Standards (CSS) with an organisation- wide Child Safe Policy that addresses the two new areas of legislation that underpin the Child Safe Standards, 'Failure to disclose' and 'Failure to protect'.

Penalties apply for 'Failure to Disclose' and 'Failure to Protect'. Failure to disclose applies to all adults aware of any type of abuse against children and young people and 'Failure to Protect' applies to organisations providing services for children and young people. Examples of abuse include child sexual abuse; grooming; physical abuse and neglect, mental and emotional abuse.

CoPP does have some existing policies and procedures in place to ensure children are safe with a particular focus on services that have high contact with children such as Early Childhood Education and Care Services, Maternal and Child Health service and Adventure Playgrounds. This provides assurance for regulated programs, whilst the CSS are in development. Working through the CSS will further strengthen these policies and procedures as well as identify any gaps that need addressing to further ensure the safety and wellbeing of children and young people.

Other statutory responsibilities

In addition to the Public Health and Wellbeing Act, many other Acts play an equally important and complementary role in protecting and promoting health and wellbeing and preventing injury across a variety of settings.

Successful prevention efforts require a whole-of-government approach. Victoria's 79 councils are an integral part of Victoria's regulatory system administering 29 Victorian Acts and many local laws.[16]

Other recent Victorian legalisation that has shaped public health and wellbeing includes the Improving Cancer Outcomes Act 2014 and amendments to the Tobacco Act 1987.

Amendments to the Tobacco Act have banned smoking in cars carrying children (2010), prohibited the display of tobacco products at retail point of sale (2011) and introduced outdoor smoking bans on patrolled beaches (2013) and around children's recreational areas such as playgrounds and sporting venues (2014). Further amendments prohibit smoking at entrances to schools, childcare centres, public hospitals and community health centres, and some Victorian Government buildings (2015).

Public health related legislation is also designed to protect the population from hazards to health, which include injuries and accidents, to control well-known risks to health such as food safety and to authorise or mandate specific population-wide interventions such as immunisation.

Legislation designed specifically to prevent injury includes road safety and workplace safety laws, consumer protection laws, laws governing the use and transport of dangerous goods in industry and various laws designed to ensure the safety of essential community infrastructure. They include the Radiation Act 2005, the Safe Drinking Water Act 2003 and the Drugs Poisons and Controlled Substances Act 1981.

The Food Act 1984 provides the regulatory framework for the food industry to ensure that food sold in Victoria is safe, suitable and correctly labelled. National food standards, which are embodied in the Food Standards Code, form part of the Food Act.

Other legislation imposes controls to prevent, or minimise, air, water, soil and noise pollution and plays an important role in protecting human health and ecosystems. This legislation includes the Environment Protection Act 1970 and the Planning and Environment Act 1987, which provides the state's framework for residential and industrial development.

The Transport Integration Act 2010 includes objectives to support social and economic inclusion through promoting forms of transport with greatest benefit for health and wellbeing.

The Sport and Recreation Act 1972 (amended in 2008) aims to promote the fitness and general health of the people of Victoria through encouraging active participation, encouraging higher standards of safety, improving the facilities available to the people of Victoria for leisure-time pursuits, and encouraging and assisting with the provision of additional opportunities for recreation.

Other laws are also of relevance to public health wellbeing such as laws governing the protection and care of children, carer recognition, liquor regulation, family violence and community safety.

The breadth and scope of the many statutory responsibilities noted above highlight the importance of an enterprise-wide approach whereby different departments in Council work towards fulfilling the objectives of these acts in a coordinated and complimentary way.

1.3.2.2. REFORM

AOD Sector Reform

The changes to the alcohol and drug treatment system will attempt to address some of the problems highlighted in a number of reviews, including a report in March 2011 by the Victorian Auditor General's Office which found that the current system is difficult for new clients to access and confusing for existing clients to navigate.

Clients have also reported that the current system doesn't take the needs of their whole family into account, particularly children, nor does it provide pathways for clients and their families to gain access to other available services and supports.

The Victorian Government has decided to address these concerns in order to work towards a more inclusive and integrated treatment system for everyone through as documented in new directions for alcohol and drug treatment services: A framework for reform.

Some of the key features of the new system include:

- A central intake service to make it easier for people to access the support they need. This is a telephone based service to help people work out what type of treatment they might need and what the next step will be.
- Intake and assessment units in each local catchment which are an important way for clients to access local services that meet their needs. These intake and assessment points are to work with the client to develop a care plan for their whole treatment journey.
- There is a change in who provides alcohol and drug treatment in some locations.
- Many of the existing treatment types have been reduced into six different streams:

1. Intake and Assessment
2. Counselling
3. Care and Recovery
4. Withdrawal
5. Residential Rehabilitation
6. Pharmacotherapy

As a result of this reform, there have been changes in the South East Metro region for services who provide alcohol and drug treatment. For example, changes included some services merging within the region.

Bayside Alcohol and Other Drug Services is the now central service for Port Phillip, Stonnington, Glen Eira, Kingston and Bayside. This service is operated by Inner South Community Health Service.

This centralised intake system aims to assist professionals to locate and refer clients to the most appropriate service to meet their needs with one phone call. The new system aims to make it easier for people to access the support they need by ensuring that clients understand the full range of options along with service availability without having to gather the information from each individual service.

The new system also involves support services for family and significant others affected by alcohol and drug use. It is acknowledged that engaging families and other important people in treatment delivers more positive and sustainable outcomes[17]

Royal Commission into Family Violence[18]

The Royal Commission in to Family Violence presented its final report to Parliament in March 2016.

Two hundred and twenty-seven recommendations were handed down and embraced by the State Government with a commitment to deliver upon each recommendation.

The recommendations span across all community sectors (judicial, health, community, government and education), and influence all age groups from early childhood through to the elderly.

There is a strong emphasis on increasing community awareness of family violence as well as increasing access to services (especially counselling and crisis accommodation) and building the capacity of services to respond to family violence.

Changes to legislation and information sharing policies have also been recommended in order to improve service responses by creating more efficient information sharing systems across different sectors.

There are several recommendations that directly impact on Council's core business. These include:

Recommendation	Impact on Council
94: The Victorian Government amend sec 26 of the *Public Health and Wellbeing Act 2008 (Vic)* which requires that Councils prepare a Municipal Public Health and Wellbeing plan to require councils to report on the measures the council proposes to take to reduce family violence and respond to the needs of victims. Alternatively the Victorian Government could amend section 125 of the *Local Government Act 1989 (Vic)* which requires each council to prepare a council plan to require councils to include these measures in their council plan (rather than their health and wellbeing plans) within 12 months	Whole of Council legislated accountability to respond to family violence via key strategic plans
5: The Victorian Government amend the *Family Violence Protection Act 2008* (Vic) to create a specific family violence information – sharing regime (within 12 months) 9: The Victorian Government examine options for the development of a single case- management data system to enable relevant agencies to view and share risk information in real time (within 12 months)	Council's key front line services such as Maternal and Child Health, Child, Youth and Family and Aged Services will be required to comply with legislated information sharing protocols
202: With the advice of the Family Violence Agency, the Victorian Secretaires Board Family Violence Sub- Committee consider how to ensure that local council performance measures are used to encourage local council activities designed to prevent family violence and to assess the outcome of any services they provide to victims and perpetrators of family violence (by 1 July 2018)	Increased accountability for local government to report on performance outcomes that relate to preventing and responding to family violence

Other recommendations that impact on Council business relate to workplace policies and entitlements around family violence leave and access to information on support services, capacity building of aged care services, faith communities and the disability sector.

Roadmap for Reform: Strong Families, Safe Children[19]

The Victorian Government is committed to reform that protects families and sets a child up for life, leaving them more likely to be healthy, to form positive relationships, to learn and grow, and to get a job.

The Roadmap for Reform: Strong Families, Safe Children aims to create services that are co-ordinated and work together to meet the needs of vulnerable families and children, forming an important step in the government's response to the Royal Commission into Family Violence.

The Roadmap takes an all-of government response and includes a number of short, medium and long-term initiatives. They will be developed collaboratively across government to ensure alignment with other major reform programs, in particular the Government's response to the Royal Commission into Family Violence and will focus on:

- strengthening communities to better prevent neglect and abuse
- delivering early support to children and families at risk
- keeping more families together through crisis
- securing a better future for children who cannot live at home.

Key features include:

- A greater focus on prevention and earlier intervention
- More visible and non-stigmatising entry points to services, making it easier for people to help themselves
- Pro-actively connecting people at risk to support through existing services (such as early childhood services, schools, general practitioners, financial counselling and community health services) and informal networks (such as a trusted community member).

While the end product of these reforms and its effect on council business is yet to be made clear, the Victorian Government have noted that they will continue to listen and test ideas with young people, families and survivors of violence and work closely with experts, practitioners and the many community leaders and organisations committed to delivering the recommendations of the Royal Commission into Family Violence and advancing the Roadmap for Reform.

1.3.2.3. POLICY/STRATEGY

Victorian Public Health and Wellbeing Plan 2015-19

The Public Health and Wellbeing Act 2008 requires the preparation of a State public health and wellbeing plan every four years.

The vision of the Victorian Public Health and Wellbeing Plan (the Plan) is: *for a Victoria free of the avoidable burden of disease and injury so that all Victorians can enjoy the highest attainable standards of health, wellbeing, and participation at every age.*

Consistent with this vision, and with the objective of the Public Health and Wellbeing Act 2008, the overarching aim of this plan is to reduce inequalities in health and wellbeing.

The plan outlines the key priorities over the next four years to improve the health and wellbeing of all Victorians, particularly the most disadvantaged.

As many chronic disease and injuries are preventable, the plan focuses on encouraging healthy living from the early years and throughout life.

The priorities for promoting health and wellbeing are based on the most significant causes of poor health and wellbeing that are most responsive to preventive action, and that cause the greatest inequalities in health outcomes across the population.

The health and wellbeing priorities for 2015-19 are:

1. healthier eating and active living
2. tobacco-free living
3. reducing harmful alcohol and drug use
4. improving mental health
5. preventing violence and injury
6. improving sexual and reproductive health.

The Plan emphasises improving health and wellbeing via a range of public health approaches. These are:

- *supporting healthy and sustainable environments;*
  Which is critical to the health and wellbeing of the current and future generations. Particular attention is given to climate change adaptation and air, food and water quality.
- *place-based approaches;*
  Which emphasise the significance of location to health and focus on a range of settings in which people spend their time.
- *people-centred approaches;*
  Which focus on building strong partnerships between health services and other networks, and emphasise prevention, empowerment, education and health literacy.

The plan sets out the challenges that Victorians will face in achieving the vision, including:

- *increases in some risks to health and only limited or no improvement in others:*
  Over the past two decades adult obesity has increased by about 40 per cent, with more than 2.3 million Victorians now overweight or obese; Victoria has also seen increases in the number of people reporting physical abuse associated with alcohol and in alcohol-related hospitalisations, despite an overall decline in alcohol consumption
- *the increasing impact of chronic disease:*
  Chronic diseases, such as cardiovascular disease, type 2 diabetes, cancers, musculoskeletal conditions, mental disorders, injuries and chronic respiratory disease, are now the largest causes of poor health and disability and more Victorians are living with one or more chronic conditions
- *persistent inequalities in health status:*
  Aboriginal people have a life expectancy 10 years lower than non-Aboriginal people and life expectancy varies by up to seven years between local government areas in Victoria; rates of adult obesity vary almost five-fold across Victoria; the smoking rate for people experiencing psychological distress is more than double that of the rate for Victoria overall
- *demographic trends require new approaches:*
  Population ageing requires a stronger emphasis on prevention efforts in later years of life; at the same time rapid population growth requires maintaining a focus on the health and wellbeing of children and families
- *environmental sustainability and health protection:*
  The impact of climate change presents environmental, economic and health challenges; communicable diseases are spreading faster and new diseases emerging more quickly

VicHealth Action Agenda for Health Promotion 2013-2023

VicHealth is the world's first health promotion foundation, established by the Victorian Parliament as part of the Tobacco Act of 1987. It was the first health promotion body in the world to be funded by a tax on tobacco.

The organisation has a mandate to promote good health for all Victorians. With a focus on promoting good health and preventing chronic disease, it leads and advocates for excellence in health-promoting policies and programs.

They have established a 10-year horizon, with associated goals and three-year priorities to guide their work with five strategic imperatives:

- promote healthy eating;
- encourage regular physical activity;
- prevent tobacco use;
- prevent harm from alcohol; and
- improve mental wellbeing.

Other Policy and Strategy

Examples of other policy and strategy that contribute to the health and wellbeing of our community include, but is not limited to:

- Heart health: improved services and better outcomes for Victorians
- Victorian Cancer Plan
- Koolin Balit: Aboriginal health strategy
- Education State and Education State: Early Childhood
- Victorian Child Friendly Cities and Communities Charter
- Every Child, Every Opportunity: Maternal and Child Health Service Program Standards
- Creative State
- Youth Policy: Building Stronger Youth Engagement in Victoria

1.3.3. REGIONAL

1.3.3.1. POLICY/STRATEGY/PARTNERS

South Eastern Melbourne Primary Health Network

On 1 July 2015, the Australian Government established 31 new Primary Health Networks (PHNs), following a review by its former Chief Medical Officer, John Horvath, of 61 Medicare Locals created under the previous Labor administration.

The Horvath review recommended, among other things, that new, larger primary health organisations be established to reduce fragmentation of care by integrating and coordinating health services, supporting the role of general practice, and leveraging and administering health program funding.

The two main objectives of the new PHNs, as stated on the Department of Health's website, are "increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time".

The PHNs have six priorities for targeted work including; mental health, Aboriginal and Torres Strait Islander health, population health, the health workforce, eHealth, and aged care. The South Eastern Melbourne PHN (includes Port Phillip within catchment) has 5 key areas identified in its strategic plan:

1. Intelligent Commissioning
   a. Build an integrated approach to service planning across the region
   b. Enhance response of the primary health care system to chronic disease
   c. Stimulate PHC markets, developing capacity including market development and business leadership activities
2. Co-Design
   a. Work with local communities and consumers to develop health and wellbeing activities that support enhanced self-care
   b. Co-design with consumers and stakeholders
   c. Enhance community capacity to stay well and healthy, through co-designed health promotion activities
3. Health System Alignment
   a. Guide consumers, carers and the community through the primary health care system
   b. Develop a shared commitment to proprietorship of system sustainable solutions
   c. Work with all stakeholder groups to increase the use of meaningful care planning tools
4. Enhance Professional Practice Capacity
   a. Developing the capacity in the primary care environment to drive sustainable practice change
   b. Embed quality improvement approaches in general practice and other settings
   c. Develop clinical leadership through capacity building activities
5. Efficient and Effective PHN Organisation
   a. Strong governance, policies and processes implemented
   b. Develop a business intelligence capacity
   c. Develop work-force capability – right skills, right time, sufficient capacity to deliver in a timely manner

Southern Melbourne Primary Care Partnership

The Victorian Government established the Primary Care Partnership Strategy in 2000 to strengthen the primary health sector and improve health and wellbeing outcomes across the service sector.

The current 28 Primary Care Partnerships (PCPs) are made up of a diverse range of member agencies who work together to improve local outcomes.

Core members of the partnerships are generally hospitals, community health, and local government with mental health, alcohol and other drug, disability and women's health services also commonly participating.

Primary Care Partnerships aim to deliver better health outcomes and stronger communities through:

- Partnership Development
- Integrated Health Promotion
- Service Coordination & Integrated Chronic Disease Management
- Client & Community Engagement

Southern Melbourne Primary Care Partnership (SMPCP) formed in July 2014 as the result of a merger between Inner South East Partnership in Community Health (ISEPiCH) and Kingston Bayside Primary Care Partnership (KBPCP). The catchment covers the local government areas of Bayside, Glen Eira, Kingston, Port Phillip and Stonnington.

Through community consultation and consideration of local, state and national evidence the following five strategic priorities were identified by SMPCP in their Strategic Plan:

1. The promotion and maintenance of mental health
2. Access to secure and affordable housing and healthy food sources
3. Promotion and support for participation in physical activity
4. Freedom from violence, abuse and the impact of alcohol and other drug use
5. Access to an integrated service system

STAR Health (formerly Inner South Community Health Service)

Victoria's network of community health services delivers a range of primary health, human services and community-based support to meet local community needs.

They provide universal access to services as well as targeted services for vulnerable population groups and sit alongside general practice and privately funded services to make up the primary health sector in Victoria.

Community health services provide state-funded primary healthcare in Victoria. These agencies receive Community Health Program funding from the Department of Health & Human Services.

They aim to improve the health and wellbeing of Victorians, particularly focusing on people with, or at risk of, poorer health.

Community Health Services across Victoria primarily deliver:

- allied health services
- chronic disease management
- disability services
- family planning
- home and community care services
- mental health services
- refugee health.
- child health services
- dental health services
- drug and alcohol services
- health promotion
- medical services
- post acute care services

The delivery of these supports and services is flexible and responsive to the needs of people and local communities. In this way, they focus on person-centred, coordinated care.

Star Health (formerly Inner South Community Health Service) is a not for profit organisation located at four dedicated centres within the St Kilda, Prahran and South/Port Melbourne areas and deliver more than 150,000 services each year across the inner southern region of Melbourne and beyond, of which Port Philip is a part of.

As one of Victoria's largest community health services, Star Health provides a broad range of services spanning pregnancy, childhood, adulthood and seniors covering general, oral and mental health, homelessness and alcohol and drug services.

As well as direct service delivery Star Health engages in community building and health promotion activities to build the health and wellbeing of the community.

Star Health's stated mission is that it 'works in partnership with people and communities to promote and improve equity, health and wellbeing, by:

- Delivering innovative, client-directed services that take into account the context of the individual and the community; and
- Championing prevention and change to address the structural reasons for health inequity.'

The ISCHS Strategic Plan 2015-18 (produced prior to rebranding) notes four key goals areas and a number of objectives:

1. ISCH understands and delivers the best possible health and wellbeing outcomes for our clients and communities by providing services that are client-directed, outcomes focused and cost-effective
   - 1.1. Client-directed and innovative
   - 1.2. Outcomes-focused
   - 1.3. Comprehensive and integrated
   - 1.4. Cost-effective
2. ISCH works with clients and communities to influence policy makers and address the structural reasons for health inequity
   - 2.1 Connection to local communities
   - 2.2 Influence policy makers
   - 2.3 Partnerships that strengthen communities and bolster influence
   - 2.4 Health promotion and prevention
3. ISCH is well resourced and has the capacity to be adaptive, responsive and sustainable into the future, in order to meet changing community and client needs and expectations
   - 3.1 Our people
   - 3.2 Improve business systems
   - 3.3 Infrastructure capacity
   - 3.4 Position for a competitive market environment
4. ISCH is a universal service accessible to all and open to growth, but maintains a focus on reaching out to those most in need
   - 4.1 Expanded services to allow universal access
   - 4.2 Expand our range of services
   - 4.3 Remain open to new mergers/alliances/ joint ventures

Other Partners

Local government acts as a primary interface between government and community. It plays a key role identifying issues and service gaps, instigating programs, facilitating partnerships, developing policy, implementing local law, providing support and services directly to residents and undertaking important infrastructure developments.

We know that Council cannot do it alone. Some of the best ideas come from within the community and need only the support and advocacy of local Council rather than its administration.

To this end, we partner with a wide range of local partners to achieve improved community health and wellbeing including, but not limited to:

- Health agencies
- Neighbourhood houses
- Education bodies
- Direct service providers
- Trader associations
- Community groups
- Not-for-profit organisations
- Industry bodies
- Sporting clubs
- Private providers

1.3.4. LOCAL

1.3.4.1. HEALTH AND WELLBEING PLANNING IN PORT PHILLIP

The City of Port Phillip has developed a number of Municipal Public Health and Wellbeing Plan, many of which incorporated unique features. Perhaps the most obvious was the *Health and Community Safety Plan 1999*, which transcended the typical three or four year planning cycle that is often structured around political terms of office, to include a 20 year scope. It recognised that significant changes to the most important determinants of our health – many which lay outside the health care system- require many years of hard work for many people. The 1999 Plan included 160 strategies/actions.

The next *Health and Wellbeing Plan 2007-2013* was the first formal community health and wellbeing check-up since 1999. While the 2007-2013 Plan was configured around the typical planning cycle, it was extended by two years to align with local and regional planning cycles (as encouraged by the Department of Health). It built on the long-term work of the previous plan, with an aim to lead and inspire a large community effort towards more healthy and enjoyable living conditions.[20] For this reason, the Plan won the 2009 National Award for "*Best Health and Wellbeing Plan*" for Local Government in the Health and Wellbeing category. Council recruited over 1,100 community members to form coalitions that planned, implemented and evaluated dozens of creative, pragmatic projected designed to improve community health and wellbeing. Council also trained and employed a team of residents who ventured into their neighbourhoods to interview people about their ideas for a health community.[21]

The most recent *Municipal Public Health and Wellbeing Plan 2013-2017* continues to identify opportunities to work collaboratively across different sections of the community to ensure integrated and informed health planning. The Plan identifies a number of Council strategies and relevant Council plans to illustrate the scope of work that is being undertaken within Council departments to support health and wellbeing.

Due to inconsistent and limited evaluation, it is difficult to assess the success of each health and wellbeing plan. However, it is worth noting the different structures and lessons learnt to continue to carefully plan and align public health and wellbeing matters across all Council business.

MPHWP 2007-13

Structure

The Plan was structured to align with the State Government's Environments for Health framework to advance public health by focusing on actions across the four environments – the natural, built, social and economic.

The cultural environment was also included. Under the environments for health framework, the Plan featured a cluster of topics (17 in total) that emerged strongly through the consultations.

Each topic had its own set of strategies that were progressed each year by council staff and community partners. The Plan included a total of 94 strategies.

Environment	Topics	Strategic Direction
Social	• Social cohesion & support • Drugs • Community safety • Local community services • Stages of life	We will contribute to a social environment that improves our community's sense of safety, connectedness and support.
Built	• Transport & community mobility • Neighbourhood facilities	We will contribute to constructing a local built environment that adapts to support our community's living needs.
Natural	• Sustainable living • Clean streets, beaches & parks	We will contribute to practices that help our community enjoy and respect our natural environment and keep it in good condition for future generations.
Cultural	• Spirituality • Managing changing communities • Cultural life & the arts • Diversity & inclusion • Community involvement & participation	We will contribute to creating a more vibrant, inclusive cultural environment that values people in all their diversity.
Economic	• Rising cost of living • The pressures of modern life • Reducing disadvantage	We will contribute to initiatives that alleviate pressures in the economic environment.

Lessons learnt

- The topics provided a useful picture of the circumstances facing the community that warranted attention in order to achieve long term changes.
- There was a distinct overlap between the strategic directions of the Plan and Council Plan and between their respective topics/objectives and sub-themes/strategic activities.
- From an evaluation perspective there was an overlap between indicators used to report on the Council Plan and those used to evaluate whether Plan strategic directions were achieved.
- As there were no measures of success established at the beginning of the Plan, it was unclear how the initiatives and partnerships contributed to the Council objectives, as well as the health of the community.
- The impact measurement largely relied on the evaluation of individual health and wellbeing programs to provide a snapshot of effectiveness, which was largely ad hoc and relied heavily on the commitment and ongoing support from Council staff and the local stakeholders involved.
- While stakeholder commitment was strong and there was a share responsibility for delivering the initiatives, reporting was often described in more general terms and lacked in-depth understanding the effectiveness of the initiative(s).
- The large volume of actions (94 in total) made evaluation and data collection challenging and time consuming.

MPHWP 2013-17

Structure

The Plan was based on nine key themes which emerged from community feedback and research. The themes form the strategic framework and serve as the priorities upon which the Action Plan was developed.

Each priority area lists a range of strategies (55 in total). Under each strategy are relevant actions, agreed indictors as well as a list of the team(s) responsible for each action.

Lessons learnt

Following a review in August 2016, the following lessons have been noted:

- Many felt that the Plan was too broad and thus difficult to use. Others felt that the board themes enabled them to easily align their work priorities to the nine priority areas.
- The absence of an integrated and well planned and monitoring and evaluation plan (i.e. health indicators) made it difficult to measure impact and show how the strategies improved health and wellbeing.
- As the Plan mostly included existing council functions and/or programs and services, most areas of council were able to grasp how they can contribute to the health and wellbeing outcomes, thus raising the profile and importance of health planning.
- However, by aligning the strategies and actions with council policies and work plans, reporting was duplicated which resulted in inefficiencies and at times confusion around the purpose of the annual action plan(s).
- Annual reporting was time consuming and often a burden for staff and stakeholders

1.3.4.2. POLICY/STRATEGY

Council has a robust planning framework currently in place to support the delivery of services to and for the community. Sitting alongside the Council Plan are the Municipal Health and Wellbeing Plan and the Port Phillip Planning Scheme. Together these high level plans ensure the current and future health and wellbeing of the City.

Figure 5: Current Council Planning Hierarchy

Council Plan 2013-17

Under the Local Government Act 1989 a Council must prepare and approve a Council Plan within the period of 6 months after each general election or by the next 30 June, whichever is later.

A Council Plan must include:

- the strategic objectives of the Council;
- strategies for achieving the objectives for at least the next 4 years;
- strategic indicators for monitoring the achievement of the objectives;
- a Strategic Resource Plan.

The Council Plan 2013-17 consists of 16 strategic objectives in four areas of focus:

- *Engaged - A well governed City*
  1.1 Provide clear and open communication and engagement that is valued by the community
  1.2 Value transparent processes in Council decision making
  1.3 Build and facilitate a network of active and informed communities
  1.4 Build strategic relations with our partners
  1.5 Achieve a reputation for organisational and service excellence
- *Healthy - A healthy, creative and inclusive City*
  2.1 Ensure our City is a welcoming and safe place for all
  2.2 Support our community to achieve improved health and wellbeing
  2.3 Ensure quality and accessible family, youth and children's services that meet the needs of our community
  2.4 Foster a community that values lifelong learning, strong connections and participating in the life of the City
  2.5 Promote an improved range of cultural and leisure opportunities that foster a connected and engaged community
- *Resilient - A strong, innovative and adaptive City*
  3.1 Build resilience through Council action and leadership
  3.2 Support and increase community action for a resilient City
- *Vibrant - A liveable and connected City*
  4.1 Encourage viable, vibrant villages
  4.2 Ensure growth is well planned and managed for the future
  4.3 Improve and manage local amenity and assets for now and the future
  4.4 Ensure people can travel with ease using a range of convenient, safe, accessible and sustainable travel choices

Port Phillip Planning Scheme / Municipal Strategic Statement

Council planning decisions shape communities, and influence the physical environment and quality of life. The consequences of planning decisions are around for a long time, therefore planning is a critical part of Council's function.

The Municipal Strategic Statement (MSS) provides direction about council land use planning, taking into account local considerations whilst also complying with state policy.

The MSS also plays a significant role in planning for the health and wellbeing by ensuring the needs of the community are met. For example, our foreshore and open spaces attract thousands of people and are assets that are highly valued by our community. It is council's role to manage its natural environment whilst also maintaining how it is accessed and used. This directly contributes to the physical, social and mental health and wellbeing of our community.

Our residents also highly value our distinct neighbourhoods, local character and heritage. Council seeks to conserve or enhance heritage and be sympathetic and respectful to heritage places, whilst also understanding that heritage is as much about people as it is about places.

Council frequently advocates on issues relating to planning, liveability and sustainability within the municipality, for example such as affordable housing, and has a strong role to play in guiding future developments to ensure long-term community benefit.

The MSS:

- provides a link to the council corporate plan and the planning framework.
- provides the strategic basis for the local content of the planning scheme, such as local policies and the choice of zones and overlays
- provides the strategic basis for decision-making by the responsible authority.

Port Phillip's vision in the MSS is to create:

- A city that produces low greenhouse gas emissions and is responsive to climate change issues;
- A city that provides a healthy and safe environment for residents, workers and visitors;
- A city where community diversity and harmony are sustained and encouraged;
- A city where all members of our community feel connected through a strong sense of place, and can enjoy the benefits of the city and participate in community life;
- A city that promotes affordable, accessible and diverse housing types to meet the needs of all current and future residents;
- A city that promotes sustainable economic growth, high accessibility to goods and services, and prosperous conditions for all residents and businesses;
- A city that manages traffic and transport in a way that maximises use of environmentally sustainable modes of travel;
- A city of distinct neighbourhoods where an understanding of local character and heritage is an important element of a sustainable future;
- A diverse and creative city that is reaching out to the future with innovative design and development, high environmental awareness and a vibrant culture; and
- A city that respects and values its past, its diversity and its link with traditional owners.

Other Policies and Strategies

Council also has plans and strategies that provide greater analysis and detail to address specific policy objectives. Within the organisation, department and individual plans align to support the delivery of the Council Plan objectives.

The table below outlines City of Port Phillip policies and strategies that are relevant to health and wellbeing:

Policy/Strategy	
Access Plan 2013-18	In Our Backyard- Growing Affordable Housing in Port Phillip 2015 - 2025
Ageing Well in Port Phillip Strategy 2006-16	Multicultural Strategic Statement
Arts and Culture Policy 2011	Municipal Emergency Management Plan
Arts Review	Open Space Strategy 2009
Childcare Policy	Play Space Strategy 2011
City of Port Phillip Housing Strategy 2007 – 2017	Public Toilet Plan 2013-23
Early Years Plan 2012-15	Reconciliation Action Plan 2012-15
Economic Development Strategy 2012-16	Social Justice Charter
Events Strategy 2015-17	Sport and Recreation Strategy 2015-24
Family Violence Commitment Statement	Sustainable Transport Strategy and sub-plans
Family, Youth and Children – Collaborative Practice Framework and Policy	Toward Zero 2007-20 and sub-plans
Family, Youth and Children Strategy 2014-19	Youth and Middle Years Commitments 2014-19
GLBTI Statement of Commitment	Homelessness Action Strategy 2015-20

2. WHO?

PORT PHILLIP HEALTH PROFILE

Contents

About this section

This section presents data on a range of demographic, health and wellbeing indicators and measures for the City of Port Phillip community, including commentary on their implications for health and wellbeing.

This section should be read in conjunction with the *'City of Port Phillip Health and Wellbeing Data Depository'* Excel file which notes in excess of 900 individual health and wellbeing indicators and measures.

About the Data

This section should be read in conjunction with the *'City of Port Phillip Health and Wellbeing Data Depository'* Excel file which notes in excess of 900 individual health and wellbeing indicators and measures. A selection of these indicators have been selected to be shown here to provide an overview of the health and wellbeing status of Port Phillip.

The most recent data available has been utilised at the time of writing this report (November 2016). Data older than 2011 has generally not been used for this report, with the exception of Youth and Middle Years related data due to insufficient recent data being available.

Data was obtained from a range of credible sources, including federal, state and local government departments, peak organisations and research bodies such as:

- Census of Population and Housing, Australian Bureau of Statistics
- Victorian Population Health Survey, Department of Health & Human Services – State Government of Victoria
- VicHealth Indicators Survey, Victorian Health Promotion Foundation
- Local Government Area Profile, Department of Health & Human Services – State Government of Victoria
- Local Government Performance Reporting Framework

Data sources were also cross referenced against known data collection initiatives such as:

- Victorian Child and Adolescent Monitoring System (VCAMS),
- Community Indicators Victoria, and
- Social Health Atlases of Australia.

Unless otherwise stated, crude rates (also known as non-standardised rates) have been presented to give an indication of the "real situation". However, crude rates are not generally appropriate for comparisons between geographic localities, as estimates have not been age-standardised and differences may be due, in part, to differing age/demographic profiles.

While noting the above limitations that may exist in comparing geographical areas at a macro-level, Victorian figures were chosen for a point of comparison to provide context. Victorian figures were used as reliable data at a lower level such as regional figures were not available for all data points.

Interpretation and analysis

Data can be interpreted in many different ways.

For example, low doctor attendance rates may represent poor access to care or low levels of self-monitoring. Conversely fewer GP visits could be attributed to good health and/or well-managed conditions that do not require a high level doctor intervention. Data should also be considered against other data sets i.e. if emergency presentations are high but GP visits are low, then interpretation is more in line with poor access/self-monitoring.

The 'traffic light' coded data in the following section shows how Port Phillip is doing in relation to the Victorian average. The '**red**', '**amber**', '**green**' and '**blue**' categories shows whether the data is:

- Less favourable than the Victorian Average
- More favourable than the Victorian Average
- Same as the Victorian Average
- Unable to determine favourable or unfavourable impact on health

This categorisation aims to assist the reader to analyse the data, however it is provided without any other external inputs or analysis. As such, indicators such as low doctor attendance rates or high mental health clients which here have been coded 'blue' warrant further investigation through an accessible and inclusive engagement process with community members, agencies, and other tiers of government.

It is important to note that the data presented in this section is only a snapshot of general population health and wellbeing related indicators.

Additionally, the outcomes for different population cohorts is likely to be very different, and will require different interventions when addressing health disparities. Similarly, there will also be discrepancies in spatial analysis of indicators.

2.1. HEALTH AND WELLBEING PROFILE

2.1.1. OUR CITY AND OUR PEOPLE

The Yalukit Willam clan of the Boon Wurrung are the first people of the City of Port Phillip, with a continued strong connection to the land. Yalukut Willam means 'river home' or 'people of the river' reflecting the original prevalence of wetlands between the Yarra River and the foreshore - a landscape that has altered vastly since European settlement.

Port Phillip is one of the oldest areas of European settlement in Melbourne, known and treasured by many for its urban village feel and artistic expression. It is a city of neighbourhoods, each with its own character, defined by heritage buildings, strip shopping precincts and tree-lined streets.

Port Phillip is one of the smallest municipalities in Victoria, only 21 square kilometres, and the most densely populated with more than twice the population density of the metropolitan Melbourne average.

Port Phillip is a popular inner city area of Melbourne, attracting more than 2.8 million visitors each year, making it the second most visited place in metropolitan Melbourne second only to the central business district. The foreshore that stretches over 11 kilometres, and vast public open spaces, make the City highly desirable to residents and visitors.

Port Phillip is a sought-after inner city area of Melbourne. The physical environment will change as the City continues to experience significant residential development. Substantial growth is anticipated over the next 40 years in the Fishermans Bend Urban Renewal Area on the northern edge of the City, expected to be home to around 80,000 residents and provide jobs for 40,000 over the next four decades.

Over the past 40 years, Port Phillip has moved from a low–density working-class suburb dominated by families to a highly affluent, high density suburb populated by city professionals who predominately live alone. Port Phillip is the most densely populated municipality in Victoria.

Despite the affluence of Port Phillip, pockets of disadvantage remain. Port Phillip has the second highest amount of community and social housing and the second highest number of people experiencing homelessness in Victoria.

The average household is small (two people), but there are many families living in Port Phillip. Our community is one of the most educated compared with other metropolitan councils. There are some wealthy households, but approximately 16 per cent of households are classified as low income. The majority of our residents rent their homes.

2.1.1.1. POPULATION PROJECTIONS

The Port Phillip population is influenced by a significant amount of tourism which adds approx. 2,180 people to the Port Phillip total. Taking into considering the number of people who were away from home on census night as well as visitors to Port Phillip, the population of usual residents in 2011was 91,373 people.

The major differences between the age structure of City of Port Phillip and Victoria in 2011were:

- A larger percentage of persons aged 25 to 29 (14.2% v 7.3%)
- A larger percentage of persons aged 30 to 34 (13.5% v 7.0%)
- A smaller percentage of persons aged 15 to 19 (2.7% v 6.4%)
- A smaller percentage of persons aged 10 to 14 (2.6% v 6.1%)

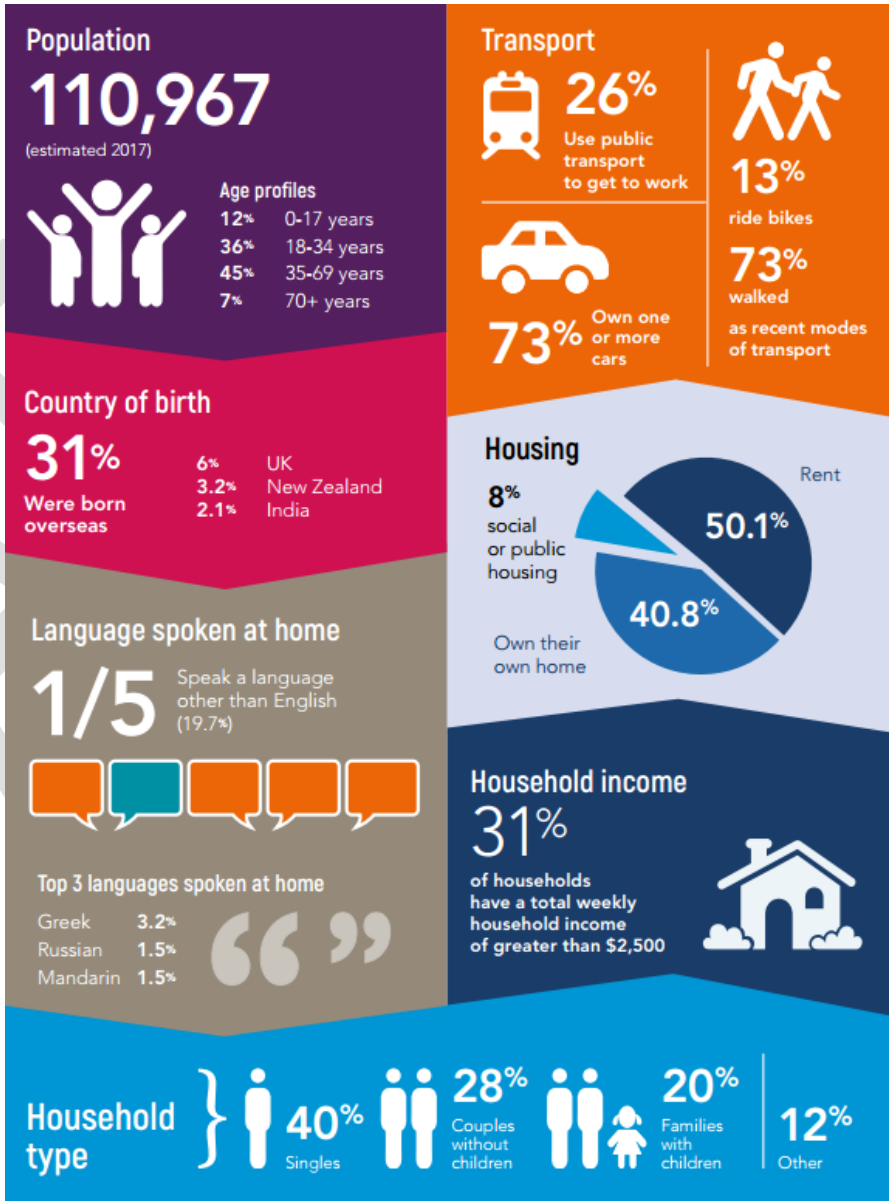
Between 2011 and 2036, the population for City of Port Phillip is forecast to increase by 32,362 persons (33% growth), at an average annual change of 1.15%.

Age group (years)	Population (percentage)				Change (number)		
	2016	2021	2026	2036	2016 - 21	2016 - 26	2016 - 36
0 to 4	4.9%	4.7%	4.6%	4.5%	69	162	610
5 to 11	4.4%	4.3%	4.2%	4.0%	124	205	500
12 to 17	3.2%	3.2%	3.2%	3.2%	197	337	761
18 to 24	9.3%	9.5%	9.7%	10.3%	694	1,427	3,545
25 to 34	26.6%	25.6%	25.4%	25.6%	129	1,206	4,863
35 to 49	25.1%	25.1%	24.7%	23.8%	1,287	2,019	4,190
50 to 59	11.1%	11.5%	11.9%	11.8%	1,068	2,044	3,524
60 to 69	8.5%	8.6%	8.7%	9.0%	539	1,180	2,678
70 to 84	5.8%	6.4%	6.6%	6.8%	928	1,564	2,632
85 and over	1.2%	1.2%	1.1%	1.0%	-12	-12	28
Total persons	106,874	111,898	117,006	130,207	5,024	10,132	23,333

Please note: The above forecast does not include Fishermans Bend

Key Stats

- The City of Port Phillip's current population is at 110,967 with a population forecast of 130,207 by 2036, which is an increase of 21.8 per cent.
- Persons aged 25-49 remain the dominant age group, making up half the population at 53.4 per cent.
- 31 per cent of the population in the City of Port Phillip are born overseas, primarily from the United Kingdom. 18 per cent came from countries where English was not their first language.
- 19.7 per cent of residents speaking a language other than English, the top three languages include Greek, Russian and Mandarin.
- We have a high transient community with 50.4 per cent of residents moving in the last five years. 19.6 per cent moved into Port Phillip from another part of Victoria, while 10.2 per cent of residents moved within Port Phillip.
- More empty nesters and retirees are choosing Port Phillip as their home, with an increase of 1,516, representing 8.1 per cent of the City's population.
- 42,044 people in City of Port Phillip had a tertiary qualification, representing 51.7 per cent of the City's population.
- We have a small Indigenous community with 284 people identifying as Aboriginal and Torres Strait Islander, representing 0.3 per cent of the population.
- 2,733 people or 3.0 per cent of the population report needing help in their day-to-day lives due to disability.
- Port Phillip is a popular tourist attraction and has approximately four million visitors per year.
- The City of Port Phillip also has a strong LGBTIQ community – making up 1.5 percent of our total population.
- 54,944 people living in City of Port Phillip were employed, of which 72 per cent worked full-time and 27 per cent part-time.
- 31 per cent of households were classified as high income earning an income of $2,500 or more per week.
- 41 per cent of households were purchasing or fully owned their home, 44.6 per cent were renting privately, and 4.8 per cent were in social[22] housing in 2011.



2.1.2. OUR HEALTH AND WELLBEING

2.1.2.1. OVERALL

Consistent with Victoria, the health and wellbeing of our community is relatively high. Available data shows that we are similar to the Victorian average on things such as general wellbeing, life satisfaction, day time safety, resilience, levels of psychological distress, participation in health screening activities (e.g. blood pressure check) neighbourhood cohesion, social trust, and fruit and water consumption.

There are areas where we have more favourable outcomes such as physical activity and obesity levels, smoking rates, income and socioeconomic indicators, and some chronic diseases. Our efforts in these areas must continue to be supported to maintain these positive outcomes.

However, there are also areas of concern such as alcohol and illicit drugs, crime, sedentary work behaviours, housing affordability, people experiencing homelessness and sexually transmissible infections. We must seek to understand the complexities of each of these areas and identify how we can work together to improve our health and wellbeing.

Favourable	Unfavourable
– Almost two-thirds of Port Phillip residents agreed that they felt safe walking alone in their local area after dark, which is significantly more than the state average – The percentage of people who do not meet physical activity guidelines is the lowest in the state – Port Phillip residents ate significantly more serves of vegetables per day than the state average – The percentage of people reporting being obese is the lowest in the state – Significantly lower smoking rate than state average – The percentage of people who believe multiculturalism makes life better is among the highest in the state – The median household income is among the highest in the state – The percentage of people with income less than $400 per week is the lowest in the state – The percentages of households with mortgage stress and rental stress are among the lowest in the state – The percentage of social housing is among the highest in the state – The percentage of journeys to work which are by public transport is the highest in the state – The percentage of people reporting arthritis is the lowest in the state, and the percentages reporting type two diabetes and high blood pressure are among the lowest – The percentage of children with the kindergarten fee subsidy is the lowest in the state – The percentage of infants fully breastfed at 3 months is among the highest in the state – The percentage of children with speech or language problems at school entry is among the lowest in the state	– The rate of total criminal offences is among the highest in the state – Significantly higher levels of time spent sitting on a usual work day than state average – Significantly more Port Phillip residents were identified as being at risk of short-term harm from alcohol in a given month and those identified as being at very high risk of short-term harm each month is the highest in state – Significantly more residents living in Port Phillip agreed that getting drunk every now and then is okay – Significantly higher rates of alcohol related ambulance attendances, hospitalisation, emergency department presentations and assault including the highest rate of male alcohol-related hospitalisations in the state – Significantly higher pharmaceutical related ambulance attendance rate – Significantly higher illicit drug related ambulance attendance rates (in particular for amphetamines, meth-amphetamines and ecstasy) and the highest hospitalisation rate in the state – The percentage of people who feel they are able to get help from neighbours is among the lowest in the state – The median weekly rent for a 3-bedroom home is the highest in the state and the median house price is among the highest in the state – The rate of homelessness (estimated) per 1,000 population is the highest in the state – Significantly higher rates of Sexually Transmissible Infections (STIs)

**This snapshot provides a general overview of available data. Any comparative descriptors i.e. higher/lower than is a comparison of CoPP vs Victorian figures. 'Gender' provides comparison of CoPP female v male figures.*

ALCOHOL AND OTHER DRUGS

- Greater supply, access and spend on alcohol contributing to higher levels of alcohol-related harm
- Low rate of smoking
- High use of licit and illicit drugs as shown by high ambulance attendance rates and drug related criminal offences

COMMUNITY CONNECTIONS

- Well-resourced and connected individuals who are supported by family and friends, less so via neighbourhood networks
- Good access to facilities/services and high level of community participation

COMMUNITY SAFETY

- Whilst there is high rates of reported criminal offences, perceptions of safety remain positive broadly
- It is important to note that spatial disparities exist in recorded offences and subsequently influencing perceptions of safety - particularly activity centres

EDUCATION, EMPLOYMENT AND INCOME

- High education and employment levels, driving high incomes
- Low reliance on support and benefits

HEALTH BEHAVIOURS

- Considerably lower obesity rates, due to positive diet and exercise habits
- More sedentary work behaviour, associated with office based employment
- Lower rates of proactive health monitoring i.e. blood pressure checks

HEALTH SERVICES

- Higher number of General Practitioners but at fewer locations, possibly attributing to lower recorded attendance rates
- Limited access to allied health services, pharmacies and the community based therapies they provide

HOUSING AND HOMELESSNESS

- High number of people experiencing homelessness
- Majority of residents are renting and experience high cost of housing (both rental and mortgage)
- Large proportion of unoccupied dwellings

INDIVIDUAL HEALTH

- Positive self-reported health status, but higher rate of chronic disease
- Extremely high rates of sexually transmissible infections (STIs)

MENTAL HEALTH

- High prevalence of mental health conditions with identification and service access rates high and lower rates of suicide
- High self-reported resilience and wellbeing levels

SUSTAINABILITY, CLIMATE CHANGE AND ENVIRONMENTAL HEALTH

- Low energy use and greenhouse gas emissions compared
- High waste production and low recycling levels
- Increased prevalence of extreme weather conditions (high temperatures, more rain)

TRANSPORT AND MOBILITY

- High levels of active and public transport access and use, despite high personal vehicle ownership
- High cyclist and pedestrian road injuries, attributable to increased use of these methods of travel

GENDER

- Females have an increased life expectancy and lower rate of STIs, but also increased lifetime prevalence of anxiety/depression and overall levels of disability
- Females have a lower perception of safety and higher rates of criminal victim reports
- Higher level of gender equity awareness contributing to lower rates of family violence incidents
- Females have lower rates of alcohol and illicit drug use but increased pharmaceutical use
- Females experience slightly lower unemployment rates but also lower income levels

SOCIAL AND CULTURAL DIVERSITY

- High proportion of population born oversea, but low proportion from non-English speaking background or that speak a language other than English (LOTE) at home
- Positive attitudes to our socially and culturally diverse community
- High Indigenous and CALD use of health and HaCC services
- Low levels of disability, but low disability pension recipients for those eligible

EARLY YEARS

- Good health service participation (i.e. MCH), contributing to positive development and education milestone attainment
- High illicit drug use – particularly amphetamines
- Low rate of children involved in criminal activity – as both offender and victim
- Lower immunisation rates
- Higher proportion of families being assessed for and accessing support services

YOUTH AND MIDDLE YEARS

- High crime rate – as both victim and offender
- Low educational milestone attainment, but also lower rates of unemployment and youth disengagement
- High levels of drug use
- Good diet but poor physical activity levels
- Poor sexual health practices
- Low self-rated health and high level of mental health conditions

OLDER ADULTS

- High proportion living alone
- High alcohol and illicit drug use
- High unemployment rate, but less reliance on age pension
- Lower rate of eligible residents using HaCC service
- Higher projected growth rate of dementia

2.1.2.2. ALCOHOL AND OTHER DRUGS

Indicator/Measure	CoPP	Vic	
Alcohol			
7 day $ spend on packaged liquor (of those purchasing)	50	45	
Liquor licences (rate per 1,000 adults) as at October 2016	8.3	4.5	
Percentage of adults who are at risk of short-term harm each month	44.4	29.4	
Percentage of adults who are at very high risk of short-term harm each month	20.6	9.2	
Percentage of adults who have an increased lifetime risk of alcohol related harm	68.8	59.2	
Percentage of adults who have an increased risk of alcohol-related injury on a single occasion (either yearly, weekly or monthly)	55.3	42.5	
Percentage of adults who purchased alcohol in the last 7 days	54.4	36.3	
Alcohol Death Rate per 10,000 population	1.2	1.5	
Alcohol ambulance attendances per 10,000 population	81.6	34.4	
Serious road injuries during high alcohol hours per 10,000 population	1.6	1.7	
Assaults during high alcohol hours (HAH) per 10,000 population	19.7	13.1	
Alcohol Family Violence incidents per 10,000 population	23.8	21.9	
Illicit and pharmaceutical drugs			
Illicit ambulance attendances per 10,000 population	29.2	12.2	
Amphetamines ambulance attendances per 10,000 population	2.6	1	
Crystal Methamphetamine ambulance attendances per 10,000 population	6	2.7	
Other stimulants ambulance attendances per 10,000 population	3.7	0.9	
Pharmaceutical ambulance attendances per 10,000 population	22.2	16.9	
Tobacco			
% Adults who support a smoking ban in outside dining areas	64.6	69.8	
Percentage of adults who are current smokers	7.4	13.1	
Gaming			
EGM expenditure per Adult as at June 2016	297.1	553.1	
EGMs per 1,000 Adults as at June 2016	4.0	5.7	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- Alcohol plays a complex role in Australian society. Most Australian adults drink alcohol for enjoyment, relaxation and socialisation at levels that cause few adverse effects[23].
- Alcohol-related harm is estimated to cost the Australian community at least $15 billion per annum with $10.8 billion attributed to tangible costs (e.g. labour and health costs) and $4.5 billion to intangible costs such as death from violence. [24]
- Millions of Australians are harmed in alcohol-related incidents each year. Almost five million people in Australia (26.0%) aged 14 and over reported being a victim of an alcohol-related incident in the preceding 12 months, and the number of Australians who experienced physical abuse in an alcohol-related incident increased from 1.3 million to 1.7 million in 2013[25].
- Harm associated with alcohol use, which includes short-term harm and long-term health consequences, is well documented[26]. A universally applicable rule is that the risk of injury increases as more alcohol is consumed during a single drinking session. Episodes of binge-drinking are predominantly associated with risks related to self-injury or injuries to others affected by the drinker's behaviour (e.g. families, friends, co-workers and strangers).
- Using a wider definition of 'harm' that includes effects such as noise disturbance, fear of physical abuse, sexual abuse, child neglect, violence and death, it is estimated that almost 70% of Australians are experiencing harm due to another person's drinking in a given year[27].
- A gender difference exists with regard to the source of harm resulting from the alcohol consumption of others: females were more likely than males to experience harm inflicted by someone they knew well in the household or family, whereas males were more likely to be exposed to alcohol-related harm inflicted by friends and coworkers[28].
- Cultural values, beliefs and norms about alcohol consumption influence alcohol-related harm, both positively and negatively. For example, societies where moderate alcohol consumption is integrated with meals (e.g. France and Italy) experience significantly fewer alcohol-related problems compared with cultures where alcohol is strongly associated with celebration and heavy episodic drinking occasions (e.g. the UK, the US, Scandinavia and Australia).[29]
- Some evidence shows that despite consuming less alcohol, people from low socioeconomic groups are more susceptible to the damaging effects of alcohol and experience higher rates of alcohol-related disease.[30]
- Tobacco use (including smoking cigarettes, cigars, and using other tobacco products) is the most preventable cause of ill health and death in Australia[31]. Smoking is known to contribute to a wide range of diseases such as cardiovascular disease (including heart attacks and stroke), cancer (including lung, mouth, liver, bladder and bowel cancers), lung disease (including chronic bronchitis and emphysema) and circulation problems[32].
- 9% of Australia's burden of disease is due to smoking.[33] Two out of three smokers, equivalent to about 1.8 million current Australian smokers, will die prematurely because of their smoking.[34]
- Exposure to second-hand smoke (also called passive smoking) occurs when individuals inhale other people's tobacco smoke. Second-hand smoking is known to cause premature death and poor health in adult non-smokers, including heart disease and lung cancer. The health risk to children includes Sudden Infant Death Syndrome (SIDS), lower birth weight, lung and respiratory infections, asthma and ear problems[35]. There is no safe level of passive smoking: exposure to even small amounts of second-hand smoke is potentially harmful.

2.1.2.3. COMMUNITY CONNECTIONS

Indicator/Measure	CoPP	Vic	
Civic Participation			
Percentage of adults who where a member of decision-making board or committee	26.5	17.8	
Percentage of adults who attended a local community event in the past six months	61.8	55.3	
Percentage of adults who feel they have opportunities to have a say	40.9	40.1	
Percentage of adults who feel valued by society	51.8	52.6	
Percentage of adults who have access to community services and resources	91.1	85.1	
Percentage of adults who have participated in citizen engagement in the previous year	59.4	50.5	
Percentage of adults who rated local neighbourhood good or very good for being an active community where people do things and get involved in local issues and activities	66.7	58.5	
Percentage of adults who have volunteered in previous 12 months	18.2	17.7	
Council decisions made at meetings closed to the public	7.3	11.6	
Community satisfaction with community consultation and engagement (out of 100)	62	55.3	
Community satisfaction with council decisions (out of 100)	59	54.6	
Social Network			
Percentage of households with no internet connection	12.7	19.1	
Percentage of adults who can get help with care in an emergency	91.8	89.8	
Percentage of adults who rated local neighbourhood good or very good for community and support groups	62.4	61.1	
Percentage of adults who believe people are willing to help each other in their neighbourhood	72	74.1	
Percentage of adults who believe people in their neighbourhood can be trusted	71.8	71.9	
Percentage of adults who believe their neighbourhood is close-knit	61	61	
Lone person households	39.4	24.5	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- People who are connected and actively engaged in their local communities are more likely to feel positive about their neighbourhood, and vice versa[36].
- Citizen engagement has the potential to engender constructive networks and relationships in a variety of settings particularly where there are common or shared interests in relation to a 'burning issue', a shared vision or agreed outcome. [37]
- Those engaged with the democratic process can feel empowered, as they have increased personal political efficacy and feel more in control of their futures. [38] Together these factors contribute to improved population health outcomes.[39]
- The importance of citizen engagement has been well documented by researchers, with a number of studies highlighting the relationship between the health of individuals and participation at the community or neighbourhood level.[40]
- More Australians are living alone compared to previous generations.[41] People who are socially isolated and excluded are more likely to experience low self-esteem, depressive symptoms and have a higher risk of coronary heart disease.[42]
- Social capital describes the benefits that arise as a consequence of social connections.[43]
- Developing positive social connections and relationships is essential for optimal development, and provides a wide range of positive physical and mental health outcomes.[44]
- Social capital is an overarching term that refers to social connections and all the benefits they generate. It includes the concepts of trust, social connection and social cohesion[45].
- In relation to neighbourhoods, these elements of social capital are interconnected and emerging research suggests that neighbourhood cohesion impacts on mental health and wellbeing[46].
- The perception of being part of a cohesive neighbourhood can also counteract adverse health effects resulting from local socioeconomic disadvantage[47].
- Mutual trust and solidarity among neighbours determines how much people are willing to cooperate and help one another[48], and is a core component of social capital.
- The perception of a neighbourhood being 'closeknit' (held tightly together through social and cultural ties) indicates high levels of social cohesion[49].
- Neighbours who trust one another are more likely to work more effectively together for the collective advantage and, generally, to have higher life satisfaction[50].
- Factors that could influence how a person feels about their neighbourhood include the physical, human and cultural characteristics of a place, as well as socioeconomic factors, age, ethnicity and the shared norms and values of the community.
- More broadly, living in communities that provide access to affordable housing, healthcare, education, stable employment and social connectedness can significantly improve our mental wellbeing[51].
- Social connections to clubs, schools, faith and interest groups have a positive influence on wellbeing, social cohesion and social capital[52].

2.1.2.4. COMMUNITY SAFETY

Indicator/Measure	CoPP	Vic	
Crime			
Alleged offender (rate per 100,000)	3355.0	2886.1	
Crimes against the person (rate per 100,000)	1410.5	1264.5	
Drug offences (rate per 100,000)	793.2	498.2	
Justice procedures offences (rate per 100,000)	901.4	1167.1	
Other offences (rate per 100,000)	50.9	27.5	
Property and deception offences (rate per 100,000)	8151.9	5290.9	
Public order and security offences (rate per 100,000)	921.8	603.6	
Total offences (rate per 100,000)	12229.6	8851.7	
Victimisation rate per 100,000	8103.7	5315.0	
Family Violence			
Family violence incidents (rate per 100,000)	1022.7	1288.7	
Percentage of adults prepared to intervene in a situation of domestic violence	95.5	93.1	
Perceptions of Safety			
Percentage of adults who feel most people can be trusted	48.6	38.9	
Percentage of adults who feel safe walking alone during day	95.5	92.5	
Percentage of adults who feel safe walking alone during night	64.9	55.1	
Percentage of adults who felt safe walking down the street at night	72.2	60.9	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- Areas of socioeconomic disadvantage are reported to have higher rates of social disorder, such as graffiti, drug use or dealing, theft, burglary and violent crime[53].
- A fear of crime is associated with reduced active transport and increased car use – which places residents at risk of being less physically active[54] and increases their risk of cardiovascular disease, obesity, diabetes and mental illness[55].
- Community safety and security are important determinants of people's health and wellbeing. When individuals feel safe within their communities, they are more likely to connect with friends, engage with other community members and experience greater levels of trust and social connection[56].
- When individuals perceive their neighbourhoods to be unsafe, they experience higher levels of anxiety and interactions between members of the community become more limited, placing them at risk of social isolation and mental illness[57].
- Community safety also influences our physical health and wellbeing by altering how people use, and interact with, the built environment, local amenities, parks and community facilities[58].
- People are more likely to be physically active when they live in neighbourhoods with better amenities for exercise (such as parks and walking or jogging paths); with less litter, vandalism and graffiti; and with street layouts that promote pedestrian access and walkability[59].
- People who perceive their neighbourhoods to be unsafe often limit their use of local infrastructure and restrict their involvement in outdoor activities (e.g. walking and cycling)[60].
- The ability to participate in equal and respectful relationships is an important contributing factor to community safety and individual mental health and wellbeing.[61] Conversely, intimate partner violence is detrimental to physical and mental health.[62]
- In Australia, more than two in five women (41%) have experienced violence from a man known to them at some point in their lifetime since the age of 15.[63]
- The cost to society of violence against women and their children is $21.7 billion annually. If no further action is taken to prevent violence against women and their children, costs will accumulate to over $323 billion over the 30 years to 2045[64].
- Male intimate partner violence contributes more to the disease burden for women aged 18 to 44 years than any other well-known risk factors like tobacco use, high cholesterol or use of illicit drugs.[65]
- Exposure to partner violence has also been associated with an increased risk of a range of health problems including suicide, anxiety, depression and other mental health problems; to substance misuse; and to reproductive health problems such as low infant birth weight and sexually transmitted infection.[66]
- In Australia and internationally, efforts to reduce the prevalence of violence against women involve a significant focus on the promotion and improvement of gender equality. Gender equality is defined as the equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society[67].
- Addressing the social norms, social practices and social structures that produce and maintain gender inequality is a pivotal strategy to reduce violence and increase equal and respectful relationships[68].

2.1.2.5. EDUCATION, EMPLOYMENT AND INCOME

Indicator/Measure	CoPP	Vic	
Education			
Completion of Year 12 or equivalent	71.1	49.8	
Education level: No qualification	26.5	43.9	
Persons who completed a higher education qualification	68.6	45.7	
Percentage of persons with No qualifications	36.5	43.9	
Employment			
Percentage of persons employed	95.7	94.6	
Percentage of persons unemployed	4.3	5.4	
Percentage of persons employed full time	69.1	59.2	
Percentage of people receiving an unemployment benefit	3.5	5.2	
Percentage of people receiving an unemployment benefit long-term	2.8	4.2	
Income and Support			
Proportion of people earning a high income (those earning $1,500 per week or more)	26.3	11.5	
Proportion of high income households (those earning $2,500 per week or more)	30.6	16.6	
Median weekly household income	$1,664	$1,213	
Proportion of low income people (those earning less than $400 per week)	21.8	36.8	
Proportion of low income households (those earning less than $600 per week)	16	21.3	
Health Care Card / Total population (%)	4.2	6.9	
SEIFA Index of Disadvantage	1065.7	1009.6	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- Inequalities exist in the health of Australians across a range of health status indicators, including mortality, morbidity, life and health expectancy and self-perceived health. Inequalities also exist in factors associated with health, including health risk factors; health knowledge, attitudes and behaviours; and use of health and preventative services. [69]
- These inequalities exist across a range of social, economic and cultural measures, the most significant and persistent being education level, occupation, income, employment status and area-based measures of socioeconomic disadvantage.[70]
- International and Australian research supports a link between less education and poorer health.[71]
- Educational attainment is associated with better health throughout life. Education equips people to achieve stable employment, have a secure income, live in adequate housing, provide for families and cope with ill health by assisting them to make informed health care choices. An individual's education level affects not only their own health, but that of their family, particularly dependent children.[72]
- People with lower education levels may be more likely to have poor working conditions, to be in receipt of a low income and to be unemployed or lack job security.[73]
- Educational attainment can be associated with developing information and cognitive skills, choices, and participation in social networks. [74] Education has also been found to be strongly linked to determinants of health such as risky health behaviours and preventative service use. [75]
- People with lower educational attainment rate their own health more poorly and report a number of illnesses more often than those with a bachelor degree or higher.[76] People with degree qualifications are more likely to have better physical and mental health than people with Year 11 or lower qualifications.[77]
- Better education leads to a better overall self-assessed health status, which, in turn, leads to higher labour force participation. In particular, having a degree or a higher qualification strongly improves labour force participation.[78]
- Income and wealth play important roles in socioeconomic position, and therefore in health. The greater the gap between the richest and poorest people, the greater the differences in health.[79]
- Besides improving socioeconomic position, a higher income allows for greater access to goods and services that provide health benefits, such as better food and housing, additional health care options, and greater choice in healthy pursuits. Loss of income through illness, disability or injury can adversely affect individual socioeconomic position and health.[80]
- Unemployed people have a higher risk of death and have more illness and disability than those of similar age who are employed.[81] The psychosocial stress caused by unemployment has a strong impact on physical and mental health and wellbeing.[82] For some, unemployment is caused by illness, but for many it is unemployment itself that causes health problems.
- While most Australians are able to manage their own wellbeing with little intervention or support, at times and in certain circumstances they may need to draw on additional support and services to help them fully participate in all facets of life. The level of support they need will depend on the life stage they are in, their level of disadvantage, and the complex interrelationships between these factors. Australia's welfare system includes a complex network of income support payments, welfare services, and welfare-related tax concessions and deductions that support people's wellbeing.

2.1.2.6. HEALTH BEHAVIOURS

Indicator/Measure	CoPP	Vic	
Diet			
Average number of cups of water consumed per day	5.9	5.4	
Percentage of adults who avoided or delayed visiting a dental professional due to cost	24.3	29.8	
Percentage of adults who did not consume sugar-sweetened soft drinks daily	93.6	87.6	
Percentage of adults who eat take-away meals/snacks at least three times a week	10.6	10.2	
Percentage of adults who have poor self-rated oral health	5.1	5.6	
Percentage of adults who met both fruit and vegetable consumption guidelines	5.6	4.4	
Percentage of adults who met fruit consumption guidelines only	48.7	47.8	
Percentage of adults who met vegetable consumption guidelines only	8	6.4	
Percentage of adults who ran out of food in the last 12 months and could not afford to buy more	3	4.6	
Physical Activity			
Average time spent sitting on usual work day (hours:minutes)	5:38	4:29	
Percentage of adults who engaged in sedentary behaviour	1.2	3.6	
Percentage of adults who sit 8+ hours on an average week end day	11.6	10.4	
Percentage of adults who sit 8+ hours on an average weekday	30.6	23.8	
Percentage of adults who undertook adequate physical activity <Sufficient time (≥150 min) and sessions (≥2)>	58.8	41.4	
Percentage of employed adults who predominantly sit at work	64.3	49.6	
Preventative Action			
Percentage of adults who had ever had an eye test by an eye health professional	92.9	89.1	
Percentage of adults who had an examination to detect bowel cancer in the previous five years	50	46.1	
Percentage of adults who completed and returned a Faecal Occult Blood Test kit in last two years	57.3	59.9	
Percentage of adults who get inadequate sleep (<7 hrs per weekday)	18.8	31.5	
Percentage of adults who had visited a GP 12 months or more ago	13.4	10.4	
Percentage of adults who have had a blood pressure check in last two years	76.7	79.9	
Percentage of adults who have had a blood sugar or diabetes check in last two years	46.1	53.1	
Percentage of adults who have had a cholesterol check in last two years	56.3	59.5	
Percentage of adults who participated in sun-protective behaviours (wear a hat and sunglasses)	31	39	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- A healthy diet is vital for optimal growth, development and health throughout life.[83] A healthy diet also helps prevent chronic diseases as well as their associated risk factors including overweight and obesity, high blood pressure and high cholesterol[84]. In Australia, dietary risk factors are responsible for 10.4% of the chronic disease burden[85].
- The World Health Organization reports that low fruit and vegetable consumption is one of the top 10 risk factors contributing to global mortality[86]. In Australia, it is estimated that inadequate fruit and vegetable consumption is responsible for 3.4% of the total burden of disease[87].
- Water comprises between 50% and 80% of body weight in adults and is essential for the body to function[88]. In contrast to water consumption, high consumption of sugar sweetened beverages has been linked to ill health with considerable evidence that it increases the risk of developing diabetes, dental caries, weight gain and obesity[89].
- In Australia, the average fast-food meal provides about half (47.5%) of an adult's daily energy intake[90] and regular consumption can increase total energy intake, which may lead to unnecessary weight gain[91]. Excess salt in the diet, such as that in take-away foods, increases the risk of developing high blood pressure – a major risk factor for cardiovascular disease and stroke, which are the two leading causes of death and disability in Victoria[92].
- Participation in physical activity has numerous benefits[93] including improved physical health, reduced risk of developing major chronic diseases, managing body weight, developing social connections and helping to prevent and manage mental health problems.[94] In Australia, the estimated cost of physical inactivity to the health sector is over $672 million dollars per year.[95]
- Prolonged sitting is a risk factor for poor health and premature death, even for those who meet or exceed Australia's physical activity and sedentary behaviour guidelines.[96] Extensive sitting is consistently associated with premature mortality, risk of cardiovascular disease, type 2 diabetes, certain cancers, a higher overall energy intake and being overweight or obese.[97]
- More than 1,600 Australians die from skin cancer each year.[98] At least two in three Australians are diagnosed with skin cancer before age 70.[99] Skin cancer is the most expensive of all cancers on the Australian health system[100] and also one of the most preventable.[101] When shade is used in conjunction with sun protective behaviours, maximum protection is achieved.[102]
- Most diseases and conditions have a better prognosis if caught and treated in the early stages. Therefore the purpose of screening is to identify individuals in the early stages of the disease so that treatment can be initiated, thus improving health outcomes and reducing mortality.
- Cervical cancer is one of the few cancers where screening can detect pre-cancerous lesions that can be effectively treated. The most common type of cervical cancer (squamous) usually takes more than 10 years to develop.[103]
- Bowel cancer is one of the most common forms of cancer in Australia, and around 80 Australians die each week from the disease. Bowel cancer can be treated successfully if detected in the early stages, but currently fewer than 40 per cent are detected early.[104]
- Breast cancer is a major health issue for females and is the second most common cause of cancer related death in Australian females.[105] Well-organised mammographic screening can substantially reduce the number of deaths from breast cancer.[106]
- Good eyesight is an important part of wellbeing and a significant factor in retaining independence and quality of life. The good news is that 75 per cent of vision loss is preventable or treatable if detected early[107].

2.1.2.7. HEALTH SERVICES

Indicator/Measure	CoPP	Vic	
Access and Use			
GP attendances per 1,000 population	4239.2	6731.9	
% with private health insurance	33.8	32.4	
Allied health sites per 1,000 population	1.2	1.4	
Ambulatory care sensitive conditions, admission rate per 1,000 population	28.7	36.1	
Community health clients per 1,000	25.8	22.0*	
Dentists (rate per 100,000 people)	78.0	56.0	
Emergency Department presentations per 1,000 population	221.2	258.8	
GPs per 1,000 pop	1.1	0.7	
Hospital inpatient separations per 1,000 population	370.3	419.8	
Intentional injuries treated in hospital per 1,000 population	1.8	1.9	
Pharmacies per 1,000 population	0.3	0.7	
Primary care type presentations at EDs, per 1,000 population	97.2	107.5	
Specialist practitioners (rate per 100,000 people)	308.2	125.1	
Unintentional injuries treated in hospital per 1,000 population	34.6	76.9	
Food Safety Regulatory Function			
Time taken to action food complaints (days)	1.8	2.1	
Percentage of required food safety assessments undertaken	100.0	90.4	
Percentage of critical and major non-compliance outcome notifications followed up by council	99.1	92.5	

*regional figure used as state data not available.

- Less favourable than the Victorian Average
- More favourable than the Victorian Average
- Same as the Victorian Average
- Unable to determine favourable or unfavourable impact on health

Why this is important

- In Australia, primary health care is typically the first contact an individual with a health concern has with the health system. Primary health care broadly encompasses health care that is not related to a hospital visit. It includes a range of activities, such as health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions.
- The primary health care system can provide community-based, patient-centred care by a team of health professionals. Because of this, primary health care is often the 'best setting for the prevention and management of chronic and complex health conditions'.[108]
- Primary health care accounted for around 38% ($55 billion) of the $145 billion recurrent health expenditure in 2013–14, compared with around 40% ($59 billion) spent on hospital services.[109]
- Australia ranks well internationally when it comes to primary health care accessibility.[110] However, a significant accessibility gap exists between the most and least socioeconomically advantaged in our society.[111] Socioeconomic status is linked to disparities in access to primary health care, and this may impact on the health of an individual.[112]
- Despite the more frequent use of general practice services by socioeconomically disadvantaged people there remains a high level of hospitalisation for preventable conditions.[113] This is evident for almost all chronic and acute medical conditions, as well as influenza and pneumonia.[114] This suggests that while use of health care services is higher, it may not be sufficient to meet the needs of socioeconomically disadvantaged Australians.
- The distribution of GPs and allied health professionals across Australia is inconsistent and does not correspond with need. The length and frequency of consultations varies markedly.[115] Whilst some data suggest that individuals from low SES areas access services more frequently, this is offset by shorter consultation times.[116] Two main reasons underlie this phenomenon:
  - GPs and allied health professionals in areas of socioeconomic deprivation have a higher rate of bulk billing.[117] This means that these practitioners must undertake more work to achieve the same income as those in higher socioeconomic areas who are more likely to charge a gap fee.
  - The distribution of GPs and allied health professionals across high and low socioeconomic areas does not match the demand for primary health care services: those in lower socioeconomic areas, who have more need, have fewer GPs and allied health professionals.[118]
- Hospital emergency departments are also a critical component of hospitals and of the health system. They provide care for patients who have an urgent need for medical or surgical care.[119]
- In Australia, hospital services are provided by both public and private hospitals. In 2013–14, there were 1,359 hospitals—747 public and 612 private.
- Public hospitals provide the majority of emergency department care (94%) and outpatient care (96%), while private hospitals deliver 67% of all elective surgery.[120]
- In 2013–14, health expenditure in Australia was estimated at $155 billion, or 9.8% of gross domestic product.
- Almost 68% of total health expenditure during 2013–14 was funded by governments, with the Australian Government contributing 41% and state and territory governments nearly 27%.
- The remaining 32% ($50 billion) was paid for by individuals through out-of-pocket expenses (18%), by private health insurers (8.3%) and through accident compensation schemes (6.1%).[121]

2.1.2.8. HOUSING AND HOMELESSNESS

Indicator/Measure	CoPP	Vic	
Housing			
Housing stress: lowest 40% of household incomes who are paying more than 30% of their usual gross weekly income on housing	8.6	10.6	
Rental housing that is affordable	0.7	15.3	
Social housing stock as a percentage of total dwellings	8.0	3.8	
Average residential rate per residential property assessment	$1,434.1	$1,524.7	
Medium and high density housing	84.6%	23.0%	
Households renting	50.1	25.9	
Renting social housing	4.8	3.2	
Paying high mortgage repayments ($2,600 per month or more)	39.6	19.2	
Paying high rental payments ($400 per week or more)	39.8	17.2	
Median weekly rent	$366	$279	
Unoccupied private dwellings	12	10.8	

- While City of Port Phillip had a lower proportion of households experiencing housing stress, it is important to note that this varied across the City. Proportions ranged from a low of 4.4% in Middle Park to a high of 13.5% in Ripponlea.
- While City of Port Phillip had a higher proportion of households who are renting from a government authority, this varied across the City. Proportions ranged from a low of 0.3% in St Kilda West to a high of 16.5% in South Melbourne neighbourhood.

Homelessness			
Estimated homeless population (percentage of total population)	1.7	0.4	
Estimated homeless population (number)	1564	22727	
Persons in other temporary lodging	8	90	
Persons in supported accommodation for the homeless	444	7,845	
Persons living in other crowded dwellings	118	N/A	
Persons living in 'severely' crowded dwellings	33	6,041	
Persons staying in boarding houses	892	4,397	
Persons staying temporarily with other households	49	3,324	
Persons who are in improvised dwellings, tents or sleeping out	136	1,092	
Persons who are marginally housed in caravan parks	0	N/A	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- Numerous academic literature point to an association between various aspects of housing and health. However, despite the evidence linking housing to health, the direction of causality between housing and health is often unclear. That is, if a particular housing factor is found to be associated with a disease, it is often not clear whether the housing factor gave rise to the disease or vice versa.[122]
- Studies in developed countries show that people spend more than 90% of their time indoors.[123] A home therefore has psychological importance as an object of attachment, a source of identity, and a refuge from stress. [124]
- Housing affordability has been found to be a key factor in relation to health. If a greater proportion of income being absorbed by higher rents, this can result in a deterioration of health status because of reduced capacity to buy essential food items and access health services.[125]
- Housing is the largest single expenditure item in the household budget for low and moderate income earners. Housing stress affects more than one in ten Australian households and one in four households in the private rental market. In the last five years the cost of housing – both to buy and rent – has increased rapidly increasing the risk of people falling into poverty. [126]
- Homelessness has a significant impact on health. Homelessness contributes to being excluded socially and economically and may intensify health related conditions.[127] In general, homeless people have been found to have much poorer health status than the general population. [128]
- Homeless people are more likely than others to suffer from bronchitis, arthritis, skin diseases and infections, frequent headaches, musculoskeletal problems, visual impairment, alcohol and drug related problems and mental disorders among others.[129]
- Increased rates of infectious diseases as well as chronic medical conditions have been reported, ranging from community-acquired pneumonia, tuberculosis, and HIV to cardiovascular disease and chronic obstructive lung disease.[130] For some cancer risk factors, prevalence rates are higher in the homeless than in the general population, including sun exposure, cigarette smoking, and alcoholism. [131]
- Individuals lacking stable housing are more likely to use the emergency department as their regular source of care. In one study, homeless individuals made 20% to 30% of all adult emergency department visits. [132]
- The transient lifestyle of homeless people results in social disadvantage and creates a barrier to health service access and to receiving health promotion messages. One way of tackling the health effects of social disadvantage is for public health interventions to remove barriers to access to health care, social services and affordable housing.[133]
- In 2015–16, 279,000 people were assisted by specialist homelessness agencies across Australia, equivalent to 1 in 85 Australians. However, 275 requests for assistance were unable to be met each day. [134]
- Not everyone who approaches specialist homelessness services is homeless: over half of people are at risk of homelessness and are looking for assistance to retain their housing or to get general help (such as material aid or brokerage). [135]
- Domestic and family violence is a major reason why people present to specialist homeless services, with 55% of female clients citing this reason and a total of 25% of all clients.[136]

2.1.2.9. INDIVIDUAL HEALTH

Indicator/Measure	CoPP	Vic	
Health Status			
Percentage of adults pre-obese and obese (BMI)	38.2	50	
Percentage of adults who are satisfied or very satisfied with life	93.5	92.4	
Percentage of adults with fair/poor self-reported health status	11.4	20.3	
Standardized Death Rate per 1,000	5	5.3	
Median age at death 2009 to 2013	81	82	
Prevalence of Illness and Disease			
Avoidable deaths 0-74 years, all causes (rate per 100,000)	170.9	131.5	
Notifications of blood borne viruses rate per 100,000	100.1	82.8	
Notifications of enteric diseases rate per 100,000	299.4	230.2	
Notifications of vaccine preventable diseases rate per 100,000	426.1	392.9	
Percentage of adult population diagnosed with high blood pressure (hypertension)	15.5	25.9	
Percentage of adult population with life-time prevalence of arthritis	17.9	19.8	
Percentage of adult population with life-time prevalence of cancer	10.1	7.4	
Percentage of adult population with life-time prevalence of heart disease	6.1	7.2	
Percentage of adult population with life-time prevalence of osteoporosis	5.4	5.2	
Percentage of adult population with life-time prevalence of stroke	1.9	2.4	
Percentage of adult population with life-time prevalence of type 2 diabetes	1.8	5.3	
Percentage of adults with at least one chronic disease	53.2	47.1	
Percentage of adults with life-time prevalence of asthma	10.3	10.9	
The top 10 specific causes of burden of disease in Port Phillip are:			
1. Ischaemic heart disease 2. Stroke 3. Dementia 4. Depression 5. Cancer lung	6. Cancer colon/rectum 7. Cancer breast 8. COPD (emphysema/chronic bronchitis) 9. Diabetes mellitus-NIDDM 10. Hearing loss		
Sexual and Reproductive Health			
Notifications of Sexually Transmissible Infections	547.8	122.7	
Total fertility rate (per 1,000)	1.13	1.7	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- Almost two-thirds (61%) of Australian adults and one-quarter (25%) of Australian children are overweight or obese. In Australia, the total costs of overweight and obesity are estimated between $58.1–62.1 billion per year with direct costs estimated at $8–21 billion per year. In Victoria, this amounts to between $14.4 billion annually in excess healthcare costs alone.[137]
- Excess weight, especially obesity, is a major risk factor for cardiovascular disease, Type 2 diabetes, some musculoskeletal conditions and some cancers. As the level of excess weight increases, so does the risk of developing these conditions. In addition, being overweight can hamper the ability to control or manage chronic disorders.[138]
- With increasing prevalence of overweight and obesity and chronic disease in our society, there is an urgent need to encourage a reduction in the consumption of discretionary food and drink (energy-dense, nutrient-poor) and to increase the consumption of a healthy diet[139].
- Burden of disease is a widely accepted, broad measure of health and wellbeing, commonly reported as disability adjusted life years or DALY. The DALY is a measure of the disease burden in a population combining the loss of years of life due to premature mortality and the loss of healthy years of life due to disease, disability or injury.
- Chronic diseases have a range of potential impacts on a person's individual circumstances, including quality of life and broader social and economic effects. Chronic diseases are the leading causes of the fatal burden of disease (the amount of life lost due to people dying early) in most age and sex groups[140] and are the leading cause of illness, disability and death in Australia, accounting for about 90 per cent of all deaths in 2011[141].
- The term 'chronic disease' applies to a group of diseases that tend to be long lasting and have persistent effects, commonly including heart disease, cancer, type 2 diabetes, osteoporosis, arthritis and asthma among others.
- The Australian Institute of Health and Welfare (AIHW) estimates that about half of all Australians have at least one chronic disease and about 20 per cent have two or more of these conditions[142]. When a person has two or more diseases that occur at the same time, it is referred to as 'comorbidity'. Comorbidities are important because they are associated with poorer health outcomes, more frequent use of health services, and higher healthcare costs.[143]
- Ageing is an important factor associated with comorbidity because older people are more vulnerable to developing disease, and increases in life expectancy are leading to greater opportunities for multiple chronic conditions to arise. Hence, as the population ages, it is expected that the prevalence of multiple chronic conditions will increase.
- The impacts of sexual and reproductive health are human and economic, and direct and indirect. Unwanted pregnancy, sexual violence, sexually transmissible infections (STIs) and infertility are major contributors to morbidity and associated costs in Australia.[144] There is evidence that investing in sexual and reproductive health is cost effective, with the potential to minimise future health system costs and to realise significant benefits at the personal, family and societal levels.[145]

2.1.2.10. MENTAL HEALTH

Indicator/Measure	CoPP	Vic	
Lifestyle and Risk Factors			
Resilience (range 0-8)	6.6	6.4	
Satisfaction with life as a whole (range 0-10)	7.7	7.8	
Subjective wellbeing index (range 0-100)	77.5	77.3	
Percentage of adults who feel under time pressure	46.9	41.3	
Percentage of adults who have an adequate work/life balance	56.4	53.1	
Prevalence of Mental Health			
Percentage adult population who sought help for a mental health problem (in previous 12 months)	18.4	16	
Percentage of adults reporting lifetime prevalence of anxiety/depression	31.2	24.2	
Percentage of adults with high or very high levels of psychological distress	12.6	12.6	
Registered mental health clients per 1,000 pop	17.9	15.7	
Suicide rate per 100,000 0-74 year olds, 2008-2012	18.3	35.1	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- Resilience is a fundamental component of mental wellbeing that enables people to cope with adversity and to reach their full potential[146]. It is described as a person's capacity to successfully overcome significant challenges or negative outcomes and restore their previous level of function[147], thus avoiding mental ill-health. High levels of resilience are associated with a lower risk of mental health problems and an improved sense of mental wellbeing.[148]
- It is generally believed that resilience develops over time, and is important because it provides people with the resources to handle the stresses involved in life transitions and builds the capacity of those at risk of mental illness to better manage it.
- Higher levels of mental wellbeing are associated with increased learning, creativity and productivity, more pro-social behaviours, positive social relationships and improved physical health and greater life expectancy[149].
- Although subjective wellbeing refers to individuals' perceptions of the quality of their lives, lifestyle factors and demographic circumstances also have predictive influences.
- For example, people who find a good work–life balance and stay healthy by eating well and exercising regularly generally report higher levels of wellbeing[150]. Conversely, people living in rental accommodation, remote regions and areas with high cost of living, long commute times and a high population density generally report lower levels of subjective wellbeing.
- Mental health and wellbeing are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life.[151]
- Mental health includes emotional, psychological and social wellbeing, and it affects how we think, feel and act as we cope with life. It also helps determine how we handle stress, relate to others and make choices.
- Wellbeing, or positive mental health, improves our quality of life in many ways including: better physical health; faster recovery from illness; fewer limitations in daily life; higher educational attainment; greater likelihood of employment and earnings; and better relationships. Poor mental health can have a significant negative impact on physical health.[152]
- Levels of mental wellbeing and prevalence of mental illness vary according to socio-demographic and socioeconomic factors, with disadvantaged and marginalised population groups having a higher risk of experiencing mental illness and poor mental wellbeing.[153]
- The World Health Organization (WHO) reports that more than 450 million people across the world suffer from mental disorders, and many more suffer from mental health problems.[154]
- Depression is the leading cause of disability in both males and females and, at its worst, often leading to suicide.[155] There is strong and consistent evidence of an association between depression and anxiety and the National Health Priority Area conditions of heart disease, stroke, diabetes, asthma, cancer, arthritis and osteoporosis.[156]
- Depression is also associated with poorer health outcomes in those with physical disease. While depression and anxiety are, for the most part, highly treatable disorders, continuing social stigma about mental illness often prevents people from seeking the help they need.
- In Victoria in 2001, suicide was the third highest cause of death in males and 10th highest cause of death in females.[157]

2.1.2.11. SUSTAINABILITY, CLIMATE CHANGE AND THE ENVIRONMENT

Indicator/Measure	CoPP	Vic	
Environment			
Percentage of adults who rated local neighbourhood good or very good for being a pleasant environment	89.7	80.6	
Number of natural public open spaces per 1,000 population, 2011	0.4	1.6*	
Per cent of municipality which is open space, 2011	18.5	13.6*	
Mean days >30 degrees celcius (1939-2016)	30.2	N/A	
Mean days >30 degrees celcius (2016)	37	N/A	
Mean maximum temperature (1939-2016)**	19.7	N/A	
Mean maximum temperature (2016)**	20.6	N/A	
Mean minimum temperature (1939-2016)**	9.3	N/A	
Mean minimum temperature (2016)**	11.1	N/A	
Mean monthly rainfall (mm); 1929-2017**	583.9	N/A	
Mean monthly rainfall (mm); 2017**	615.6	N/A	
Mean number of days over 10mm of rain (1929-2017)	13.4	N/A	
Water quality of bay and rivers rated as 'very poor' (Dandenong v state catchment)	98	28	
Waste and Energy			
Household electricity use (megawatts an hour per occupied private dwelling	5.5	5.7	
Household gas use (gigajoules per occupied private dwelling)	35.8	52.5	
Non-recyclable garbage generated by households (kg per household)	593.7	488.1	
Percentage of people in households collecting waste water	27.4	41.3	
Greenhouse gas emissions (total emissions of CO2 in tonnes per occupied private dwelling)	8.9	9.9	
Kerbside collection waste diverted from landfill	34.1	42.9	

* Regional figures used as state data not available

** due to unavailable state level data, a comparison of time series data against most recent year data has been utilised to produce traffic light system indication

- Less favourable than the Victorian Average
- More favourable than the Victorian Average
- Same as the Victorian Average
- Unable to determine favourable or unfavourable impact on health

Why this is important

- The international medical journal The Lancet in May 2009 described climate change as the biggest global health threat of the 21st century. Climate change poses serious immediate and long term threats to the health and wellbeing of the Australian and global population.
- In Victoria, this means warmer average temperatures, more frequent and severe heatwaves, more very high fire danger days, reduced average and more variable rainfall, increased incidence and extent of drought, reduced snow cover, and sea level rise.[158]
- The Climate Change Act 2010 (the Act) recognises that Victoria's climate is changing and s. 14 of the Act introduces a duty that requires a number of key government decision-makers to take climate change into account when making specified decisions. Local government is identified as one of the decision makers that must consider climate change when preparing a municipal public health and wellbeing plan (MPHWP). [159]
- Climate change poses serious health risks to Australians. More frequent and more severe extreme weather events, including heatwaves, floods, fires and storms will increase illness, injury and death. Other effects include an increased infectious diseases, vector borne diseases, air pollution, mental illness, poor water quality and food insecurity.[160]
- Health care services in Australia are already experiencing the health effects from climate change with increases in service demand from heatwave related illnesses and deaths.[161]
- A single heatwave in Victoria in January 2009 saw a 62% increase in mortality, from both direct heat related illnesses and associated exacerbations of chronic medical conditions. It is reported that during this five day event, ambulances had a 46% increase in demand; emergency departments experienced an eight-fold increase in heat related presentations; a 2.8 fold increase in cardiac arrests; and a threefold increase in patients dead on arrival.[162]
- Temperature rises are contributing to an increased incidence of food or water borne infectious diseases. Asthma, allergies, and respiratory diseases are increasing as a result of rising temperatures and higher CO2 concentrations.[163] The mental health consequences of living with climate change are also expected to increase in incidence and severity.[164]
- Other impacts include effects on our food and water supply as decreasing productivity of land leads to declines in production volumes and nutritional value.[165]
- Shifting away from coal as a fuel source for electricity will improve air quality and reduce related deaths from lung cancer and heart disease. [166]
- Australia collects the second most waste per capita per annum (600-700 kg) in the Westernised world, following closely behind the United States (700+kgs).[167]
- Recycling plays an important role in maintaining and improving our environment. As waste rots in landfill, carbon dioxide and methane are created. The latter is a major greenhouse gas, which contributes to global warming 21 times more than carbon dioxide.[168]
- There are considerable health and economic benefits associated with action to deliver significant emissions reductions. Actions to reduce greenhouse gas emissions not only reduce the health risks associated with climate change and environmental harm, but can also improve health outcomes, and reduce health care costs from increases in physical activity, improved air quality and improved diet. [169]

2.1.2.12. TRANSPORT AND MOBILITY

Indicator/Measure	CoPP	Vic	
Sustainable Transport			
Percentage of adults who did not cycle at all for transport in preceding week	86.9	92.9	
Percentage of adults who did not walk for transport for trips longer than 10 minutes during the preceding week	27.1	57.4	
Percentage of employed persons who travel to work by active transport	11.4	4.5	
Percentage of road injuries - cyclists	28.7	8.6	
Percentage of road injuries - pedestrians	12.9	7.9	
Per cent of municipality within 400m of the bicycle network	76.5	26.0*	
Highly Walkable Schools' Index	1.4	1.2*	
Transport			
Passenger vehicles per 1,000 population	667.2	606.8	
Population near public transport	98.1	74.2	
Proportion of households with no vehicle	17.4	8.3	
Work journeys which are by car	45.7	66.2	
Percentage of crashes occurring on local roads	15.1	36.4	
Sealed local road requests per 100km of sealed local roads	52.1	36.6	
Sealed local roads maintained adequately	96.9	96.6	
Community satisfaction with sealed local roads	70 /100	55.5 /100	
Population density per length of road	396.8	102.1	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- Transport can affect health through the process or means of transport (i.e. the journey itself) as well as through the goal or ends of transport (i.e. providing access to destinations). Health effects from the journey may include both risks (e.g. air pollution emissions and noise from motorized vehicles, risks of road traffic injury) and benefits (e.g. the health benefits of physical activity from walking and cycling). Transport also impacts on patterns of access to services and social interaction, which in turn can affect social determinants of health.[170]
- As well as being a leading source of greenhouse gas (GHG) emissions, the transport sector is responsible for a large proportion of urban air pollution. This has major health implications, with urban air pollution estimated by WHO to cause 1.3 million deaths per year.[171]
- Overall, higher urban air pollution concentrations increase the risk of cardiovascular and respiratory disease, cancer, adverse birth outcomes, and higher death rates.[172]
- Increasing motorization in countries is known to be associated with rising road fatalities. [173] Road traffic injuries cause 1.3 million deaths and up to 50 million injuries each year. Road traffic injury was the ninth leading cause of death worldwide in 2004 and is projected to rise to the fifth leading cause of death by 2030. [174]
- Despite the scale of the problem, road traffic injury is considered largely predictable and preventable with the right measures.[175] For instance, vehicle speeds and vehicle kilometres of travel are both important risk factors for road traffic injury. Cities with strong rail systems also have fewer road traffic injuries[176]
- A World Health Organisation systematic review of health literature found that one of the most effective means of encouraging physical activity generally was through transport and urban planning policies.[177]
- Road traffic is the biggest cause of community noise in most cities. Community noise exposure has a range of health effects - as well as provoking a more general annoyance response, excessive noise exacerbates stress levels, increases blood pressure, and leads to sleep disturbance. There is increasing evidence that chronic noise-induced stress raises the risk of cardiovascular disease and that it negatively affects mental health.[178]
- Land-use patterns are key determinants of transport patterns and have both direct and indirect influences on health. By determining the proximity of people to their potential destinations, land use influences both distance travelled by motorized transport and the feasibility of non-motorized transport. Patterns of land use also influence the proximity of people to transport hazards such as air pollution, noise and pedestrian injury. Hence, the negative health impacts of transport tend to be concentrated in inner-city areas with high traffic density.[179]
- Healthier lower-carbon transport strategies also are cost-efficient investments for individuals and societies. The infrastructure costs of better networks for walking and cycling, or of siting schools nearer to residential areas, are very modest compared with the costs of developing new vehicle technologies. For households, and particularly the poor, more effective public transport and safer walking/ cycling routes can yield significant savings in travel time and expense as well as preventing disease and promoting better health. [180]
- There is some research to show that neighbourhoods based around active transport have better social outcomes. Residents on low-traffic streets are more connected to their neighbours and more "walkable" communities have higher levels of social capital (such as connectedness to neighbours, trust in other people and social engagement).[181]

2.1.2.13. EARLY YEARS

Indicator/Measure	CoPP	Vic	
AOD			
Illicit ADIS Rate 0-14yrs	5.1	4.1	
Amphetamines ADIS Rate 0-14yrs	31.1	0.3	
Pharmaceutical ADIS Rate 0-14yrs	0	0.2	
% smoking during pregnancy	6.3	11.4	
COMMUNITY CONNECTIONS			
Percentage of adults who were actively involved in their children's school	12.8	14.2	
Rate of Crime where the offender was a child or young person per 1,000 children and young people) 2011/12	18.5	22.7	
Rate of Crime where the victim was a child or young person per 1000 children and young people aged between 0-17) 2011/12	8.6	9.6	
Proportion of family violence incidents where children and young people are involved as other parties	20.4	34.5	
Rate of child protection substantiations for children aged 0 to 17 years (per 1000)	7.7	13.1	
Rate of children on child protection orders	6	5.4	
Rate of substantiated child abuse (per 1000)	4.1	6.1	
EDUCATION, EMPLOYMENT AND INCOME			
% Children whose parents report one or more concerns with child speech or language on entry to primary school	10.6	14.1	
% of children with emotional or behavioural problems at school entry	2.4	4.3	
Communication skills and general knowledge domain - developmentally vulnerable (%)	4.2	7.6	
Emotional maturity domain - developmentally vulnerable (%)	5.7	8	
Language and cognitive skills domain - developmentally vulnerable (%)	3.9	6.3	
Physical health and wellbeing domain - developmentally vulnerable (%)	5.4	7.9	
Social competence domain - developmentally vulnerable (%)	5.7	8.7	
Vulnerability on one or more domain(s) (%)	13.9	19.9	
Vulnerability on two or more domain(s) (%)	6	9.9	
Per cent prep pupils who had not attended pre-school before their first year at school	9	11*	
Percentage of Year 5 students achieving national minimum standard in numeracy	96.9	95.8	
Percentage of Year 5 students at or above national minimum standard in literacy	96.1	94.3	
Percentage of Year 3 students at or above national minimum standard in literacy	96.6	95.5	
Percentage of Year 3 students at or above national minimum standard in numeracy	96.9	95.3	
Kindergarten participation rate	87.9	98.1	
Proportion of children attending kindergarten whose placement attracts a kindergarten fee subsidy	4	26.8	
School children attending government schools	49.8	61.6	
Percentage of jobless families with children under 15	8.6	12.3	
% children in low income, welfare-dependent families	14.3	22.6	
One-parent headed families	11.7	15.5	
HEALTH SERVICES			
Number of Child FIRST assessments per 1,000 eligible pop	14.4	12.2	
Per cent of families accessing Family and Community Support Services	10.3	6.2	
Rate of hospital separations, for all principal diagnosis, per 1,000 children aged 0 to 8 years	236.2	231.2	
Potentially preventable hospitalisations due to dental conditions for children 0-4 years (per 1,000 population)	2.73	3.85	
Low Birthweight babies	5.3	6.6	
Child fully breastfed: At 6 Months %	53.9	34.0	
Child fully breastfed: On Discharge %	79.2	72.8	
Immunisation Rate (12-<15 Months) % Fully	93.0	93.2	
Immunisation Rate (24-<27 Months) % Fully	88.9	91.1	
Immunisation Rate (60-<63 Months) % Fully	88.6	93.1	
Total Participation Rates for Key Ages and Stages Consultations: 3.5 Years	69.8	66.1	
Total Participation Rates for Key Ages and Stages Consultations: Home Consultation	101.7	100.9	
Participation in first MCH home visit	103.9	102.4	
Infant enrolments in the MCH service	99.8	98.3	
Participation in the MCH service	84.2	78.5	
Participation in the MCH service by Aboriginal children	87.2	70.6	
INDIVIDUAL HEALTH			
Reported health status of Prep children as Excellent/very good	95.5	91.4	
Proportion of children with an allergy that leads to anaphylaxis	2.1	2	
MENTAL HEALTH			
Top causes of family stress in the past 12 months, for children entering school in Port Phillip - move to a new school	26.9	14.1	
% Children at entry to primary school who's parent report high family stress	10.4	9.9	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- The early years of a child's life provide the foundation for future heath, development and wellbeing. A positive start in life helps children to reach their full potential, while a poor start increases the chances of adverse outcomes.
- This can have far-reaching consequences, not just throughout the lives of the children themselves but potentially for successive generations. Social and economic factors are powerful determinants of infant and child mortality in both developed and developing countries.[182] Infant and child mortality have been shown to be associated with parental disadvantage.[183]
- Children living in households where parents misuse drugs are more likely to develop behavioural and emotional problems, tend to perform more poorly in school and are more likely to be the victims of child maltreatment. Children with parents who drink heavily, smoke or take drugs are more likely to do so themselves, leading to intergenerational misuse and harms. Family breakdown and job loss is also associated with problematic drug use. [184]
- Smoking during pregnancy is a significant risk factor for the mother and her unborn baby. This increases the risk of spontaneous abortion and ectopic pregnancy. It can also result in poor health outcomes for the newborn, including low birthweight, intrauterine growth restriction, prematurity, placental complications, birth defects, lung function abnormalities and respiratory symptoms, and perinatal mortality. The effects of smoking during pregnancy persist into infancy and childhood. Smoking during pregnancy has been found to be associated with sudden infant death syndrome (SIDS), as well as childhood cancers, high blood pressure, asthma, obesity, lowered cognitive development and psychological problems.[185]
- Literacy and numeracy skills enable children to engage in learning and ultimately to fully participate in society and lead productive lives. Literacy means more than just being able to read and write—it is related to learning in all areas and enables people to develop knowledge and understanding. Numeracy is also central to life inside and outside school, and is important in many occupations as well as daily life.
- Literacy and numeracy skills are the building blocks for further educational attainment, social development and employment. Literacy means more than just being able to read and write—literacy is integrally related to learning in all areas of the curriculum and enables individuals to develop knowledge and understanding.[186] Numeracy is also central to many areas of education, and life outside school. It is the ability to use, apply, interpret, and communicate mathematical information and ideas, and is important in many types of employment and daily life.[187]
- Breastfeeding provides babies with the best start in life and is a key contributor to infant health. Australia's dietary guidelines recommend exclusive breastfeeding of infants until six months of age, with the introduction of solid foods at around six months and continued breastfeeding until the age of 12 months.
- Evidence shows that breastfed babies are less likely to suffer from gastroenteritis, respiratory illness and middle ear infection. [188] Breastfeeding also benefits mother's by promoting faster recovery from childbirth; and reducing the risks of breast and ovarian cancers in later life. [189]
- Protective effects of breastfeeding in infancy may also extend to later life, with reduced risks of obesity and chronic disease.[190] The Productivity Commission noted that several Australian and overseas studies estimated substantial hospitalisation costs associated with premature weaning because of the association with infant illness. [191]
- Birthweight is a key indicator of infant health and a principal determinant of a baby's chance of survival and good health. Low birthweight is a risk factor for neurological and physical disabilities, with the risk of adverse outcomes increasing with decreasing birthweight. Children with extremely low birthweight (less than 1,000 grams) are more likely to have psycho-social problems and an increased risk of experiencing difficulties at school. [192] The health effects of low birthweight can also continue into adulthood. Research has found an increased risk of Type 2 diabetes, high blood pressure, metabolic and cardiovascular diseases and, possibly, obesity in later life among adults who were of low birthweight.
- The Maternal and Child Health Service (MCH) is a universal primary care service for Victorian families with children from birth to school age. The service provides a comprehensive and focused approach for the promotion, prevention, early detection, and intervention of the physical, emotional or social factors affecting young children and their families.[193]
- The 10 Key Ages and Stages (KAS) child health assessments provide an opportunity for parents to gain information, support and advice, to assist in caring for their child. Assessments are intended to support parents to keep their baby well and provide the opportunity for any potential problems to be dealt with promptly. The assessment evaluates the child's development at particular ages, including growth, physical movements, behaviour, play, physical examinations, hearing and eye screenings and behavioural interactions with family members and peers, and as such, participation in KAS assessments are important in positive child health.
- Australia has shown significant progress in reducing infant and child deaths, particularly through the work of neonatal intensive care units, increased community awareness of the risk factors for sudden infant death syndrome (SIDS), and reductions in vaccine-preventable diseases through national childhood immunisation programs.
- Children who are not fully immunised are at risk of contracting vaccine-preventable diseases, such as diphtheria, tetanus, measles and polio, and the short- and long-term health consequences associated with these. Immunisation also plays a role in protecting individuals who are not immunised, through the concept of 'herd immunity'. Immunisation coverage needs to exceed 90% in order to achieve and maintain the level of herd immunity needed to interrupt the spread of vaccine-preventable diseases. [194]
- The Australian Early Development Census (AEDC) is a population measure of how young children in Australia have developed by the time they start their first year of full-time school.
- Differences in children's development emerge early and are evident by the time they reach school. Children who enter school when they are not ready for this type of educational setting have lower levels of academic achievement and are at an increased risk of teenage parenthood, mental health problems, getting into trouble with the law and poorer job outcomes.[195]
- All families need support to meet their own and their children's needs. Some families need a family support service when they are experiencing difficulties that make them more vulnerable, and impact on their parenting and family life. ChildFIRST (Child and Family Information, Referral and Support Teams) have been established across Victoria to provide an entry point into family services or other support services for vulnerable children, young people and their families to protect and promote their healthy development.
- Adult survivors of childhood abuse and neglect tend to experience higher levels of alcohol and substance abuse, homelessness, chronic physical ill health, and mental health problems such as depression, self-harm and post-traumatic stress. They are also more likely to experience abuse and violence in adulthood, and abuse or neglect their own children. The short- and long-term consequences of abuse are thought to be related to the type, severity and duration of abuse, and the context in which it occurs.[196]

2.1.2.14. YOUTH AND MIDDLE YEARS

Indicator/Measure	CoPP	Vic	
AOD			
% 12-14 year olds who drank alcohol in the past 30 days	28.6	23.8	
% 15-17 year-olds who drank alcohol in the past 30 days	50.1	52.3	
Alcohol Ambulance Rate 15-24yrs	144.7	55.8	
% 12-14 year-olds who ever - sniffed glue or chromed	4.8	7.9	
% 12-14 year-olds who ever - used marijuana	9	3.7	
% 12-14 year-olds who ever - used other illegal drugs	0	1	
% 15-17 year-olds who ever - sniffed glue or chromed	7.7	7	
% 15-17 year-olds who ever - used marijuana	16.2	16	
% 15-17 year-olds who ever - used other illegal drugs	6.4	4.7	
Illicit Ambulance Rate 15-24yrs	62.8	29.2	
Crystal Methamphetamine Ambulance Rate 15-24yrs	12.2	6.7	
Pharmaceutical Ambulance Rate 15-24yrs	43.5	29.4	
% 12-14 year-olds who smoked in the past 30 days	5	5.6	
% 15-17 year-olds who smoked in the past 30 days	18.8	17.7	
Proportion of adolescents who are exposed to tobacco smoke in the home	14.4	24.5	
COMMUNITY CONNECTIONS			
Proportion of adolescents who 'agreed' or 'strongly agreed' that they have access to basic services	84.5	76.1	
Proportion of adolescents who report adults in neighbourhood pay attention to what adolescents say	63.3	61	
Proportion of adolescents who report opportunities to make decisions regarding activities in neighbourhood	44.4	47.1	
COMMUNITY SAFETY			
Crime where the offender was a young person 10 to 17 years old (rate per 1000)	77.9	65.3	
Crime where the victim was a young person 10 to 17 years old (rate per 1000)	27.6	17.5	
Proportion of adolescents who feel safe in their neighbourhood	83.7	82.4	
EDUCATION, EMPLOYMENT AND INCOME			
% Children who are connected to their school in years 5/6	84.0	84.8	
% Children who are connected to their school in years 7-9	65.0	62.3	
% Students in Years 3, 5, 7 and 9 who did not meet or exceed the benchmarks for literacy	17.0	8.4	
% Students in Years 3, 5, 7 and 9 who did not meet or exceed the benchmarks for numeracy	15.2	6.5	
% young people 16-24 years receiving an unemployment benefit	1.7	3.4	
Disengaged youth (aged 15-24 not employed or in education)	6.5	8.1	
Youth unemployment rate (persons aged 15-24)	9.7	12.0	
Youth Allowance / Population 20-24 (%)	24.2	22.0	
HEALTH BEHAVIOURS			
Proportion of adolescents who eat the minimum recommended serves of fruit and vegetables every day	20.4	19	
Proportion of adolescents who do the recommended amount of physical activity every day	9.8	12.3	
Proportion of adolescents who use electronic media for more than two hours per day	47.7	58.7	
Proportion of adolescents aware of sun protection	0.8	3.1	
Proportion of adolescents who brush their teeth at least twice per day.	72.9	67.4	
HEALTH SERVICES			
Proportion of adolescents who feel that they can access physical health services if needed	86.2	79.4	
Rate of adolescent hospitalisation (per 1,000)	58.1	74.7	
Young people who feel that they can access dental services when needed	87.5	78.3	
INDIVIDUAL HEALTH			
Proportion of adolescents who are satisfied with their quality of life	73.9	77.1	
Proportion of adolescents with self-rated good health	85.5	89.2	
Proportion of adolescents with special health care need	12.9	15.3	
Proportion of adolescents with asthma	11.4	11.6	
Proportion of sexually active adolescent females who have used contraception to avoid pregnancy	66.7	78.9	
Proportion of sexually active adolescents who practice safe sex by using a condom	42.3	58.1	
Rate of births to women aged under 19 years (per 1,000 women in this age group)	12.5	14.3	
MENTAL HEALTH			
Young people who feel that they can access mental health services when needed	58.7	70.4	
Proportion of adolescents living in families with healthy family functioning	81.5	83.1	
Proportion of adolescents who have someone to turn to for advice when having problems	86.8	86.1	
% of adolescents who report being bullied	17.9	13.8	
Level of resilience - Year 3-6: good/excellent	65.0	N/A	
Level of resilience - Year 7-12: good/excellent	35.0	N/A	
Proportion of adolescents with a high level of emotional wellbeing	58.7	61.1	
Proportion of adolescents with an eating disorder	3.4	2.4	
Proportion of adolescents with the highest level of psychological distress	11.4	13	
Psychiatric hospitalisation rate for young people aged 10 to 17 years old (per 1,000)	16.6	6.7	
SUSTAINABILITY, CLIMATE CHANGE AND THE ENVIRONMENT			
Proportion of adolescents who 'agreed' or 'strongly agreed' that they have access to playgrounds, parks or gyms near home	61.9	48.3	
Proportion of adolescents who perceived their neighbourhood to be clean	76.7	77.2	
TRANSPORT AND MOBILITY			
Proportion of adolescents living in neighbourhoods with heavy traffic	16	19.3	
Proportion of adolescents whose lack of access to transport impacts on their capacity to work, study, see a doctor or socialise	17.2	9.3	

Why this is important

- The health and wellbeing of young people not only affects their immediate quality of life and productivity but also shapes the future health of the whole population and, in a broader social sense, the health of society. Tackling health and wellbeing issues when they occur in adolescence is socially and economically more effective than dealing with enduring problems in adulthood. Many of the attitudes and behaviours— even the illnesses—that largely determine adult health and wellbeing have their origins in childhood, adolescence and early adulthood. [197]
- Youth is a time of rapid emotional, physical and intellectual changes as the transition is made from childhood to adolescence to independent adulthood, and is also a crucial period for establishing positive health and social behaviours. During this period, young people acquire a range of skills and behaviours, face a range of life events and make decisions that can influence their physical and psychological health, their social development, and their educational and employment opportunities.[198]
- When young people are in good health they are more likely to achieve better educational outcomes, make a successful transition to full-time work, develop healthy adult lifestyles, experience fewer challenges forming families, and are more actively engaged.[199]
- Young people who are unable to make the transition to adulthood smoothly can face significant difficulties and barriers in both the short and long term. Youth is a critical period for the reinforcement of positive health and social behaviours, as behaviours at this age are strong predictors of behaviours in later life. [200]
- A young person's learning and education is integral to their overall health and wellbeing as well as their future productivity and contribution to society. In the long term, learning is essential to securing a job, and participating in and connecting with the wider community. Early educational experiences also influence the onset and progression of physical and mental impairments across the life course, and individuals with higher levels of education are less likely to smoke, be physically inactive and overweight or obese than those with lower levels of education. [201]
- Adolescents who were bullied reported higher absenteeism, felt less connected to school, experienced lower academic achievement and consequent lower vocational and social achievement, school failure, lower self-esteem, higher levels of physical harm, psychological and health problems (such as anxiety, depression, physical and somatic symptoms, and risk of suicide), and alcohol and substance use. [202]
- Secure and satisfactory employment offers young people not only financial independence but also a sense of control, self-confidence and social contact. In contrast, unemployment, insecure employment and unfavourable working conditions have all been associated with low self-esteem and poor physical and mental health. Unemployment in particular has been shown to be associated with adverse health effects, such as lower levels of general and physical health, more anxiety and depression, higher rates of smoking, and higher suicide rates. [203]
- Although most young people rate their health as good or excellent, some serious health problems specific to this age group have the potential to undermine an individual's overall wellbeing, including mental disorders, overweight, obesity or problems with substance use.[204]
- Certain mental disorders have implications for a young person's psychosocial growth and development, health care needs, educational and occupational attainment, and involvement with the justice system.[205]
- In adolescence and early adulthood, young people are most vulnerable to the influences of peer pressure and popular culture, and may be inclined to experiment, push boundaries and take

Why this is important

risks that could result in accidents, injury and substance use.[206] This is the stage of life when young people engage in behaviours that can jeopardise not only their current state of health but often their health for years to come.

- The result is an over-representation of young people in injury and poisoning death statistics, in Australia and around the world. In the long term, alcohol and other drug use can lead to depression, infections with bloodborne diseases, damage to the liver, heart and brain, and increased risk of cancers and other serious health conditions [207]
- Young people are also likely to engage in unsafe sexual behaviours and intravenous drug use. Young people are therefore particularly vulnerable to contracting and transmitting vaccine-preventable diseases, sexually transmitted infections (STIs) and bloodborne viruses. A lack of knowledge about STIs, inconsistent condom use, or a lack of communication and negotiation skills which can make using condoms difficult, also contributes to adolescents being at increased risk.[208] Sexual activity can also result in unplanned pregnancies for young women. Teenage motherhood poses significant long-term risks, including poorer health, educational and economic outcomes for both mother and child.[209]
- Overweight and obesity increases a young person's risk of poor health and is a risk factor for developing many serious health conditions in both the short and long term. In the short term, overweight and obesity affects the psychological wellbeing of young people, and increases the risk of developing cardiovascular conditions, asthma and Type 2 diabetes. Long-term health consequences include adult obesity, increased rates of coronary heart disease, diabetes, certain cancers, gall bladder disease, osteoarthritis and endocrine disorders.
- Regular physical activity is important in maintaining good health and reduces the risk of overweight or obesity, high blood pressure and Type 2 diabetes, and improves the psychosocial wellbeing of young people.
- Good nutrition is important in supporting the rapid growth and development that occurs during childhood and adolescence, and is important in maintaining good health. Consuming a variety of foods, including adequate daily consumption of fruit and vegetables and choosing foods low in salt, is a protective factor against many diseases including coronary heart disease, hypertension, stroke, Type 2 diabetes, oxidative stress and many forms of cancer. The development of healthy eating habits is particularly important during childhood and adolescence as these habits are likely to persist across the lifespan. [210]
- Asthma is one of the most common long-term conditions affecting young Australians. Young people with asthma report a lower quality of life than their healthy peers, although the extent to which asthma affects their quality of life is dependent on the severity of the condition.[211]
- Sun exposure during childhood and adolescence is considered to be the most significant risk factor for developing the most serious type of skin cancer—melanoma—as well as other types of skin cancer in adulthood. While the risk of melanoma increases with age, melanoma remains the most common cancer diagnosed among young Australians aged 15–24 years.[212]
- Social capital is an important aspect of the social context in which a young person develops. Studies looking specifically at the link between social support and adolescent health have found a relationship between a young person's low level of social support and a number of health risk factors, including physical inactivity, depression and tobacco smoking. Similarly, studies have found that young people with high levels of social support report better self-assessed health than those with low support.[213]

2.1.2.15. OLDER ADULTS

Indicator/Measure	CoPP	Vic	
AOD			
Alcohol Death Rate 65+yrs	4.7	4.9	
Alcohol Ambulance Rate 65+yrs	41.6	19	
Illicit ADIS Rate 65+yrs	7.5	2.3	
COMMUNITY CONNECTIONS			
Persons aged 75+ living alone	45.7	35.9	
EDUCATION, EMPLOYMENT AND INCOME			
Seniors unemployment rate (persons aged 55 or more)	4.9	3.7	
Aged Pension/ Population 65+ (%)	49.9	67.3	
HEALTH BEHAVIOURS			
Cervical cancer screening participation, females aged 50-69 years	62.0	60.0	
Percentage of females 50-79 years who had a mammogram in previous two years	70.2	73	
HEALTH SERVICES			
Aged care High-Care beds per 1,000 eligible population	66	65	
Aged care Low-Care beds per 1,000 eligible population	127	89	
HACC clients aged 0-64 per 1,000 HACC target pop	257.2	927.9	
HACC clients aged 65+ per 1,000 HACC target pop	906.9	1514.8	
Percentage of HACC indigenous clients (per Indigenous population)	11.4	7.4	
Time taken to commence the HACC service (days)	30.1	18.7	
Compliance with Community Care Common Standards	94.4	87.1	
Percentage of eligible residents receiving HACC services	20.2	26.7	
Percentage of eligible CALD residents receiving HACC services	14.7	19.2	
INDIVIDUAL HEALTH			
Percentage of persons aged 65 years and over with a profound or severe disability	16.6	18.5	
MENTAL HEALTH			
Number of mental health clients aged 55+ years	297	15034	
Projected annual growth rate of dementia to 2050	4.4	4.1	

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- Older Australians are a diverse group, with different ages and socioeconomic backgrounds and different life experiences and lifestyles. These factors all influence the ageing process. Today's older Australians live generally healthier and longer lives than previous generations. Life expectancy is increasing as most Australians enjoy greater standards of living and better access to high-quality healthcare.
- This also means that the proportion of older people - that is, people aged 65 and over - in the Australian population is increasing. The number of people aged 65+ has more than tripled over fifty years and there has also been a ninefold increase in the number of people aged 85+.[214]
- Increases to life expectancy are good news, reflecting older Australians' improved health and well-being. Various health surveys have found that an increasing proportion of older Australians rate their health as good, very good or excellent.[215]
- Most older Australians report having healthy lifestyles; in 2014–15, most people aged 65 and over reported very low levels of smoking (93% not current smokers), 41% reported being sufficiently active during the preceding week, and more than half (51%) were fully vaccinated. However, 7 in 10 older people are overweight or obese.
- While longer lives are a positive outcome for individuals, at the population level, increased lifespans and older age generally also result in increased ill health. Many health conditions and associated impairments, such as arthritis, dementia, and hearing loss, become more common as people get older. [216]
- The most commonly reported condition (excluding short- and long-sightedness) is arthritis, affecting half of people aged 65 and over. Hypertensive disease and hearing loss follows. Other conditions that have higher prevalence rates in older Australians include heart, stroke and vascular diseases, diabetes, and osteoporosis.[217]
- In 2013, the leading causes of death of older Australians were coronary heart disease, dementia, and cerebrovascular disease (such as stroke). Deaths due to cerebrovascular disease have historically been the second leading cause of death in Australia; however, in 2013 this moved to the third leading cause. Deaths due to dementia have increased over the last decade, and in 2013, for the first time, dementia and Alzheimer disease became the second leading cause of death. Twice as many women as men died from dementia, and the overall number of deaths from dementia had increased by 137% since 2004.[218]
- In Australia, the aged care system offers a range of care options to meet the different care needs of each individual. This enables people to enjoy a good quality of life for longer and to participate fully in the community. It also reduces the general demand for health services.[219]
- Two mainstream care options are available for older people: residential aged care and community-based aged care. Often people first enter the aged care system through community-based care (Home and Community Care/ HACC in Victoria), before eventually progressing to permanent residential care.
- Residential aged care provides care within a supported accommodation setting for those whose care needs can no longer be met within their own homes. Permanent care offers ongoing care in a residential aged care facility, tailored to an individual's needs. While permanent care was previously offered at two levels - low and high care - this distinction was removed in 2014.
- Interestingly, most older Australians are not using aged care services; during 2014–15, 2 in 3 (67%) older Australians did not use aged care services.

2.1.2.16. SOCIAL AND CULTURAL DIVERSITY

Indicator/Measure	CoPP	Vic	
COMMUNITY CONNECTIONS			
Percentage of adults who are accepting of diverse cultures	73.6	50.6	
Percentage of adults who think that multiculturalism makes life in the area better	66.5	51	
COMMUNITY SAFETY			
Proportion of alleged offenders identified as Indigenous (%)	5.5	5.9	
EDUCATION, EMPLOYMENT AND INCOME			
Disability pension recipients per 1,000 eligible population	43.3	54.9	
Disability Pension / Total population (%)	3.0	3.2	
HEALTH SERVICES			
Indigenous community health clients per 1,000	0.5	0.1*	
Percentage of HACC indigenous clients (per Indigenous population)	11.4	7.4	
Percentage of eligible CALD residents receiving HACC services	14.7	19.2	
INDIVIDUAL HEALTH			
Percentage of persons aged 65 years and over with a profound or severe disability	16.6	18.5	
Persons with core activity need for assistance	3.0	4.8	
DEMOGRAPHICS			
Provide unpaid assistance to a person with disability, long term illness or old age	8.5	11.3	
Born in a non-English speaking country	18.0	20.0	
Born overseas	31.0	26.2	
Low English proficiency	2.8	4.0	
Speaks LOTE at home	19.7	23.0	
Proportion of population who are Aboriginal or Torres Strait Islander	0.3	0.7	

- The majority of people born overseas come from the UK, New Zealand and Greece.
- The largest non-English speaking country of birth was India.
- Greek, Russian and Mandarin are the primary languages other than English spoken at home.

** Regional figures used as state data not available*

Less favourable than the Victorian Average
More favourable than the Victorian Average
Same as the Victorian Average
Unable to determine favourable or unfavourable impact on health

Why this is important

- The social determinants of health related to socioeconomic position help to explain the differences seen in socially and culturally diverse communities. Factors such as ethnicity, culture, religion, sexual orientation and ability all play an important role in one's health status.
- Studies have found that between one-third and one-half of the health gap between Indigenous and non-Indigenous Australians are associated with differences in socioeconomic position.[220] Despite improvements in Indigenous health in recent years (such as the decline in infant and child mortality and in mortality related to circulatory and kidney diseases), Indigenous Australians have a lower life expectancy, higher rates of chronic and preventable illnesses, and poorer self-reported health than non-Indigenous Australians. [221] Indigenous Australians experience a disproportionate amount of harms from alcohol, tobacco and other drug use and are more likely to die of smoking-related illnesses, such as diseases of the respiratory system and cancers. [222] Smoking is the primary cause of chronic disease among Aboriginal and Torres Strait Islander peoples.[223]
- Due to a range of factors - some of which may be directly related to a person's disability - people with disability, as a group, experience significantly poorer health than those without disability. Disability may affect a person's mobility, communication or learning and can also affect their income and participation in education, social activities and the labour force - all known social determinants of health. [224]
- Half of people aged 15–64 with severe or profound core activity limitation self-assessed their health as 'poor' or 'fair', compared with 5.6% for people without disability. [225] They had a higher prevalence of various types of long-term health conditions and were 3.3 times as likely as people without disability to have three or more long-term health conditions.[226] Half (50%) had mental health conditions, compared with 7.7% of people without disability. [227] One in 5 had arthritis - 3.9 times the rate for people without disability.[228]
- People with severe or profound core activity limitation were also 1.7 times as likely as those without disability to be obese. Almost half did no exercise, compared with 31% of people without disability. They are twice as likely as those without disability to be current daily smokers and 1.8 times as likely to start daily smoking before the age of 18. Adults with severe or profound core activity limitation were 18 times as likely as those without disability to have a very high level of psychological distress. [229]
- Australians of diverse sexual orientation, sex or gender identity may account for up to 11 per cent of the Australian population. Almost half of all gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) people hide their sexual orientation or gender identity in public for fear of violence or discrimination significantly affecting their mental health. It was also found that nearly a third hide their sexuality or gender identity when accessing services.[230] GLBTIQ people are three times more likely to experience depression compared to the broader population and report higher rates of smoking.[231]
- Community acceptance of multiculturalism is an important component of social cohesion. In Australia, 47 per cent of people born in non-English speaking countries reported experiencing race-based discrimination.[232] Experiencing race-based discrimination can result in; anxiety, depression, poor self-esteem, and stress-related illness; unhealthy coping behaviours, such as dropping out of physical activity and community activities, smoking, and misusing alcohol or drugs; restricted access to education, information, employment, social support and human rights; long-term social and material disadvantage; and lower rates of participation in sports, cultural and civic activities. [233]

2.1.2.17. GENDER

Topic/Subtopic	Indicator/Measure	CoPP	Vic	
AOD				
	Alcohol Ambulance Rate Male	109.7	44.3	
	Alcohol Ambulance Rate Female	53.5	24.7	
	Alcohol SRI HAH Male	2	2.2	
	Alcohol SRI HAH Female	1	1.2	
	Alcohol Assault HAH Rate Male	26.6	15.3	
	Alcohol Assault HAH Rate Female	12.8	10.9	
	Alcohol Family Violence Rate Male	14.7	10.6	
	Alcohol Family Violence Rate Female	32.3	32.9	
	Illicit Ambulance Rate Male	38.7	16.3	
	Illicit Ambulance Rate Female	19.7	8.2	
	Amphetamines Ambulance Rate Male	3.3	1.4	
	Amphetamines Ambulance Rate Female	2	0.6	
	Crystal Methamphetamine Ambulance Rate Male	9.2	3.4	
	Crystal Methamphetamine Ambulance Rate Female	2.7	1.9	
	Other Stimulants Ambulance Rate Male	4.7	1.2	
	Other Stimulants Ambulance Rate Female	2.7	0.6	
	Pharmaceutical Ambulance Rate Male	20.5	13.5	
	Pharmaceutical Ambulance Rate Female	23.8	20.3	
COMMUNITY SAFETY				
	Rate of sexual offence victim reports: female (per 10,000)	10.6	10.2	
	Rate of sexual offence victim reports: male (per 10,000)	2.9	2.6	
	Stalking, Harassment and Threatening Behaviours victim reports (female) rate per 10,000	6.8	N/A	
	Stalking, Harassment and Threatening Behaviours victim reports (male) rate per 10,000	3.9	N/A	
	Sexual offences victim reports (female) rate per 10,000	10.6	N/A	
	Sexual offences victim reports (male) rate per 10,000	2.9	N/A	
	Low gender equality score	32.1	35.7	
	Percentage of reported incidents of family violence; female reporting	73.3	76.1*	
	Percentage of reported incidents of family violence; male reporting	26.7	23.9*	
	% People who feel safe when walking alone at night (female)	71.8	N/A	
	% People who feel safe when walking alone at night (male)	85.3	N/A	
EDUCATION, EMPLOYMENT AND INCOME				
	Completion of Year 12 or equivalent (female)	65	N/A	
	Completion of Year 12 or equivalent (male)	61.5	N/A	
	Percentage of persons unemployed (female)	4.4	N/A	
	Percentage of persons unemployed (male)	4.7	N/A	
	Chief Executives, General Managers and Legislators (male)	67.4	N/A	
	Chief Executives, General Managers and Legislators (female)	32.6	N/A	
	Female income < $400 per week	27.4	47.1	
	Male income < $400 per week	20.7	32.1	
	% Below minimum weekly wage ($0-$599); female	29.5	N/A	
	% Below minimum weekly wage ($0-$599); male	21.6	N/A	
	One-parent headed families, % female parent	81.8	82.8	
	One-parent headed families, % male parent	18.2	17.2	
HEALTH BEHAVIOURS				
	Cervical cancer screening participation, females aged 50-69 years	62.0	60.0	
	Percentage of females 50-79 years who had a mammogram in previous two years	70.2	73	
	Percentage of females who had a pap test in the previous two years	67.8	72.1	
INDIVIDUAL HEALTH				
	Female life expectancy	82.8	84.8	
	Male life expectancy	75.7	78.1	
	Proportion of population that are Female	51	51	
	Persons with core activity need for assistance (female)	3.5	N/A	
	Persons with core activity need for assistance (male)	3.0	N/A	
	Notifications of chlamydia (female) rate per 10,000	41.3	N/A	
	Notifications of chlamydia (male) rate per 10,000	40.8	N/A	
	Notifications of gonorrhoea (female) rate per 10,000	2.2	N/A	
	Notifications of gonorrhoea (male) rate per 10,000	18.3	N/A	
	Notifications of HIV (newly acquired) per 10,000 population (female)	0.3	N/A	
	Notifications of HIV (newly acquired) per 10,000 population (male)	2.6	N/A	
	Number of notifications of Hepatitis B (female) rate per 10,000	0.99	N/A	
	Number of notifications of Hepatitis B (male) rate per 10,000	1.2	N/A	
MENTAL HEALTH				
	Personal wellbeing index score (females)	79	N/A	
	Personal wellbeing index score (males)	75.7	N/A	
	Percentage of adults reporting lifetime prevalence of anxiety/depression (female)	27.5	N/A	
	Percentage of adults reporting lifetime prevalence of anxiety/depression (male)	14.3	N/A	
TRANSPORT AND MOBILITY				
	Experienced transport limitations (female)	22.2	N/A	
	Experienced transport limitations (male)	28.9	N/A	

**The above traffic light system analysis considers the CoPP female against male figure, as opposed to analysis against state figures. This is to provide context regarding the differences in health and wellbeing indicators that females experience when compared to males based on a gender equity principle. For comparison of CoPP and State figures, please see each individual topic table previously provided.*

- Less favourable than the Victorian Average
- More favourable than the Victorian Average
- Same as the Victorian Average
- Unable to determine favourable or unfavourable impact on health

Why this is important

- Gender is one of the most powerful determinants of health outcomes. Gender refers to the socially constructed characteristics of women and men – such as the norms, roles and relationships that exist between them. Gender expectations vary between cultures and can change over time. Gender norms, relations and roles also impact the health outcomes of people with transgender or intersex identities.
- While most people are born either male or female (biological sex), they are taught appropriate behaviours for males and females (gender norms) – including how they should interact with others of the same or opposite sex within households, communities and workplaces (gender relations) and which functions or responsibilities they should assume in society (gender roles).
- When individuals do not conform to established gender norms, relations or roles, they often face stigma, discriminatory practices or social exclusion – all of which negatively impact health.
- Gender norms, roles and relations result in differences between men and women in; exposure to risk factors or vulnerability; household-level investment in nutrition, care and education; access to and use of health services; experiences in health-care settings; and social impacts of ill-health.
- Research has consistently shown a sex differential in illness and mortality. Males have a shorter life expectancy, higher mortality from most causes of death (particularly injuries and intentional self-harm) and a higher lifetime risk of many cancers and chronic conditions. [234]
- Overall, males are more likely than females to engage in risky lifestyle behaviours such as smoking, consumption of alcohol and illicit drug use, drink sugar sweetened beverages and are more likely to be overweight and obese. Health service use is also generally lower among males, particularly services associated with preventive health, such as lifestyle modification or cancer screening.[235]
- The suicide rate for males was at least three times higher than females, with more males reporting that they do not feel valued by society. Death rates from motor vehicle accidents were nearly three times higher in males than females, and drug-induced death rates were over one and half times higher than those of females. [236]
- Proportions of males and females with disability are similar, however more females report profound or severe core activity limitation. [237]
- Females were slightly more likely to report a long-term condition than males, continuing a long-term trend. Arthritis continues to be a commonly reported long-term health condition for both males and females, especially those aged 65 years and over, where the proportions with arthritis grew to around 41% of men and 60% of women.[238]
- Females are 10 per cent more likely to suffer from cardiovascular disease than men and have higher rates of osteoarthritis, osteoporosis, breast cancer and asthma.[239] Females are also more likely to develop dementia than males. [240]
- Women experience common mental health disorders such as depression, post-traumatic stress disorder and anxiety at two to three times the rate of men. They also make up over 60 per cent of reported cases of intentional self-harm and attempted suicide in Australia (however more males are successful in suicide attempts. [241]
- Female participation rates in sport and recreation are lower than those of men. This trend begins at an early age and persists into adulthood. [242]

Why this is important

- Physical activity improves mental and physical health, confidence and self-esteem. The benefits of sport and recreation are particularly significant for women and girls, who are twice as likely as men to suffer from depression, and are more likely to suffer lower self-esteem and body image issues. [243]
- Being overweight or obese is the equal leading risk factor for poor health in Australian females, but tobacco smoking is the leading risk behaviour for males. Alcohol does not feature as prominently as a risk factor for women as it does for men, and intimate partner/family violence has significantly more health consequences for women than men.[244]
- The majority of victims of family violence —75 per cent—are women. Violence against women is the leading cause of preventable death, disability and illness for women aged between 15 and 44 years. [245]
- A 2012 study found that Victoria had a higher proportion of women who had experienced multiple incidents of violence during the 12 months prior to the survey, compared to the national average. There are considerable savings to be realised by reducing violence against women and girls. In Victoria family violence costs our economy more than $3.4 billion a year and constitutes 40 per cent of police work. [246]
- Gender inequalities in workforce participation, caring responsibilities and remuneration contribute to poor health outcomes for women. Women's concentration in low-paid, low-status and often insecure lines of work exposes them to greater stress and vulnerability to serious illness, including heart disease, mental illness and musculoskeletal disorders. Women also tend to be underrepresented in clinical trials for new drugs, treatments and devices in Australia and around the world. This can mean that gender responsive data and research is limited. [247]
- The most unequal societies also tend to be the least cohesive, with higher rates of anti-social behaviour and violence. We also know that discrimination can lead to exclusion and that those who find themselves on the fringes are more likely to encounter discrimination. In contrast, countries that maintain greater equality between men and women also experience a range of social benefits, including increased social cohesion, connectivity and greater health and wellbeing. [248]
- In 2002 the World Health Organization (WHO) released the Madrid Statement, stating: *"To achieve the highest standard of health, health policies have to recognize that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities."*[249]
- Initiatives specifically targeting either women or men or equality between them are considered to be necessary and complementary to a mainstream strategy. The objective of such gender specific initiatives is to create optimal outcomes for women and men by compensating for historical and social disadvantage that prevent men and women from operating on a level playing field.[250]
- Gender equity means that women and men are given equal opportunity to realise good health.[251] A gender equity approach recognises that gender is a determinant of health and that men and women face different challenges in managing their health, including their different health requirements and the different barriers they face in accessing services.
- Gender equity is not a question of which sex 'really' has worse health. Rather, it is about social justice in the sometimes gendered distribution of those resources fundamental to good health.

3. WHAT?

OUR FINDINGS AND CHALLENGES

Contents

About this section

The following section provides analysis of the 11 defined topics, 29 sub-topics and 5 demographic cohorts from the 'Who?' section of this report to identify emerging health issues.

Additionally, during the 2017 Integrated Council Plan process the organisation identified seven long-term challenges that will impact the liveability of our City, our infrastructure and the services we provide to our community. Commentary surrounding what each challenge means for health and wellbeing has been provided.

3.1. OUR EMERGING HEALTH ISSUES

Identifying emerging health issues requires the use of more than epidemiology and statistics. We must use the principles of social justice, consider costs of the issue for our community, as well as the potential for prevention or early intervention.

The emerging health issues should stem from an established need in the community; align to federal, state and local government policies and plans; and have measurable goals and objectives to enable identification of outcomes.
It is crucial to define to what extent local government can influence the particular need in the community. It is important that strategic objectives are within the scope of local government and that resources are allocated to the most appropriate health need in the Port Phillip community.

Arguably the most important component of identifying emerging health issues lies within community and stakeholder engagement. Understanding of existing and/or emerging issues and their solutions, will be found in our community, through their lived experience and by virtue of their diverse knowledge and skills.

3.1.1.1. PROCESS

The 11 topics and subsequent 29 sub-topics identified in the 'Who?' section of this Background Report have been assessed against the criteria below. A full account of each topic assessed against this criteria, including the scoring process, is provided in 'Appendix 2 – Emerging Health Issue Matrix'.

Criteria	Considerations
Measurable objectives and outcomes	– Heavily reliant on availability of data to produce measurable outcomes. – A baseline/comparison group is required to measure change.
Established need in the community	– Comprehensive data analysis and consultation is required. – Heavily reliant on availability of data of different population groups.
Capacity of local government impact	– Need to consider the level of impact local government can make on the particular issue. Is the health issue under local government jurisdiction? – What work is being carried out in that space? – by both other levels of government and community organisations
Alignment to federal, state and local policies and plans	– The priority should be aligned to relevant federal, state and local policies and plans including things such as: o National Frameworks for Action and National Health Priority Areas o Victorian Public Health and Wellbeing Plan 2015-2019 o The City of Port Phillip – Council Plan and Social Justice Charter

3.1.1.2. OUTCOME

Topic	Criteria				Total
	Measurable outcomes	Established need	Alignment	Local government impact	
AOD					
Alcohol	11	15	12	9	47
Gaming	9	6	12		36
Illicit and Pharmaceutical Drugs	11	15	12		47
Tobacco	12	3	12		36
COMMUNITY CONNECTIONS					
Civic Participation	11	3	12	10.5	36.5
Social Network	11	9	12		42.5
COMMUNITY SAFETY					
Crime	10	12	9	12	43
Family Violence	11	6	12		41
Perceptions	10	6	9		37
EDUCATION, EMPLOYMENT AND INCOME					
Early Child Development	11	6	9	10.5	36.5
Education	11	3	6		30.5
Employment	10	6	6		32.5
Income and Support	11	6	9		36.5
HEALTH BEHAVIOURS					
Diet	11	6	12	10.5	39.5
Physical Activity	10	3	12		35.5
Preventative Action	12	9	9		40.5
HEALTH SERVICES					
Access and Use	10	9	9	12	40
Maternal and Child Health	11	9	9		41
HOUSING AND HOMELESSNESS					
Homelessness	11	15	12	12	50
Housing	10	15	12		49
INDIVIDUAL HEALTH					
Health Status	10	9	12	9	40
Prevalence of Illness / Disease	10	9	12		40
Sexual and Reproductive Health	10	15	12		46
MENTAL HEALTH					
Lifestyle and Risk Factors	9	9	15	9	42
Prevalence of Mental Health	11	12	15		47
SUSTAINABILITY, CLIMATE CHANGE AND THE ENVIRONMENT					
Environment	3	15	9	10.5	37.5
Waste and Energy	9	6	9		34.5
TRANSPORT AND MOBILITY					
Sustainable Transport	12	3	12	9	36
Transport	11	6	6		32

3.1.1.3. ANALYSIS

Utilising these results the 29 sub-topics can be ranked in priority order*:

	Sub-Topic	Total
1.	Homelessness	50
2.	Housing	49
3.	Alcohol	47
4.	Illicit and Pharmaceutical Drugs	47
5.	Prevalence of Mental Health	47
6.	Sexual and Reproductive Health	46
7.	Crime	43
8.	Social Network	42.5
9.	Lifestyle and Risk Factors – Mental Health	42
10.	Maternal and Child Health	41
11.	Family Violence	41
12.	Preventative Action	40.5
13.	Access and Use – Health Services	40
14.	Health Status	40
15.	Prevalence of Illness and Disease	40

	Sub-Topic	Total
16.	Diet	39.5
17.	Environment	37.5
18.	Perceptions	37
19.	Early Child Development	36.5
20.	Income And Support	36.5
21.	Civic Participation	36.5
22.	Gaming	36
23.	Tobacco	36
24.	Sustainable Transport	36
25.	Physical Activity	35.5
26.	Waste and Energy	34.5
27.	Employment	32.5
28.	Transport	32
29.	Education	30.5

** Note: When sorted in order of 'established need' only, notable changes include 'Environment' jumping to number 8 and 'Family Violence' drops to number 16.*

Although the five demographic cohorts are unable to be put through a similar prioritisation process, the available data in the 'Who?' section of this Background Report provides sufficient information to provide the following insights for priority health issues for each cohort:

Group	Priority Health Issue	Group	Priority Health Issue
Early Years	• Health Services • Mental Health	Social and Cultural Diversity	• Health Services
Youth and Middle Years	• Alcohol and Other Drugs • Community Safety • Education, Employment and Income • Individual Health • Mental Health	Gender	• Community Safety • Education, Employment and Income • Mental Health
Older Adults	• Alcohol and Other Drugs • Community Connections • Health Services • Mental Health		

Analysis of the top 15 ranked sub-topics provides scope to refine these into four emerging health issues:

Priority Health Issue/Area	Relevant topic/sub-topic included
HOUSING AND HOMELESSNESS	• Housing • Homelessness
SOCIAL INCLUSION AND DIVERSITY	• Lifestyle and Risk Factors for mental health • Prevalence of Mental Health • Social Network
SAFETY	• Crime • Alcohol • Illicit and Pharmaceutical Drugs • Family Violence
ACCESS TO INFORMATION AND SERVICES	• Access to and use of health services • Maternal and Child Health Services • Sexual and Reproductive Health • Preventative Action • Health Status • Prevalence of Illness and Disease

3.1.2. HOUSING AND HOMELESSNESS

Topics:	Housing	Homelessness
Data says:	Port Phillip has a high cost of housing (both rental and mortgage repayments) with only a small proportion identified as affordable. Despite this, we have a higher proportion of social housing stock comparative to State averages, a large proportion of unoccupied dwellings and over half of our residents renting their home.	Port Phillip has a high number of people experiencing homelessness with more than four times the State average. Approximately 6% of people experiencing homelessness are sleeping rough on the street or in vehicles. 17% are 'couch surfing', 37% reside in boarding houses and supported accommodation and 39% are staying in severely overcrowded dwellings[252].
Why this is important:	• Numerous academic literature point to an association between various aspects of housing and health.[253] Housing is the largest single expenditure item in the household budget for low and moderate-income earners. If a greater proportion of income being absorbed by higher rents, this can result in a deterioration of health status because of reduced capacity to buy essential items and access health services.[254] • Housing stress affects more than one in ten Australian households and one in four households in the private rental market. In the last five years the cost of housing has increased rapidly increasing the risk of people falling into poverty. [255]	• Homelessness has a significant impact on health. Homelessness contributes to being excluded socially and economically and may intensify health related conditions.[256] In general, homeless people have been found to have much poorer health status than the general population. [257] • People experiencing homelessness are more likely than others to suffer from bronchitis, arthritis, skin diseases and infections, frequent headaches, musculoskeletal problems, visual impairment, alcohol and drug related problems and mental disorders among others.[258] • The transient lifestyle of homeless people results in social disadvantage and creates a barrier to health service access and to receiving health promotion messages.[259]
Key stats:	• 0.7% rental housing that is affordable • 8% social housing stock • 8.6% experiencing housing stress • 50.1% households renting	• 1.7% proportion of population experiencing homelessness • 1,564 estimate homeless population • 892 staying in boarding houses • 444 in supported accommodation

3.1.3. SOCIAL INCLUSION AND DIVERSITY

Topics:	Social network and diversity	Mental health
Data says:	We are a well-connected community who have good access to facilities/services, high levels of community participation and support our socially and culturally diverse community.	High prevalence of mental health awareness with identification and service access rates high combined with comparatively standard self-reported mental wellbeing rating.
Why this is important:	• More Australians are living alone compared to previous generations.[260] People who are socially isolated and excluded are more likely to experience low self-esteem, depressive symptoms and have a higher risk of coronary heart disease.[261] • Developing positive social connections and relationships is essential for optimal development, and provides a wide range of positive physical and mental health outcomes.[262] The perception of being part of a cohesive neighbourhood can also counteract adverse health effects resulting from local socioeconomic disadvantage[263]. • The perception of a neighbourhood being 'closeknit' indicates high levels of social cohesion[264]. Neighbours who trust one another are more likely to work more effectively together for the collective advantage and, generally, to have higher life satisfaction[265]. • Community acceptance of multiculturalism is an important component of social cohesion. In Australia, 47 % of people born in non-English speaking countries reported experiencing race-based discrimination.[266] Experiencing discrimination can result in; anxiety, depression, poor self-esteem, and stress-related illness; unhealthy coping behaviours, such as dropping out of physical activity and community activities, smoking, and misusing alcohol or drugs. [267]	• Wellbeing, or positive mental health, improves our quality of life in many ways including: better physical health; faster recovery from illness; fewer limitations in daily life; higher educational attainment; greater likelihood of employment and earnings; and better relationships. Poor mental health can have a significant negative impact on physical health.[268] • Depression is the leading cause of disability in both males and females and, at its worst, often leading to suicide. [269] There is strong and consistent evidence of an association between depression and heart disease, stroke, diabetes, asthma, cancer, arthritis and osteoporosis.[270] • Resilience is a fundamental component of mental wellbeing that enables people to cope with adversity and to reach their full potential[271]. It is described as a person's capacity to successfully overcome significant challenges or negative outcomes and restore their previous level of function[272], thus avoiding mental ill-health. High levels of resilience are associated with a lower risk of mental health problems and an improved sense of mental wellbeing.[273] • More broadly, living in communities that provide access to affordable housing, healthcare, education, stable employment and social connectedness can significantly improve our mental wellbeing. [274]
Key stats:	• 72% agree that people in their neighbourhood are willing to help each other out • 61% feel that they live in a close-knit neighbourhood • 71.8% agree that people in their neighbourhood can be trusted • 66.5% think that multiculturalism makes life in the area better	• 77.5/100 wellbeing score and a 7.7/10 life satisfaction score • 6.6/8 resilience score • 31.2% report a lifetime prevalence of anxiety/depression • 18.4% sought help for a mental health problem in the last 12 months

3.1.4. SAFETY

Topics:	Crime and perceptions of safety	Family violence	Alcohol	Other drugs (tobacco, illicit substances and pharmaceuticals)
Data says:	While crime rates are among the highest in the state, community perceptions of safety remain high.	Higher level of gender equity awareness contributing to lower rates of family violence incidents.	Greater supply, access and spend on alcohol contributing to higher levels of alcohol-related harm.	While smoking rates remain low, use of other licit and illicit drugs is among the highest in the state.
Why this is important:	• Community safety and security are important determinants of people's health and wellbeing. When individuals feel safe within their communities, they are more likely to connect with friends, engage with other community members and experience greater levels of trust and social connection[275]. • When individuals perceive their neighbourhoods to be unsafe, they experience higher levels of anxiety and interactions between members of the community become more limited, placing them at risk of social isolation and mental illness[276]. • Community safety also influences our physical health and wellbeing by altering how people use, and interact with, the built environment, local amenities, parks and community facilities[277].	• The ability to participate in equal and respectful relationships is an important contributing factor to community safety and individual mental health and wellbeing.[278] Conversely, intimate partner violence is detrimental to physical and mental health.[279] • In Australia, more than two in five women (41%) have experienced violence from a man known to them at some point in their lifetime since the age of 15.[280] • The cost to society of violence against women and their children is $21.7 billion annually. If no further action is taken to prevent violence against women and their children, costs will accumulate to over $323 billion over the 30 years to 2045[281]. • Male intimate partner violence contributes more to the disease burden for women aged 18 to 44 years than any other well-known risk factors like tobacco use, high cholesterol or use of illicit drugs.[282]	• Harm associated with alcohol use is well documented[283]. A universally applicable rule is that the risk of injury increases as more alcohol is consumed during a single drinking session. • Using a wider definition of 'harm' that includes effects such as noise disturbance, fear of physical abuse, sexual abuse, child neglect, violence and death, it is estimated that almost 70% of Australians are experiencing harm due to another person's drinking in a given year[284]. • Alcohol-related harm is estimated to cost the Australian community at least $15 billion per annum with $10.8 billion attributed to tangible costs (e.g. labour and health costs) and $4.5 billion to intangible costs such as death from violence. [285] • Millions of Australians are harmed in alcohol-related incidents each year. Almost five million people in Australia (26.0%) aged 14 and over reported being a victim of an alcohol-related incident in the preceding 12 months, and the number of Australians who experienced physical abuse in an alcohol-related incident increased from 1.3 million to 1.7 million in 2013[286].	• Tobacco use is the most preventable cause of ill health and death in Australia[287]. • 9% of Australia's burden of disease is due to smoking.[288] Two out of three smokers, equivalent to about 1.8 million current Australian smokers, will die prematurely because of their smoking.[289] • Illicit drug use has both short-term and long-term health effects, which may include poisoning, mental illness, self-harm, suicide and death. The social impacts of illicit drug use include stressed family relationships, family breakdown, domestic violence, child abuse, assaults and crime[290] • 1 in 12 people in Australia (8.3%) had been a victim of an illicit drug-related incident in the previous 12 months and drug use was responsible for 1.8% of the total burden of disease and injury in 2011[291]
Key stats:	• 12,230 total offender rate per 100,000 population • 95.5% feel safe walking alone during the day • 64.9% feel safe walking alone at night	• 32.1% have a low gender equality score • 1,023 family violence incidents per 100,000 population	• 43.8% believe getting drunk every now and then is ok • 68.8% have an increased lifetime risk of alcohol-related harm • 20.6% at very high risk of short term harm each month • 8.3 liquor licences per 1,000 population	• 7.4% current smokers • 29.2 Illicit drug related ambulance attendances per 10,000 population • 22.2 pharmaceutical drug related ambulance attendances per 10,000 population

3.1.5. ACCESS TO INFORMATION AND SERVICES

Topics:	Health status and prevalence of illness / disease	Preventative action	Sexual and reproductive health	Access and use of health services
Data says:	We have the lowest obesity levels in the state coupled with relatively low levels of chronic disease (particularly for arthritis, diabetes and high blood pressure) contributing to positive perceptions of individual health status.	The health benefits delivered by our comparatively positive diet and exercise behaviours may be amplified by reducing sedentary work behaviours. We have lower rates of proactive health monitoring i.e. blood pressure checks possibly linked to low health service accessibility.	Our rate of sexually transmissible infections (STIs) is nearly 4 times the state average and may lead to serious reproductive health consequences beyond the immediate impact of the infection	We have high numbers of General Practitioners but at fewer locations, possibly attributing to low recorded attendance rates. We also have limited access to allied health services, pharmacies and the community based therapies they provide.
Why this is important:	• Almost two-thirds (61%) of Australian adults and one-quarter (25%) of Australian children are overweight or obese. In Australia, the total costs of overweight and obesity are estimated between $58.1–62.1 billion per year with direct costs estimated at $8–21 billion per year. In Victoria, this amounts to between $14.4 billion annually in excess healthcare costs alone.[292] • Chronic diseases have a range of potential impacts on a person's individual circumstances, including quality of life and broader social and economic effects. Chronic diseases are the leading causes of the fatal burden of disease (the amount of life lost due to people dying early) in most age and sex groups[293] and are the leading cause of illness, disability and death in Australia, accounting for about 90 % of all deaths in 2011[294]. • The term 'chronic disease' applies to a group of diseases that tend to be long lasting and have persistent effects, commonly including heart disease, cancer, type 2 diabetes, osteoporosis, arthritis and asthma among others.	• A healthy diet is vital for optimal growth, development and health throughout life.[295] A healthy diet also helps prevent chronic diseases such as cardiovascular disease, cancer and diabetes as well as their associated risk factors including overweight and obesity, high blood pressure and high cholesterol[296]. • Participation in physical activity has numerous benefits[297] including improved physical health, reduced risk of developing major chronic diseases, managing body weight, developing social connections and helping to prevent and manage mental health problems.[298] In Australia, the estimated cost of physical inactivity to the health sector is over $672 million dollars per year.[299] • Prolonged sitting is a risk factor for poor health and premature death, even for those who meet or exceed physical activity and sedentary behaviour guidelines.[300] • Most diseases and conditions have a better prognosis if caught and treated in the early stages. Therefore the purpose of screening is to identify individuals in the early stages of the disease so that treatment can be initiated, thus improving health outcomes and reducing mortality.	• The impacts of sexual and reproductive health are human and economic, and direct and indirect. Unwanted pregnancy, sexual violence, sexually transmissible infections (STIs) and infertility are major contributors to morbidity and associated costs in Australia.[301] • There is evidence that investing in sexual and reproductive health is cost effective, with the potential to minimise future health system costs and to realise significant benefits at the personal, family and societal levels.[302] • Sexually transmissible infections are a major cause of infertility, particularly in women, and place a significant burden on the Victorian community.	• The primary health care system can provide community-based, patient-centred care by a team of health professionals. Because of this, primary health care is often the 'best setting for the prevention and management of chronic and complex health conditions'.[303] • Primary health care accounted for around 38% ($55 billion) of the $145 billion recurrent health expenditure in 2013–14, compared with around 40% ($59 billion) spent on hospital services.[304] • Australia ranks well internationally when it comes to primary health care accessibility.[305] However, a significant accessibility gap exists between the most and least socioeconomically advantaged in our society.[306] Socioeconomic status is linked to disparities in access to primary health care, and this may impact on the health of an individual.[307] • Despite the more frequent use of general practice services by socioeconomically disadvantaged people there remains a high level of hospitalisation for preventable conditions.[308] This is evident for almost all chronic and acute medical conditions, as well as influenza and pneumonia.[309] This suggests that while use of health care services is higher, it may not be sufficient to meet the needs of socioeconomically disadvantaged Australians.
Key stats:	• 38.2% pre-obese and obese • 53.2% have at least one chronic disease • 11.4% have fair/poor self-reported health status	• 5:38 (hrs:mins) time spent sitting on work days • 37% do not meet physical activity guidelines • 5.1% report poor dental health • 5.6% met both fruit and vegetable consumption guidelines	• 547.8 notifications of sexually transmissible infections per 100,000	• 1.5 GPs per 1,000 population • 4,527.2 GP attendances per 1,000 population • 0.9 allied health service sites per 1,000 population • 0.3 dental service sites per 1,000 population • 0.3 pharmacies per 1,000 population

3.2. OUR CHALLENGES

The factors shaping health and wellbeing are not static, and the nature of determinants may change significantly over time as a result of wider trends and social changes.

Global demographic, social, economic and political conditions and relationships impact on people's health and wellbeing. Consideration of this wider context helps inform public health responses and identify where to focus efforts.

During the development process of the Integrated Council Plan 2017, the organisation identified seven significant, long-term challenges facing our City:

- Climate Change
- Population growth
- Urbanisation
- Transport and parking
- Legislative and policy influence
- Changing economic conditions
- Rapid evolution of technology

How we respond to these challenges impacts the liveability of our City, and the health of our communities.

Challenge	Health Perspective
1. Climate Change	Different groups have differential exposure and/or vulnerability to a range of daily living conditions. Those less resourced - for example, those residing in inadequate housing or sleeping rough - will be more adversely affected by climate change (e.g. increased utility costs to manage temperature comfort) and extreme weather events (e.g. flooding).
2. Population growth	Population growth will increase demand for Council's services and amenities. Service needs and areas of demand will change and health inequities and wealth disparity will mean unequal access to services and amenities.
3. Urbanisation	Higher urban density and demand for all types of housing will reduce housing affordability, impact ageing in place and limit access for some residents. We are fast becoming a 24 hour city with increases in night time economy and social issues like drug and alcohol abuse or family violence become more visible and intensified in urban areas.
4. Transport and parking	Limitations on safe and accessible transport will impede the ability of some people to stay connected and participate in important aspects of community life such as work, exercise, visiting friends and family, accessing services and programs.
5. Legislative and policy influence	State and Federal cost shifting and funding withdrawal from the health and human services sector is placing expectations on local government to fill gaps. This issue is being exacerbated by service model changes through sector reform which has impacted the access to services of those with the most complex needs.
6. Changing economic conditions	Equal societies do better on a range of health and economic indicators, however the spectrum of people considered vulnerable is widening due to increased costs of living, rental and property costs, social exclusion and health inequity. These economic conditions means that some community members will have less money for food, utilities, transport, health visits, education, etc. – all important aspects of health and wellbeing.
7. Rapid evolution of technology	Service models are being challenged by recent reform and will continue to evolve with new technology. New technologies will enable our workforce to be more mobile and deliver services that support our community's health and wellbeing where, when and how they want them. While there is a rise of technology and an abundance of information at our fingertips, there is a digital divide that limits access to information and participation in community life by some groups.

3.2.1. CLIMATE CHANGE

Port Phillip is already experiencing the impacts of climate change, including temperature increases (of between 1.2 and 1.4 degrees since 1950), lower than average rainfall (a decrease of between 100 and 200 millimetres since 1950), more flooding, sea level rise (of between 0.08 - 0.17 metres above the 2005 level) and a notable increase in the number of days over 35 degrees.

Our City is Melbourne's playground. The beach lifestyle and coastal activities are very attractive and important to residents and visitors. However, Port Phillip is built on reclaimed land to the south and north. Much of the City is only one to three metres above sea level and coastal areas are exposed to the impacts of climate change, especially flooding and erosion. Port Phillip is located at the bottom of the Elster Creek and Yarra River catchments, requiring a regional 'whole-of catchment' partnership approach to enable both proactive and emergency flood management responses.

We can expect increased flooding of coastal properties and public amenities, storm damage to infrastructure, beach erosion, decreased water quality and security of water supply, reduced summer outdoor activities and hotter urban spaces. Council assets and the Port Phillip community have varying abilities to cope with these changes.

This will have an impact on Council services. Assets may be unable to provide the same level of service to the community. In particular, drainage (currently beyond capacity) and Council facilities may become cost-prohibitive to operate if they are not developed to the required sustainable design standards.

Greenhouse gas emissions reduction is one important way to address climate change and avoid dangerous temperature increases. More vulnerable members of our community will be adversely affected by climate change and weather events. Ninety-nine per cent of Port Phillip emissions are community generated, and these are increasing as our City grows and reliance on car travel continues.

3.2.2. POPULATION GROWTH

Port Phillip's population is expected to grow to more than 167,870 people by 2041, a significant 51 per cent increase from the 2017 estimate of 110,967 people. Over the life of this plan, our population is expected to grow by 23 per cent to 136,300.

Our worker population will also rise dramatically. Fishermans Bend is expected to cater for 60,000 jobs by 2050, with just over half of these jobs (33,715) projected to be within Port Phillip. Adjacent municipalities are also expected to grow significantly. The population of the City of Melbourne is projected to double over the next 30 years.

Growth will not be uniform across our City. The St Kilda Road, Sandridge / Wirraway and Montague neighbourhoods are projected to grow significantly. Other established neighbourhoods will experience lower population growth.

In 2041, the population will continue to be highly mobile and dominated by 25-39 year olds, but with an increasing number of older people. The forecast median age for the Fishermans Bend suburbs (Montague, Sandridge / Wirraway) is 29, 30 and 34 years of age respectively. Our community will likely be more diverse, as the number of people born overseas grows. More than two-thirds of our households will be single person or couples without children.

Population growth will increase demand for all Council services and amenities. Coupled with the increasing cost of providing services, increasing demand will stretch services and infrastructure. Health inequities and wealth disparity will mean unequal access to these services. Achieving a balance between the economic benefits of tourism and thriving entertainment and shopping precincts, and minimising social harm and protecting residential amenity may become more challenging.

3.2.3. URBANISATION

Population growth will drive an increase in urban density. Fishermans Bend will make a significant contribution to housing growth, with new high density neighbourhoods. The density of established areas across the City will also increase, with the St Kilda / St Kilda West and St Kilda Road neighbourhoods accounting for more than half of the projected housing growth outside Fishermans Bend over the next 20 years. We will see more medium to high density residential development and continued pressure to convert commercial areas to residential use.

Maintaining liveability in a higher density city will take concerted effort.

With increasing density and vertical living, more people will use our parks, villages, roads and footpaths, beaches and public transport. Improving travel choices and access to high frequency public transport will ensure liveability for residents, workers and visitors.

Our public spaces and waterfront will need to be welcoming to all and cater for different and increased use as they become residents' 'backyards'.

Our neighbourhoods will need to be safe and walkable, with good access to shops and flexible community spaces, and have a balance of residential and business use so we can reap the benefits of a vibrant 'mixed use' city and support healthy, active and connected communities.

Housing affordability will continue to be a concern. Housing costs in Port Phillip are twice the Melbourne average and many low and moderate income households find buying a home and private rentals increasingly unaffordable.

3.2.4. TRANSPORT AND PARKING

Road network congestion will continue to be an issue as our population grows. The road network for cars is at capacity and cannot be increased. The Victorian Government is prioritising more efficient and sustainable modes like trams, walking and bike riding. So we can expect that, in real terms, the capacity road network for private cars is likely to remain static or decrease over time.

Managing on-street car parking for different users - residents, workers and visitors - is also an ongoing challenge. In many parts of the City, demand for parking outstrips supply, and decisions will need to be made about how to best allocate this scarce resource.

Managing congestion as our City grows will only be possible by supporting people to travel by non-car modes. This will require ongoing investment in walking and bike riding infrastructure, behaviour change initiatives, and partnerships with the Victorian Government to deliver 'place and movement' projects that invest in our public spaces and increase public transport service levels, capacity and accessibility.

Traffic and parking congestion has a significant impact on our environment and health, and compromises the liveability of our City. Increases in car trips cannot easily be accommodated, especially during peak travel times. It is expected that there will be a continuing shift to public transport, walking and bike riding, where these alternatives are safe, direct and convenient.

Ensuring our public spaces are places for people, accessible by walking and riding a bike, and offer opportunities to be healthy, will be important. Learning from European cities, early planning for high capacity bicycle parking across the City will be required, with the new Domain station presenting a significant opportunity.

3.2.5. LEGISLATIVE AND POLICY INFLUENCE

All Victorian councils operate in a complex legislative and policy environment that includes 75 Acts of Parliament and 28 Regulations. The key Act (the Local Government Act 1989) is under review.

Government funding is being reduced or withdrawn from several sectors, placing additional expectation on local government to fill the gap. This trend of government cost shifting along with increased compliance will likely continue.

In addition, the cap on rate increases means local government's ability to control revenue is constrained. As a result, we are experiencing increased strain on our financial sustainability. The cap on rate increases is forecast to impact our bottom line by $35 million over the next 10 years if we don't make changes to the way we operate. Difficult decisions will need to be made about our services, investments and assets to ensure the health and wellbeing of our people and places within these fiscal constraints.

3.2.6. CHANGING ECONOMIC CONDITIONS

Port Phillip's economy was close to $12 billion in 2015, contributing 4.2 per cent of the greater Melbourne economy. Our economy grew significantly in the early 2000s, and slowed over the last 10 years, but we experienced 2.9 per cent growth in GRP between 2013 and 2015.

In recent years we have experienced some growth in the number of businesses and jobs - particularly in construction, manufacturing and some services. We have a higher than average proportion of professional, scientific and technical services (23.6 per cent compared to 9.1 per cent in Victoria), arts and recreation services (2.8 per cent compared to 1.6 per cent) and information media and telecommunications (4 per cent compared to 2.2 per cent). The South Melbourne precinct has one of the highest concentrations of creative industries in Australia. Despite this, 75 per cent of our working population leave the area for work.

The Port Phillip neighbourhoods of Fishermans Bend are currently home to over 750 businesses and approximately 12,000 workers. The transition of Fishermans Bend to a mixed use community will have a significant impact on the number and type of businesses and jobs in that area.

Our people can expect to spend more time travelling to work outside of the City. We may also continue to experience a change in the nature of our business community as high rental prices put pressure on smaller businesses.

The spectrum of people considered vulnerable is widening due to increased costs of living, rental and property costs, social exclusion and health inequity. More than 8,000 residents are living in housing stress and 2,500 residents are on the public housing waiting list (excluding local community housing waiting lists). In the last two years, we have seen an increase of 104 per cent in the number of calls received about people sleeping rough in public places. We expect to observe ever-increasing vulnerability in our communities.

3.2.7. RAPID EVOLUTION OF TECHNOLOGY

The world is becoming more connected. People, businesses and governments are increasingly moving online to connect, to deliver and access services, to obtain information and to perform activities like shopping and working. Technology is also changing the way our residents work. Around one in every 12 workers works from home.

We can expect increasing demand for council services to be delivered online, and engagement through social media and other digital means. We will need to respond to this demand and think about how we operate and support people to connect with Council, particularly those who have limited online access and/or digital literacy. The digital shift will reshape how we deliver services and engage our community in decision making.

Technological advances also present opportunities for Council to consider new methods of service delivery, such as electronic parking management, that have the potential to offer efficiencies and improved community outcomes.

4. HOW AND WHEN?

OUR COUNCIL PLAN 2017-27

Contents

About this section

This section highlights how the data analysis and findings of this Background Report has informed the Integrated Council Plan 2017-27.

4.1. INTEGRATED COUNCIL PLAN

In recognising the unique role councils play in supporting health and wellbeing, The City of Port Phillip have incorporated the planning, implementation and evaluation requirements into our Council Plan. Integrating our plans in this way ensures we are working to protect, improve and promote public health and wellbeing in everything we do.

The six strategic directions of the Integrated Council Plan have been developed via an analysis of population health data and community consultation feedback, reviewing international, national, state and local research and policy, and are guided by the Victorian Public Health and Wellbeing Plan 2015–2019. This ensures we are playing our role in achieving the State's vision of 'a Victoria free of the avoidable burden of disease and injury, so that all Victorians can enjoy the highest attainable standards of health, wellbeing, and participation at every age'.

The four emerging health issues identified in this report were used as the basis to develop Strategic Direction 1. 'We embrace difference, and people belong'. While this direction has a particular focus on the health promotion and reducing health inequalities, it must be noted that in line with our integrated planning focus, the other five strategic directions were developed in reference to the determinants of health and focused on improving health and wellbeing outcomes for our community.

The following table shows the relationship between the Council Plan priorities, identified emerging health issues and the Victorian Public Health and Wellbeing Plan (VPHWP) 2015-19.

Direction	Outcomes by 2027	Emerging health issues	VPHWP priorities
1. We embrace difference, and people belong	1.1 A safe and active community with strong social connections	• Social inclusion and diversity • Safety	• reducing harmful alcohol and drug use • preventing violence and injury
	1.2 An increase in affordable housing	• Housing and homelessness	• improving mental health
	1.3 Access to services that support the health and wellbeing of our growing community	• Access to information and services	• all
	1.4 Community diversity is valued and celebrated	• Social inclusion and diversity	• improving mental health
2. We are connected and it's easy to move around	2.1 An integrated transport network that connects people and places	• Access to information and services • Social inclusion and diversity • Safety	• healthier eating and active living • preventing violence and injury
	2.2 The demand for parking and car travel is moderated as our City grows		
	2.3 Our streets are designed for people		
3. We have smart solutions for a sustainable future	3.1 A greener, cooler and more liveable City	• Access to information and services • Housing and homelessness	• healthier eating and active living • improving mental health
	3.2 A City with lower carbon emissions		
	3.3 A City that is adapting and resilient to climate change		
	3.4 A water sensitive City		
	3.5 A sustained reduction in waste		
4. We are growing and keeping our character	4.1 A liveable, higher density City	• Housing and homelessness • Access to information and services • Social inclusion and diversity • Safety	• healthier eating and active living • improving mental health
	4.2 A City of diverse and distinctive neighbourhoods and places		
5. We thrive by harnessing creativity	5.1 A City of dynamic and distinctive retail precincts	• Access to information and services • Safety • Social inclusion and diversity	• reducing harmful alcohol and drug use • preventing violence and injury • improving mental health
	5.2 A prosperous City that connects and grows business		
	5.3 A City where arts, culture and creative expression is part of everyday life		
6. Our commitment to you	6.1 Transparent governance and an actively engaged community	• Social inclusion and diversity • Access to information and services	• all
	6.2 A financially sustainable, high performing and community focused organisation		
	6.3 Achievement through leadership and partnerships		

4.2. DELIVERING THE PLAN

4.2.1. HEALTH AND WELLBEING IMPLEMENTATION PLAN

The Integrated Council Plan identifies two core strategies that will support the organisation to deliver on its 10 year vision and strategic direction:

- **City Plan -** Integrated spatial strategy and municipal strategic statement; and
- **Health and Wellbeing Implementation Strategy**

These strategies will provide further detail regarding the delivery and evaluation of initiatives to support the Integrated Council Plan.

The Health and Wellbeing Implementation Strategy will focus on the previously identified emerging health issues and their relationship across the ICP's six strategic directions.

4.2.2. MEASURING SUCCESS

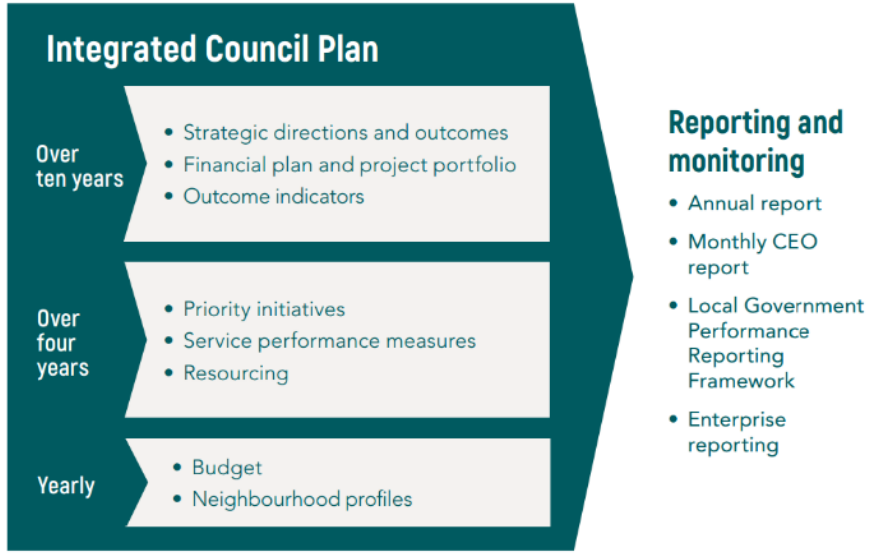
Each strategic direction of the Council Plan has a number of outcome statements that articulate what we want to see by 2027.

Outcome indicators have been provided to enable us to track our progress in making this vision a reality. These outcome indicators are driven by population health data and go beyond the typical four year council term in recognition that achieving health changes at the population level require long term outlook and sustained effort.

Additionally, service performance measures have been provided against each strategic direction to articulate how we will monitor our direct service delivery outcomes.

The Health and Wellbeing Implementation Plan will further articulate the measuring and reporting framework and its relationship to improving health outcomes for our community.

Figure 6 – Measuring and Reporting Framework



4.2.3. PARTNERSHIPS

The Council Plan does not attempt to provide solutions to all of the issues affecting health and wellbeing within our community. Rather it is designed as a framework upon which the imperatives of health and wellbeing can be built.

Most importantly, it articulates the role that Council can play in fostering change – whether that be through Council run programs and projects, by advocating and advising other agencies or government bodies, or supporting community-led initiatives.

We recognise our ability to work collaboratively with State and Federal government, community and business organisations, service providers and residents to promote the conditions in which people can be healthy and reduce inequalities in health and wellbeing.

We have highlighted this commitment to collaboration through clearly identifying three key areas for delivering each strategic direction: Advocacy priorities; Engagement and partnership priorities; and Strategies/plans.

We have identified key partners in the delivery of health and wellbeing outcomes, particularly through a continued commitment to our Health and Wellbeing Alliance. In this way we hope to provide coordinated, robust and appropriate responses to what are often very complex issues.

Working with our partners – the Health and Wellbeing Alliance

The Port Phillip Health and Wellbeing Alliance was established to coordinate the delivery of community health and wellbeing initiatives across Port Phillip and provide feedback on Council initiated programs and policies.

It includes representation from State government departments (i.e. Department of Health and Human Services), Victoria Police, Inner South Community Health, South Melbourne Primary Care Partnership and other relevant local and regional community and health sector agencies.

By working collaboratively in this way, City of Port Phillip and the Alliance members are better positioned to identify key social and environmental health issues, better support local organisations and key stakeholders and avoid duplication of services.

5. APPENDICES

5.1. APPENDIX 1 – EMERGING HEALTH ISSUE MATRIX

5.1.1. TOPIC MATRIX SCORE CARD

Criteria	Scoring
Measurable Objectives and Outcomes **Maximum Score = 15**	*Can the data be tracked regularly for evaluation purposes?* – 1 score per box – 0 score for unknown. *Is there a Victorian Benchmark?* – Yes = 6 scores – No = 0 score *What level of data is available?* – 1 score per box **Maximum Score = 15**
Established Need in the Community **Maximum Score = 15**	*What does the data tell us?* – Substantially favourable = 1 score – Slightly favourable = 2 scores – More or less the same as the Victorian average = 3 scores – Slightly not favourable = 4 scores – Substantially not favourable = 5 scores **Maximum Score = 5*** **Each score is multiplied by 3*
Alignment to Federal, State and Local Policies and Plans **Maximum Score = 15**	*Does the health issue align to the following;* – 1 score per box **Maximum Score = 5*** **Each score is multiplied by 3*
Capacity of Local Government **Maximum Score = 15**	*Does the health issue align with the Local Government Act 1989?* – 1 – 3 ticked boxes = 1 score – 4 – 6 ticked boxes = 2 scores – 7 – 9 ticked boxes = 3 scores – 10 – 12 ticked boxes = 4 scores – 13 – 14 ticked boxes = 5 scores *Does the health issue align with the Public Health and Wellbeing Act 2008?* – 1 ticked box = 1 score – 2 – 3 ticked boxes = 2 scores – 4 – 5 ticked boxes = 3 scores – 6 ticked boxes = 4 scores – 7 ticked boxes = 5 scores **Maximum Score = 10*** **Each score multiplied by 1.5*

MAXIMUM TOTAL SCORE = 60

5.1.2. SCORING EXPLANATION

A total of 11 topics with 29 sub-topics were run through the matrix and assessed against the criteria. The results were scored and categorised into high, medium or low for each criteria to provide a clear ranking of each health sub topic for the Port Phillip community.

Measurable Objectives and Outcomes		**Classification**
High	The health issue can be regularly tracked for evaluation purposes, has a Victorian benchmark and has a range of data available at different levels.	HIGH = 10 – 15 MEDIUM = 5 – 9 LOW = 0 – 4
Medium	The health issue can be tracked for evaluation purposes, has a Victorian benchmark and has data available at one or two different levels.	
Low	The health issue cannot be tracked regularly for evaluation purposes and has limited data available at different levels.	
Established Need in the Community		
High	Port Phillip is substantially/slightly unfavourable compared to the Victorian average. This means that Port Phillip is experiencing a higher rate of harm than the Victorian average.	HIGH = 10 – 15 MEDIUM = 5 – 9 LOW = 0 – 4
Medium	The Port Phillip data is more or less the same as the Victorian average.	
Low	Port Phillip is substantially/slightly favourable compared to the Victorian average. This means that Port Phillip is experiencing a lower rate of harm than the Victorian average.	
Alignment to relevant federal, state and local policies and plans		
High	The health issue is strongly aligned to relevant federal, state and local plans and policies.	HIGH = 10 – 15 MEDIUM = 5 – 9 LOW = 0 – 4
Medium	The health issue aligns to some relevant federal, state and local plans and policies.	
Low	The health issue is poorly aligned to relevant federal, state and local plans and policies.	
Capacity of local government		
High	The health issue aligns strongly to the Local Government Act 1989 and Public Health and Wellbeing Act 2008. This health issue is under local government jurisdiction and action aligns to the role and functions of Council as specified in the Acts.	HIGH = 10 – 15 MEDIUM = 5 – 9 LOW = 0 – 4
Medium	The health issue aligns to the Local Government Act 1989 and Public Health and Wellbeing Act 2008. This health issue is under local government jurisdiction and action comes under the role and functions of Council as specified in the Acts.	
Low	The health issue does not align well to the Local Government Act 1989 and Public Health and Wellbeing Act 2008. This health issue is not directly under local government jurisdiction.	

5.1.3. MATRIX RESULTS

Criteria	Considerations	ALCOHOL AND OTHER DRUGS			
		Alcohol	Illicit Drugs and Pharmaceutical Drugs	Tobacco	Gaming
Measurable objectives and outcomes	Data sources:	• Victorian Population Health Survey • VicHealth Indicators Survey • AOD Stats • Current Victorian Licenses by location • Measures of Health Activity and Outcome	• AOD Stats • Adolescent Community Profiles – Port Phillip LGA • AOD Stats	• VicHealth Indicators Survey – Port Phillip LGA Profile • Victorian Population Health Survey • Social Health Atlas of Victoria LGA Areas	• LGA population density and gaming
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☒ Annually ☒ 2-4 years ☐ 4+ years ☐ Unknown **Score: 2**	☐ Quarterly ☒ Annually ☒ 2-4 years ☐ 4+ years ☐ Unknown **Score: 2**	☐ Quarterly ☒ Annually ☒ 2-4 years ☐ 4+ years ☒ Unknown **Score: 2**	☒ Quarterly ☐ Annually ☐ 2-4 years ☐ 4+ years ☐ Unknown **Score: 1**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☒ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 4**	☐ Federal ☒ State ☐ Regional ☒ LGA ☐ Suburb **Score: 2**
Established need in the community	What does the data tell us?	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☒ **Substantially not favourable** compared to the Victorian average **Score: 5**	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☒ **Substantially not favourable** compared to the Victorian average **Score: 5**	☒ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 1**	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • National Drug Strategy 2016 - 2025 • Liquor Control Reform Act Ice Action Plan • VicHealth Alcohol Cultures Framework • Victoria 10-year Mental Health Plan **Score: 4**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • National Drug Strategy 2016 – 2025 • Victoria 10-year Mental Health Plan **Score: 4**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • National Drug Strategy 2016 - 2025 • National Tobacco Strategy 2012 – 2018	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • Victoria 10-year Mental Health Plan • *Gambling Regulation Act 2003* **Score: 4**

<table>
<tr><td></td><td></td><td colspan="2"></td><td colspan="2">• Victoria 10-year Mental Health Plan
Score: 4</td><td></td></tr>
<tr><td rowspan="9">Capacity of local government</td><td rowspan="8">Does the health issue align with the Local Government Act 1989?
Score: 9 ticked boxes</td><td colspan="2">Clause 3D, sub - section (2): What is the role of a Council?</td><td colspan="2">Clause 3E, sub –section (1): What are the functions of a Council?</td></tr>
<tr><td>☒</td><td>2(a) acting as a representative government by taking into account the diverse needs of the local community in decision making</td><td>☒</td><td>1(a) advocating and promoting proposals which are in the best interests of the local community</td></tr>
<tr><td>☒</td><td>2(b) providing leadership by establishing strategic objectives and monitoring their achievement;</td><td>☐</td><td>1(b) planning for and providing services and facilities for the local community</td></tr>
<tr><td>☐</td><td>2(c) maintaining the viability of the Council by ensuring that resources are managed in a responsible and accountable manner</td><td>☐</td><td>1(c) providing and maintaining community infrastructure in the municipal district</td></tr>
<tr><td>☒</td><td>2(d) advocating the interests of the local community to other communities and governments</td><td>☒</td><td>1(d) undertaking strategic and land use planning for the municipal district</td></tr>
<tr><td>☒</td><td>2(e) acting as a responsible partner in government by taking into account the needs of other communities</td><td>☐</td><td>1(e) raising revenue to enable the Council to perform its functions</td></tr>
<tr><td>☒</td><td rowspan="2">2(f) fostering community cohesion and encouraging active participation in civic life</td><td>☒</td><td>1(f) making and enforcing local laws</td></tr>
<tr><td>☐</td><td>1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts</td></tr>
<tr><td>☒</td><td>1(h) any other function relating to the peace, order and good government of the municipal district</td></tr>
<tr><td>Does the health issue align with the Public Health and Wellbeing Act 2008?
Score: 5</td><td colspan="4">SECTION 24: The function of a Council under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by -

☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;

☒ (b) initiating, supporting and managing public health planning processes at the local government level

☒ (c) developing and implementing public health policies and programs within the municipal district

☒ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected

☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community

☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district

☐ (g) ensuring that the municipal district is maintained in a clean and sanitary condition</td></tr>
</table>

Criteria	Considerations	CLIMATE CHANGE, SUSTAINABILITY AND ENVIRONMENTAL HEALTH	
		Environment	Waste and Energy
Measurable objectives and outcomes	Data sources:	• Adolescent Community Profiles – Port Phillip LGA • Victorian Population Health Survey • Health and Wellbeing Index 2013- 2017 • Climate Statistics for Australian Locations • Monthly Rainfall Report • Water Quality Report Card	• Community Indicators Victoria • Adolescent Community Profiles – Port Phillip LGA • Know Your Council – Local Government Performance Reporting Framework
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☒ Annually ☒ 2-4 years ☐ 4+ years ☒ Unknown **Score: 2**	☐ Quarterly ☒ Annually ☐ 2-4 years ☐ 4+ years ☒ Unknown *Know Your Council – Local Government Performance Reporting Framework is published annually* **Score: 1**
	Is there a Victorian benchmark?	☐ Yes ☒ No *There is only a benchmark for 4 of the 20 indicators **Score: 0**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☐ State ☐ Regional ☒ LGA ☐ Suburb **Score: 1**	☐ Federal ☒ State ☐ Regional ☒ LGA ☐ Suburb **Score: 2**
Established need in the community	What does the data tell us?	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 0**	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☐ The City of Port Phillip – Social Justice Charter ☒ Other; • National Climate Resilience and Adaptation Strategy • The Australian Government's Action on Climate Change Policy • Victoria's Emissions Reduction Target – Net Zero by 2050 • Toward Zero – Sustainable Environment Strategy • City of Port Phillip Greenhouse Plan • City of Port Phillip Water Plan – Toward a Water Sensitive City • Port Phillip Open Space Strategy • **Score: 3**	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☐ The City of Port Phillip – Social Justice Charter ☒ Other; • National Climate Resilience and Adaptation Strategy • The Australian Government's Action on Climate Change Policy • Victoria's Emissions Reduction Target – Net Zero by 2050 • Toward Zero – Sustainable Environment Strategy • City of Port Phillip Greenhouse Plan • City of Port Phillip Water Plan – Toward a Water Sensitive City **Score: 3**

<table>
<tr><td rowspan="11">Capacity of local government

Score: 7</td><td rowspan="10">Does the health issue align with the Local Government Act 1989?</td><td colspan="2">Clause 3D, sub - section (2): What is the role of a Council?</td><td colspan="2">Clause 3E, sub –section (1): What are the functions of a Council?</td></tr>
<tr><td>☒</td><td>2(a) acting as a representative government by taking into account the diverse needs of the local community in decision making</td><td>☒</td><td>1(a) advocating and promoting proposals which are in the best interests of the local community</td></tr>
<tr><td>☐</td><td>2(b) providing leadership by establishing strategic objectives and monitoring their achievement;</td><td>☒</td><td>1(b) planning for and providing services and facilities for the local community</td></tr>
<tr><td>☒</td><td>2(c) maintaining the viability of the Council by ensuring that resources are managed in a responsible and accountable manner</td><td>☒</td><td>1(c) providing and maintaining community infrastructure in the municipal district</td></tr>
<tr><td>☒</td><td>2(d) advocating the interests of the local community to other communities and governments</td><td>☒</td><td>1(d) undertaking strategic and land use planning for the municipal district</td></tr>
<tr><td>☒</td><td>2(e) acting as a responsible partner in government by taking into account the needs of other communities</td><td>☐</td><td>1(e) raising revenue to enable the Council to perform its functions</td></tr>
<tr><td rowspan="3">☒</td><td rowspan="3">2(f) fostering community cohesion and encouraging active participation in civic life</td><td>☐</td><td>1(f) making and enforcing local laws</td></tr>
<tr><td>☐</td><td>1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts</td></tr>
<tr><td>☐</td><td>1(h) any other function relating to the peace, order and good government of the municipal district</td></tr>
<tr><td>Does the health issue align with the Public Health and Wellbeing Act 2008?</td><td colspan="4">SECTION 24: The function of a Council under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by -

☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;

☒ (b) initiating, supporting and managing public health planning processes at the local government level

☒ (c) developing and implementing public health policies and programs within the municipal district

☒ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected

☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community

☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district

☒ (g) ensuring that the municipal district is maintained in a clean and sanitary condition</td></tr>
</table>

Criteria	Considerations	COMMUNITY CONNECTIONS	
		Civic Participation	Social Network
Measurable objectives and outcomes	Data sources:	• Measures of Community Strength and Connection • Victorian Population Health Survey • VicHealth Indicators Survey – Port Phillip LGA • Adolescent Community Profiles – Port Phillip LGA • Know Your Council – Local Government Performance Reporting Framework	• Census of Population and Housing • Victorian Population Health Survey • VicHealth Indicators Survey – Port Phillip LGA
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☐ Annually ☒ 2-4 years ☒ 4+ years ☒ Unknown **Score: 2**	☐ Quarterly ☐ Annually ☒ 2-4 years ☒ 4+ years ☐ Unknown **Score: 2**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**
Established need in the community	What does the data tell us?	☒ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 1**	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☒ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 3**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 4**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 4**

Capacity of local government **Score: 7**	Does the health issue align with the Local Government Act 1989?	**Clause 3D, sub - section (2): What is the role of a Council?**		**Clause 3E, sub –section (1): What are the functions of a Council?**	
		☒	2(a) acting as a representative government by **taking into account the diverse needs** of the local community **in decision making**	☒	1(a) **advocating** and promoting proposals which are in the best interests of the local community
		☒	2(b) providing **leadership** by establishing strategic objectives and monitoring their achievement;	☒	1(b) planning for and **providing services and facilities** for the local community
		☒	2(c) maintaining the viability of the Council by ensuring that **resources are managed** in a responsible and accountable manner	☒	1(c) providing and maintaining **community infrastructure** in the municipal district
		☒	2(d) **advocating** the interests of the local community to other communities and governments	☐	1(d) undertaking **strategic and land use planning** for the municipal district
		☒	2(e) acting as a responsible **partner** in government by taking into account the needs of other communities	☐	1(e) **raising revenue** to enable the Council to perform its functions
		☒	2(f) fostering **community cohesion** and encouraging **active participation** in civic life	☐	1(f) making and enforcing **local laws**
				☐	1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts
				☒	1(h) any other function relating to the **peace, order and good government** of the municipal district
	Does the health issue align with the Public Health and Wellbeing Act 2008?	**SECTION 24: The function of a Council** under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by **-**			
		☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;			
		☒ (b) initiating, supporting and managing public health planning processes at the local government level			
		☒ (c) developing and implementing public health policies and programs within the municipal district			
		☐ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected			
		☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community			
		☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district			
		☐ (g) ensuring that the municipal district is maintained in a clean and sanitary condition			

Criteria	Considerations	COMMUNITY SAFETY		
		Crime	Perceptions of Safety	Family Violence
Measurable objectives and outcomes	Data sources:	• LEAP • Adolescent Community Profiles – Port Phillip LGA • VCAMS Indicators	• Victorian Population Health Survey • VicHealth Indicators Survey = Port Phillip LGA Profile • Victorian Population Health Survey • Adolescent Community Profiles • Claims Data – Victorian Government	• LEAP • VicHealth Indicators Survey – Port Phillip LGA Profile • VCAMS Indicators • Early Childhood Community Profiles – Port Phillip • Adolescent Community Profiles
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☒ Annually ☐ 2-4 years ☐ 4+ years ☐ Unknown **Score: 1**	☐ Quarterly ☒ Annually ☒ 2-4 years ☐ 4+ years ☐ Unknown **Score: 2**	☐ Quarterly ☒ Annually ☐ 2-4 years ☒ 4+ years ☒ Unknown **Score: 2**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☐ Regional ☒ LGA ☒ Suburb **Score: 3**	☐ Federal ☒ State ☐ Regional ☒ LGA ☐ Suburb **Score: 2**	☐ Federal ☒ State ☐ Regional ☒ LGA ☒ Suburb **Score: 3**
Established need in the community	What does the data tell us?	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☒ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 4**	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 3**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 3**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • Preventing Violence Against Together: A Strategy for the Southern Metropolitan Region • Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia • Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria. • Victoria's Action Plan to Address Violence Against Women and Children Strong Culture, Strong Peoples, Strong Families: Towards a safer future for Indigenous families and communities. • National Plan to Reduce Violence Against Women and their Children **Score: 4**

		Clause 3D, sub - section (2): What is the role of a Council?		Clause 3E, sub –section (1): What are the functions of a Council?	
Capacity of local government **Score: 8**	Does the health issue align with the Local Government Act 1989?	☒	2(a) acting as a representative government by **taking into account the diverse needs** of the local community **in decision making**	☒	1(a) **advocating** and promoting proposals which are in the best interests of the local community
		☒	2(b) providing **leadership** by establishing strategic objectives and monitoring their achievement;	☒	1(b) planning for and **providing services and facilities** for the local community
		☐	2(c) maintaining the viability of the Council by ensuring that **resources are managed** in a responsible and accountable manner	☒	1(c) providing and maintaining **community infrastructure** in the municipal district
		☐	2(d) **advocating** the interests of the local community to other communities and governments	☒	1(d) undertaking **strategic and land use planning** for the municipal district
		☐	2(e) acting as a responsible **partner** in government by taking into account the needs of other communities	☐	1(e) **raising revenue** to enable the Council to perform its functions
		☒	2(f) fostering **community cohesion** and encouraging **active participation** in civic life	☒	1(f) making and enforcing **local laws**
				☒	1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts
				☒	1(h) any other function relating to the **peace, order and good government** of the municipal district
	Does the health issue align with the Public Health and Wellbeing Act 2008?	**SECTION 24: The function of a Council** under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by **-** ☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health; ☒ (b) initiating, supporting and managing public health planning processes at the local government level ☒ (c) developing and implementing public health policies and programs within the municipal district ☐ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected ☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community ☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district ☒ (g) ensuring that the municipal district is maintained in a clean and sanitary condition		

Criteria	Considerations	EDUCATION, EMPLOYMENT AND INCOME			
		Education	Employment	Income/Social Gradient	Early Childhood Development
Measurable objectives and outcomes	Data sources:	• City of Port Phillip Community Profile – Profile I.D • Australian Early Development Census • VCAMS Indicators • Census Population and Housing	• Census of Population and Housing • Social Health Atlas of Victoria LGA Area	• Census of Population and Housing • Social Health Atlas of Victoria LGA Area • SEIFA Disadvantage Profile id. • Centrelink Payments • Know Your Council: Local Government Performance Reporting Framework	• VCAMS Indicators • Australian Early Development Census
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☒ Annually ☒ 2-4 years ☒ 4+ years ☐ Unknown **Score: 3**	☐ Quarterly ☐ Annually ☐ 2-4 years ☒ 4+ years ☒ Unknown **Score: 1**	☒ Quarterly ☐ Annually ☐ 2-4 years ☒ 4+ years ☐ Unknown **Score: 2**	☐ Quarterly ☒ Annually ☒ 2-4 years ☐ 4+ years ☐ Unknown *VCAMS Indicators are released annually* **Score: 2**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☐ Regional ☒ LGA ☐ Suburb **Score: 2**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☒ Federal ☒ State ☐ Regional ☒ LGA ☐ Suburb **Score: 3**
Established need in the community	What does the data tell us?	☒ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 1**	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 2**	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☐ The City of Port Phillip – Social Justice Charter ☒ Other; • Economic Development Strategy 2012 - 2016 **Score: 2**	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 3**	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • City of Port Phillip Family, Youth and Children Strategy • City of Port Phillip Early Years Strategy **Score: 3**

		Clause 3D, sub - section (2): What is the role of a Council?		Clause 3E, sub –section (1): What are the functions of a Council?	
Capacity of local government **Score: 7**	Does the health issue align with the Local Government Act 1989?	☒	2(a) acting as a representative government by **taking into account the diverse needs** of the local community **in decision making**	☒	1(a) **advocating** and promoting proposals which are in the best interests of the local community
		☒	2(b) providing **leadership** by establishing strategic objectives and monitoring their achievement;	☒	1(b) planning for and **providing services and facilities** for the local community
		☒	2(c) maintaining the viability of the Council by ensuring that **resources are managed** in a responsible and accountable manner	☒	1(c) providing and maintaining **community infrastructure** in the municipal district
		☒	2(d) **advocating** the interests of the local community to other communities and governments	☐	1(d) undertaking **strategic and land use planning** for the municipal district
		☒	2(e) acting as a responsible **partner** in government by taking into account the needs of other communities	☐	1(e) **raising revenue** to enable the Council to perform its functions
		☒	2(f) fostering **community cohesion** and encouraging **active participation** in civic life	☐	1(f) making and enforcing **local laws**
				☐	1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts
				☒	1(h) any other function relating to the **peace, order and good government** of the municipal district
	Does the health issue align with the Public Health and Wellbeing Act 2008?	**SECTION 24: The function of a Council** under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by **-**			
		☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health; ☒ (b) initiating, supporting and managing public health planning processes at the local government level ☒ (c) developing and implementing public health policies and programs within the municipal district ☒ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected ☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community ☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district ☐ (g) ensuring that the municipal district is maintained in a clean and sanitary condition			

Criteria	Considerations	HEALTH BEHAVIOURS		
		Healthy Eating	Physical Activity	Preventative Action
Measurable objectives and outcomes	Data sources:	• VicHealth Indicators Survey – Port Phillip LGA Profile • Victorian Population Health Survey • Adolescent Community Profiles	• VicHealth Indicators Survey – Port Phillip LGA Profile • Victorian Population Health Survey • Adolescent Community Profiles	• Victorian Population Health Survey • VicHealth Indicators Survey – Port Phillip LGA Profile
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☐ Annually ☒ 2-4 years ☒ 4+ years ☐ Unknown **Score: 2**	☐ Quarterly ☐ Annually ☒ 2-4 years ☐ 4+ years ☐ Unknown **Score: 1**	☐ Quarterly ☒ Annually ☒ 2-4 years ☒ 4+ years ☐ Unknown \ **Score: 3**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**
Established need in the community	What does the data tell us?	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**	☒ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 1**	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☒ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 3**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • Australian Dietary Guidelines 2013 **Score: 4**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • National Sport and Active Recreation Policy Framework • City of Port Phillip Sport and Recreation Strategy 2015-2024 **Score: 4**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 3**

Capacity of local government **Score: 7**	Does the health issue align with the Local Government Act 1989?	**Clause 3D, sub - section (2): What is the role of a Council?**		**Clause 3E, sub –section (1): What are the functions of a Council?**	
		☒	2(a) acting as a representative government by **taking into account the diverse needs** of the local community **in decision making**	☒	1(a) **advocating** and promoting proposals which are in the best interests of the local community
		☒	2(b) providing **leadership** by establishing strategic objectives and monitoring their achievement;	☒	1(b) planning for and **providing services and facilities** for the local community
		☒	2(c) maintaining the viability of the Council by ensuring that **resources are managed** in a responsible and accountable manner	☒	1(c) providing and maintaining **community infrastructure** in the municipal district
		☒	2(d) **advocating** the interests of the local community to other communities and governments	☐	1(d) undertaking **strategic and land use planning** for the municipal district
		☒	2(e) acting as a responsible **partner** in government by taking into account the needs of other communities	☐	1(e) **raising revenue** to enable the Council to perform its functions
		☒	2(f) fostering **community cohesion** and encouraging **active participation** in civic life	☐	1(f) making and enforcing **local laws**
				☐	1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts
				☒	1(h) any other function relating to the **peace, order and good government** of the municipal district
	Does the health issue align with the Public Health and Wellbeing Act 2008?	**SECTION 24: The function of a Council** under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by **-**			
		☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;			
		☒ (b) initiating, supporting and managing public health planning processes at the local government level			
		☒ (c) developing and implementing public health policies and programs within the municipal district			
		☒ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected			
		☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community			
		☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district			
		☐ (g) ensuring that the municipal district is maintained in a clean and sanitary condition			

Criteria	Considerations	HEALTH SERVICES	
		Access and Use	Maternal and Child Health
Measurable objectives and outcomes	Data sources:	• Department of Health and Human Service Profiles 2014 • Local Government Area Profile for the City of Port Phillip • Social Health Atlas of Victoria LGA Areas • VCAMS Indicators • Adolescent Community Profiles – Port Phillip LGA • Know Your Council: Local Government Performance Reporting Framework • Early Childhood Community Profiles • Oral Health Profile – City of Port Phillip	• Maternal and Child Health Services Annual Report • Australian Childhood Immunisation Registry
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☒ Annually ☐ 2-4 years ☐ 4+ years ☒ Unknown *(Know your Council: Local Government Performance Reporting Framework published annually)* **Score: 1**	☒ Quarterly ☒ Annually ☐ 2-4 years ☐ 4+ years ☐ Unknown **Score: 2**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**
Established need in the community	What does the data tell us?	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☒ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 3**	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☒ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 3**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 3**	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☐ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • City of Port Phillip Family, Youth and Children Strategy **Score: 3**

<table>
<tr><td rowspan="9">Capacity of local government

Score: 8</td><td rowspan="8">Does the health issue align with the Local Government Act 1989?</td><td colspan="2">Clause 3D, sub - section (2): What is the role of a Council?</td><td colspan="2">Clause 3E, sub –section (1): What are the functions of a Council?</td></tr>
<tr><td>☒</td><td>2(a) acting as a representative government by taking into account the diverse needs of the local community in decision making</td><td>☒</td><td>1(a) advocating and promoting proposals which are in the best interests of the local community</td></tr>
<tr><td>☒</td><td>2(b) providing leadership by establishing strategic objectives and monitoring their achievement;</td><td>☒</td><td>1(b) planning for and providing services and facilities for the local community</td></tr>
<tr><td>☒</td><td>2(c) maintaining the viability of the Council by ensuring that resources are managed in a responsible and accountable manner</td><td>☒</td><td>1(c) providing and maintaining community infrastructure in the municipal district</td></tr>
<tr><td>☒</td><td>2(d) advocating the interests of the local community to other communities and governments</td><td>☒</td><td>1(d) undertaking strategic and land use planning for the municipal district</td></tr>
<tr><td>☒</td><td>2(e) acting as a responsible partner in government by taking into account the needs of other communities</td><td>☐</td><td>1(e) raising revenue to enable the Council to perform its functions</td></tr>
<tr><td rowspan="3">☒</td><td rowspan="3">2(f) fostering community cohesion and encouraging active participation in civic life</td><td>☐</td><td>1(f) making and enforcing local laws</td></tr>
<tr><td>☐</td><td>1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts</td></tr>
<tr><td>☒</td><td>1(h) any other function relating to the peace, order and good government of the municipal district</td></tr>
<tr><td>Does the health issue align with the Public Health and Wellbeing Act 2008?</td><td colspan="4">SECTION 24: The function of a Council under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by -

☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;

☒ (b) initiating, supporting and managing public health planning processes at the local government level

☒ (c) developing and implementing public health policies and programs within the municipal district

☒ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected

☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community

☒ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district

☐ (g) ensuring that the municipal district is maintained in a clean and sanitary condition</td></tr>
</table>

Criteria	Considerations	HOUSING AND HOMELESSNESS	
		Housing	Homelessness
Measurable objectives and outcomes	Data sources:	• Social Atlas – Port Phillip • Census of Population and Housing • Affordable lettings by LGA • Social Health Atlas of Victoria LGA Area	• Census of Population and Housing – Estimating Homelessness 2011
	Can the data be tracked regularly (for evaluation purposes)?	☒ Quarterly ☐ Annually ☐ 2-4 years ☒ 4+ years ☐ Unknown *Affordable lettings data is released quarterly, every other data source is released every 5 years.* **Score: 2**	☐ Quarterly ☐ Annually ☐ 2-4 years ☒ 4+ years ☐ Unknown **Score: 1**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☐ Regional ☒ LGA ☐ Suburb **Score: 2**	☒ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 4**
Established need in the community	What does the data tell us?	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☒ **Substantially not favourable** compared to the Victorian average **Score: 5**	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☒ **Substantially not favourable** compared to the Victorian average **Score: 5**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • City of Port Phillip Homelessness Action Strategy 2015-2020 • City of Port Phillip In Our Backyard – Growing Affordable Housing in Port Phillip 2015-2025 • City of Port Phillip Housing Strategy 2007 – 2017 • Port Phillip Housing Association Strategic Direction 2015 – 2018 • St Kilda Community Housing • South Port Community Housing **Score: 4**	☐ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • City of Port Phillip Homelessness Action Strategy 2015-2020 • City of Port Phillip In Our Backyard – Growing Affordable Housing in Port Phillip 2015-2025 • City of Port Phillip Housing Strategy 2007 – 2017 **Score: 4**

Capacity of local government **Score:** 8	Does the health issue align with the Local Government Act 1989?	**Clause 3D, sub - section (2): What is the role of a Council?**		**Clause 3E, sub –section (1): What are the functions of a Council?**	
		☒	2(a) acting as a representative government by **taking into account the diverse needs** of the local community **in decision making**	☒	1(a) **advocating** and promoting proposals which are in the best interests of the local community
		☒	2(b) providing **leadership** by establishing strategic objectives and monitoring their achievement;	☐	1(b) planning for and **providing services and facilities** for the local community
		☒	2(c) maintaining the viability of the Council by ensuring that **resources are managed** in a responsible and accountable manner	☒	1(c) providing and maintaining **community infrastructure** in the municipal district
		☒	2(d) **advocating** the interests of the local community to other communities and governments	☒	1(d) undertaking **strategic and land use planning** for the municipal district
		☒	2(e) acting as a responsible **partner** in government by taking into account the needs of other communities	☐	1(e) **raising revenue** to enable the Council to perform its functions
		☒	2(f) fostering **community cohesion** and encouraging **active participation** in civic life	☒	1(f) making and enforcing **local laws**
				☐	1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts
				☒	1(h) any other function relating to the **peace, order and good government** of the municipal district
	Does the health issue align with the Public Health and Wellbeing Act 2008?	**SECTION 24: The function of a Council** under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by **-**			
		☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;			
		☒ (b) initiating, supporting and managing public health planning processes at the local government level			
		☒ (c) developing and implementing public health policies and programs within the municipal district			
		☒ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected			
		☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community			
		☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district			
		☒ (g) ensuring that the municipal district is maintained in a clean and sanitary condition			

Criteria	Considerations	INDIVIDUAL HEALTH		
		Health Status	Prevalence of Illness and Disease	Sexual and Reproductive Health
Measurable objectives and outcomes	Data sources:	• Department of Health and Human Service Profiles 2014 • Local Government Area Profile for the City of Port Phillip • Victorian Population Health Survey • Measures of Health Activity and Outcome • Adolescent Community Profiles – Port Phillip LGA • Early Childhood Community Profiles – Port Phillip • Deaths Australia	• HeartMaps – Heart Foundation • Department of Health and Human Service Profile 2014 • Local Government Area Profile for the City of Port Phillip • Social Health Atlas of Victoria LGA Areas • Victorian Notifiable Infectious Disease Surveillance database • Victorian Population Health Survey • Community Indicators Victoria • Adolescent Community Profiles • VCAMS Indicators • Early Childhood Community Profiles	• Adolescent Community Profiles – Port Phillip LGA • Victorian Notifiable Infectious Diseases Surveillance database • Women's Health in the South East dataset
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☐ Annually ☒ 2-4 years ☐ 4+ years ☒ Unknown **Score: 1**	☐ Quarterly ☐ Annually ☒ 2-4 years ☐ 4+ years ☒ Unknown • *The Victorian Population Health Survey is released every 3 years.* • *The Victorian Notifiable Infectious Disease Surveillance database is updated daily.* **Score: 1**	☒ Quarterly ☐ Annually ☐ 2-4 years ☐ 4+ years ☐ Unknown • *The Victorian Notifiable Infectious Disease Surveillance database is updated daily.* **Score: 1**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**
Established need in the community	What does the data tell us?	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☒ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 3**	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☒ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 3**	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☒ **Substantially not favourable** compared to the Victorian average **Score: 5**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 4**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 4**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☐ Other; **Score: 4**

		Clause 3D, sub - section (2): What is the role of a Council?		Clause 3E, sub –section (1): What are the functions of a Council?	
Capacity of local government **Score: 6**	Does the health issue align with the Local Government Act 1989?	☒	2(a) acting as a representative government by **taking into account the diverse needs** of the local community **in decision making**	☒	1(a) **advocating** and promoting proposals which are in the best interests of the local community
		☒	2(b) providing **leadership** by establishing strategic objectives and monitoring their achievement;	☒	1(b) planning for and **providing services and facilities** for the local community
		☒	2(c) maintaining the viability of the Council by ensuring that **resources are managed** in a responsible and accountable manner	☒	1(c) providing and maintaining **community infrastructure** in the municipal district
		☒	2(d) **advocating** the interests of the local community to other communities and governments	☐	1(d) undertaking **strategic and land use planning** for the municipal district
		☐	2(e) acting as a responsible **partner** in government by taking into account the needs of other communities	☐	1(e) **raising revenue** to enable the Council to perform its functions
		☒	2(f) fostering **community cohesion** and encouraging **active participation** in civic life	☐	1(f) making and enforcing **local laws**
				☐	1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts
				☐	1(h) any other function relating to the **peace, order and good government** of the municipal district
	Does the health issue align with the Public Health and Wellbeing Act 2008?	**SECTION 24: The function of a Council** under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by **-**			
		☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health; ☒ (b) initiating, supporting and managing public health planning processes at the local government level ☒ (c) developing and implementing public health policies and programs within the municipal district ☐ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected ☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community ☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district ☒ (g) ensuring that the municipal district is maintained in a clean and sanitary condition			

Criteria	Considerations	MENTAL HEALTH	
		Lifestyle and Risk Factors	Prevalence of Mental Health
Measurable objectives and outcomes	Data sources:	• VicHealth Indicators Survey – Port Phillip LGA Profile • Adolescent Community Profiles – Port Phillip LGA • Early Childhood Community Profiles – Port Phillip	• VCAMS Indicators • Victorian Population Health Survey • Claims Data – Victorian Government Data Directory • Resilience Survey – Port Phillip • Mental Health Service Clients dataset • Dementia Statistics for Victoria • Department of Health and Human Service Profiles 2014 • Social Health Atlas of Victoria LGA Areas
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☐ Annually ☐ 2-4 years ☒ 4+ years ☒Unknown **Score: 1**	☐ Quarterly ☒ Annually ☒ 2-4 years ☐ 4+ years ☒ Unknown **Score: 2**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☐ Regional ☒ LGA ☐ Suburb **Score: 2**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**
Established need in the community	What does the data tell us?	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☒ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 3**	☐ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☒ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 4**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • Victoria's 10 year Mental Health Plan • Fifth National Mental Health Plan • National Suicide Prevention Strategy • National Aboriginal and Torres Strait Islander Suicide Prevention Strategy • VicHealth Mental Wellbeing Strategy 2015 - 2019 **Score: 5**	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☒ The City of Port Phillip – Social Justice Charter ☒ Other; • Victoria's 10 year Mental Health Plan • Fifth National Mental Health Plan • National Suicide Prevention Strategy • National Aboriginal and Torres Strait Islander Suicide Prevention Strategy • VicHealth Mental Wellbeing Strategy 2015 - 2019 **Score: 5**

<table>
<tr><td rowspan="9">Capacity of local government

Score: 6</td><td rowspan="8">Does the health issue align with the Local Government Act 1989?</td><td colspan="2">Clause 3D, sub - section (2): What is the role of a Council?</td><td colspan="2">Clause 3E, sub –section (1): What are the functions of a Council?</td></tr>
<tr><td>☒</td><td>2(a) acting as a representative government by taking into account the diverse needs of the local community in decision making</td><td>☒</td><td>1(a) advocating and promoting proposals which are in the best interests of the local community</td></tr>
<tr><td>☒</td><td>2(b) providing leadership by establishing strategic objectives and monitoring their achievement;</td><td>☒</td><td>1(b) planning for and providing services and facilities for the local community</td></tr>
<tr><td>☐</td><td>2(c) maintaining the viability of the Council by ensuring that resources are managed in a responsible and accountable manner</td><td>☒</td><td>1(c) providing and maintaining community infrastructure in the municipal district</td></tr>
<tr><td>☒</td><td>2(d) advocating the interests of the local community to other communities and governments</td><td>☐</td><td>1(d) undertaking strategic and land use planning for the municipal district</td></tr>
<tr><td>☒</td><td>2(e) acting as a responsible partner in government by taking into account the needs of other communities</td><td>☐</td><td>1(e) raising revenue to enable the Council to perform its functions</td></tr>
<tr><td rowspan="3">☒</td><td rowspan="3">2(f) fostering community cohesion and encouraging active participation in civic life</td><td>☐</td><td>1(f) making and enforcing local laws</td></tr>
<tr><td>☐</td><td>1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts</td></tr>
<tr><td>☒</td><td>1(h) any other function relating to the peace, order and good government of the municipal district</td></tr>
<tr><td>Does the health issue align with the Public Health and Wellbeing Act 2008?</td><td colspan="4">SECTION 24: The function of a Council under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by -

☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;

☒ (b) initiating, supporting and managing public health planning processes at the local government level

☒ (c) developing and implementing public health policies and programs within the municipal district

☐ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected

☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community

☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district

☐ (g) ensuring that the municipal district is maintained in a clean and sanitary condition</td></tr>
</table>

Criteria	Considerations	TRANSPORT AND MOBILITY	
		Sustainable Transport	Transport
Measurable objectives and outcomes	Data sources:	• Victorian Population Health Survey • Census of Population and Housing • Crash Stats – VicRoads • Health and Wellbeing Index 2013-2017 – Department of Education and Training Victoria	• VicHealth Indicators Survey – Port Phillip LGA Profile • Local Government Area Profile for the City of Port Phillip • Census for Population and Housing • Adolescent Community Profiles – Port Phillip • Crash Stats - VicRoads • Know Your Council: Local Government Performance Reporting Framework • Health and Wellbeing Index 2013-2017 – Department of Education and Training Victoria
	Can the data be tracked regularly (for evaluation purposes)?	☐ Quarterly ☒ Annually ☒ 2-4 years ☒ 4+ years ☐Unknown **Score: 3**	☐ Quarterly ☒ Annually ☐ 2-4 years ☒ 4+ years ☒ Unknown **Score: 2**
	Is there a Victorian benchmark?	☒ Yes ☐ No **Score: 6**	☒ Yes ☐ No **Score: 6**
	What level of data is available?	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**	☐ Federal ☒ State ☒ Regional ☒ LGA ☐ Suburb **Score: 3**
Established need in the community	What does the data tell us?	☒ **Substantially favourable** compared to the Victorian average ☐ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 1**	☐ **Substantially favourable** compared to the Victorian average ☒ **Slightly favourable** compared to the Victorian average ☐ More or less the **same** as the Victorian average ☐ **Slightly not favourable** compared to the Victorian average ☐ **Substantially not favourable** compared to the Victorian average **Score: 2**
Alignment to federal, state and local policies and plans	Does the health issue align to the following:	☒ National Health Priority Areas ☒ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☐ The City of Port Phillip – Social Justice Charter ☒ Other; • Sustainable Transport Strategy: A Connected and Liveable City • Bike Plan: Pedal Power, making bike riding better • Walk Plan: Feet first, making pedestrian the priority • Toward Zero – Sustainable Environment Strategy **Score: 4**	☐ National Health Priority Areas ☐ Victorian Public Health and Wellbeing Plan 2015-2019 ☒ The City of Port Phillip – Council Plan ☐ The City of Port Phillip – Social Justice Charter ☒ Other; • Sustainable Transport Strategy: A Connected and Liveable City • Toward Zero – Sustainable Environment Strategy **Score: 2**

Capacity of local government **Score: 6**	Does the health issue align with the Local Government Act 1989?	**Clause 3D, sub - section (2): What is the role of a Council?**		**Clause 3E, sub –section (1): What are the functions of a Council?**	
		☒	2(a) acting as a representative government by **taking into account the diverse needs** of the local community **in decision making**	☒	1(a) **advocating** and promoting proposals which are in the best interests of the local community
		☒	2(b) providing **leadership** by establishing strategic objectives and monitoring their achievement;	☒	1(b) planning for and **providing services and facilities** for the local community
		☒	2(c) maintaining the viability of the Council by ensuring that **resources are managed** in a responsible and accountable manner	☒	1(c) providing and maintaining **community infrastructure** in the municipal district
		☒	2(d) **advocating** the interests of the local community to other communities and governments	☒	1(d) undertaking **strategic and land use planning** for the municipal district
		☒	2(e) acting as a responsible **partner** in government by taking into account the needs of other communities	☐	1(e) **raising revenue** to enable the Council to perform its functions
		☒	2(f) fostering **community cohesion** and encouraging **active participation** in civic life	☐	1(f) making and enforcing **local laws**
				☐	1(g) exercising, performing and discharging the duties, functions and powers of Councils under this Act and other Acts
				☒	1(h) any other function relating to the **peace, order and good government** of the municipal district
	Does the health issue align with the Public Health and Wellbeing Act 2008?	**SECTION 24: The function of a Council** under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by **-**			
		☒ (a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health;			
		☐ (b) initiating, supporting and managing public health planning processes at the local government level			
		☐ (c) developing and implementing public health policies and programs within the municipal district			
		☐ (d) developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected			
		☒ (e)facilitating and supporting local agencies whose work has an impact on public health and wellbeing to improve public health and wellbeing in the local community			
		☐ (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district			
		☐ (g) ensuring that the municipal district is maintained in a clean and sanitary condition			

REFERENCES

6. REFERENCES

[1] Environments for Health, Victorian Department of Human Services
[2] Environments for Health, Victorian Department of Human Services
[3] Victorian Public Health and Wellbeing Plan 2015-19, Department of Health and Human Services Victorian Government
[4] Guide to municipal public health and wellbeing planning, Department of Health
[5] Fair Foundations: The VicHealth framework for health equity, VicHealth
[6] Closing the gap in a generation: health equity through action on the social determinants of health, WHO: Commission on Social Determinants of Health.
[7] Policies and Strategies to Promote Social Equity in Health, Dahlgren G, Whitehead M. for the Institute for Futures Studies.
[8] Fair Foundations: The VicHealth framework for health equity, VicHealth
[9] The equity action spectrum: taking a comprehensive approach, The Regional Office for Europe of the World Health Organization
[10] Fair Society, Healthy Lives. The Marmot Review
[11] Fair Foundations: The VicHealth framework for health equity, VicHealth
[12] Victorian Public Health and Wellbeing Plan 2015-19, Department of Health and Human Services, Victorian Government
[13] Aged Care Reform, Department of Health, Australian Government
[14] Why is Aged Care Changing?, Department of Health
[15] About NDIS, Victorian Government
[16] Local government for a better Victoria, An Inquiry into streamlining government regulation, Victorian Competition and Efficiency Commission
[17] Victorian Alcohol and Drug Association, 2014, Frequently Asked Questions: Sector Reform, <http://www.vaada.org.au/wp-content/uploads/2014/06/FAQs-for-Sector-Reform-Website.pdf>.
[18] Report and Recommendation, Royal Commission into Family violence
[19] Strong Families, Safe Children, Victorian Government
[20] The City of Port Phillip's Health and Wellbeing Plan 2007-2013
[21] The City of Port Phillip Annual Report 2008-2009
[22] Social housing is here defined as households renting from a State/Territory Government housing authority (generally referred to as public housing) and households renting from a housing co-operative, community organisation or church group.
[23] National Health And Medical Research Council (NHMRC) 2009, Australian guidelines to reduce health risks from drinking alcohol, NHMRC, Canberra.
[24] Collins, D & Lapsley, H 2008, The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05, Department of Health, Canberra.
[25] Australian Institute of Health and Welfare (AIHW) 2014, National Drug Strategy Household Survey detailed report: 2013, Drug statistics series no. 28, AIHW cat. no. PHE 183, AIHW, Canberra.
[26] Rehm, J, Baliunas, D, Borges, GL, Graham, K, Irving, H, Kehoe, T, Parry, CD, Patra, J, Popova, S, Poznyak, V, Roerecke, M, Room, R, Samokhvalov, AV & Taylor, B 2010, 'The relation between different dimensions of alcohol consumption and burden of disease: An overview', Addiction, vol. 105, no. 5, pp. 817–43.
[27] Laslett, AM, Room, R, Ferris, J, Wilkinson, C, Livingston, M & Mugavin, J 2011, 'Surveying the range and magnitude of alcohol's harm to others in Australia', Addiction, vol. 106, no. 11, pp. 1603–11.
[28] Laslett, AM, Room, R, Ferris, J, Wilkinson, C, Livingston, M & Mugavin, J 2011, 'Surveying the range and magnitude of alcohol's harm to others in Australia', Addiction, vol. 106, no. 11, pp. 1603–11.
[29] Ahlström, SK & Österberg, EL 2004, 'International perspectives on adolescent and young adult drinking', Alcohol Research and Health, vol. 28, issue 4, p. 258.
[30] Jones, L, Bates, G, Mccoy, E & Bellis, MA 2015, 'Relationship between alcohol-attributable disease and socioeconomic status, and the role of alcohol consumption in this relationship: A systematic review and metaanalysis', BMC Public Health, 15, 1–14.
Makela, P & Paljarvi, T 2008, 'Do consequences of a given pattern of drinking vary by socioeconomic status? A mortality and hospitalisation follow-up for alcohol-related causes of the Finnish Drinking Habits Surveys', J Epidemiol Community Health, 62, 728–33.

[31] AIHW (Australian Institute of Health and Welfare) 2012. Risk factors contributing to chronic disease. Cat. no. PHE 157. Canberra: Australian Institute of Health and Welfare.
[32] Scollo, M.M. and M.H.Winstanley (eds) 2008, Tobacco in Australia: facts and issues, http://tobaccoinaustralia.org.au/
[33] Australian Institute of Health and Welfare 2016, Australian burden of disease study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4, AIHW, Canberra.
[34] Banks, E, Joshy, G, Weber, M, Liu, B, Grenfell, R, Egger, S, Paige, E, Lopez, A, Sitas, F & Beral, V 2015, 'Tobacco smoking and all-cause mortality in a large Australian cohort study: Findings from a mature epidemic with current low smoking prevalence', BMC Medicine, 13, 38.
[35] US Department of Health and Human Services, 2006, The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General, US Department of Health and Human Services, Atlanta.
[36] Office for National Statistics 2016, Social capital across the UK: 2011 to 2012, Office for National Statistics, London.
[37] Carpini, MXD, Cook, FL & Jacobs, LR 2004, 'Public deliberation, discursive participation, and citizen engagement: a review of the empirical literature', Annual Review of Political Science, vol. 7, pp. 315-344.
[38] Carpini, MXD, Cook, FL & Jacobs, LR 2004, 'Public deliberation, discursive participation, and citizen engagement: a review of the empirical literature', Annual Review of Political Science, vol. 7, pp. 315-344.
[39] Baum, FE, Bush, RA, Modra, CC, Murray, CJ, Cox, EM, Alexander, KM & Potter, RC 2000, 'Epidemiology of participation: an Australian community study', Journal of Epidemiology and Community Health, vol. 54(6), pp. 414-423.
[40] Woolcock, M 1998, 'Social capital and economic development: toward a theoretical synthesis and policy framework', Theory and Society, vol. 27(2), pp. 151-208.
Woolcock, M & Narayan, D 2000, 'Social capital: implications for development theory, research, and policy', The World Bank Research Observer, vol. 15(2), pp. 225-249.
[41] Australian Bureau of Statistics, 2004, Household and family projections: Australia 2001–2006, cat. no. 3236.0, ABS, Canberra.
[42] Cornwell, E & Waite, L, 2009, 'Social disconnectedness, perceived isolation, and health among older adults', Journal of Health & Social Behaviour, vol. 50, no. 1, pp. 31–48.
[43] Office for National Statistics 2014, Measuring social capital, Office for National Statistics, UK.
[44] Friedli, L 2009, Mental health, resilience and inequalities, World Health Organization Europe Regional Office, Copenhagen.
Baumeister, RF & Leary, MR 1995, 'The need to belong: Desire for interpersonal attachments as a fundamental human motivation', Psychological Bulletin, 117, 497–529.
Hart, J, Shaver, PR & Goldenberg, JL 2005, 'Attachment, self-esteem, worldviews, and terror management: Evidence for a tripartite security system'. Journal of Personality and Social Psychology, 88, 999–1013.
[45] Office for National Statistics 2016, Social capital across the UK: 2011 to 2012, Office for National Statistics, London.
[46] Elliott, J, Gale, CR, Parsons, S, Kuh, D, The HALCyon Study Team 2014, 'The neighbourhood cohesion and mental wellbeing among older adults: A mixed methods approach', Social Science & Medicine, vol. 107, pp. 44–51.
[47] Robinette, JW, Charles, ST, Mogle, JA, & Almeida, DM 2013, 'Neighborhood cohesion and daily well-being: Results from a diary study', Social Science & Medicine, vol. 96, pp. 174–82.
[48] Coleman, J 1990, Foundations of social theory, Harvard University Press, Cambridge, Mass.
Putnam, J 1993, Making democracy work: Civic traditions in modern Italy, Princeton University, Princeton NJ.
[49] Strahilevitz, L 2003, Social norms from close-knit groups to loose-knit groups, University of Chicago Law Review, vol. 70, no. 1, pp. 359–72.
[50] Office for National Statistics 2016, Social capital across the UK: 2011 to 2012, Office for National Statistics, London.
[51] Reavley, N, Bassilios, B, Ryan, S, Schlichthorst, M & Nicholas, A 2015, Interventions to build resilience among young people: a literature review, Victorian Health Promotion Foundation, Melbourne.
Tollit, M, McDonald, M, Borschmann, R, Bennett, K, von Sabler, M & Patton, G 2015, Epidemiological evidence relating to resilience and young people: a literature review, Victorian Health Promotion Foundation, Melbourne.
[52] Friedli, L 2009, Mental health, resilience and inequalities, World Health Organization Europe Regional Office, Copenhagen.
Mead, R & Cummins, R 2010, What makes us happy? Ten years of the Australian Unity Wellbeing Index, Australian Unity, Deakin University, Melbourne.
[53] Australian Bureau of Statistics (ABS) 2010, Australian social trends: Who's afraid? Feelings of personal safety, ABS cat. no. 4102.0, ABS, Canberra.

[54] Ross, CE 1993, 'Fear of victimization and health', Journal of Quantitative Criminology, vol. 9, issue 2, pp. 2159–75.
[55] Warburton, DE, Nicol, CW & Bredin, SS 2006, 'Health benefits of physical activity: The evidence', Canadian Medical Association Journal, vol. 174, no. 6, pp. 801–09.
[56] Baum, FE, Ziersch, AM, Zhang, G & Osborne, K 2009, 'Do perceived neighbourhood cohesion and safety contribute to neighbourhood differences in health?', Health & Place, vol. 15, no. 4, pp. 925–34.
[57] Cubbin, C, Pedregon, V, Egerter, S & Braveman, P 2008, Where we live matters for our health: Neighborhoods and health. Issue brief 3: Neighbourhoods and health, Robert Wood Johnson Foundation, San Francisco.
[58] Stafford, M, Chandola, T & Marmot, M 2007, 'Association between fear of crime and mental health and physical functioning', American Journal of Public Health, vol. 97, no. 11, pp. 2076–81.
[59] Giles-Corti, B & Donovan, R 2002, 'The relative influence of individual, social and physical environment determinants of physical activity', Social Science & Medicine, vol. 54, no. 12, pp. 1793–1812.
[60] Stafford, M, Chandola, T & Marmot, M 2007, 'Association between fear of crime and mental health and physical functioning', American Journal of Public Health, vol. 97, no. 11, pp. 2076–81.
[61] UN Women 2015, A Framework to underpin action to prevent violence against women, UN Women, New York.
Webster, K 2016, A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women (ANROWS Compass, 07/2016), Australia's National Research Organisation for Women's Safety Limited (ANROWS), Sydney.
[62] Webster, K 2016, A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women (ANROWS Compass, 07/2016), Australia's National Research Organisation for Women's Safety Limited (ANROWS), Sydney.
[63] Australian Bureau of Statistics (ABS) 2013, Personal safety, Australia, 2012, ABS cat. no. 4906.0, viewed 18 May 2016, www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4906.0Main+Features12012.
[64] PricewaterhouseCoopers Australia (PwC) 2015, A high price to pay: The economic case for preventing violence against women, PricewaterhouseCoopers, Sydney.
[65] Webster, K 2016, A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women (ANROWS Compass, 07/2016), Australia's National Research Organisation for Women's Safety Limited (ANROWS), Sydney.
[66] VicHealth 2004, The health costs of violence: Measuring the burden of disease caused by intimate partner violence. A summary of findings, Victorian Health Promotion Foundation, Melbourne.
Rees, S, Silove, D, Chey, T, Ivancic, L, Steel, Z, Creamer, M, Tesson, M, Bryant, R, Mcfarlane, A, Mills, K, Slade, T, Carrgher, N, O'Donnell, M & Forbes, D 2011, 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', Journal of the American Medical Association 306, 513–521.
World Health Organization 2013, Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, World Health Organization, Geneva.
[67] World Health Organization (WHO) 2010, Violence prevention: The evidence, WHO, Geneva.
[68] UN Women 2015, A Framework to underpin action to prevent violence against women, UN Women, New York.
[69] VicHealth (2005). Health Inequalities: A Position Paper for VicHealth
[70] VicHealth (2005). Health Inequalities: A Position Paper for VicHealth
[71] Stanwick, J., K. Ong et al (2006). Vocational education and training, health and wellbeing: Is there a relationship? Adelaide, National Centre for Vocational Education Research
Turrell, G., L. Stanley et al (2006). Health Inequalities in Australia: Morbidity, Health Behaviours, Risk Factors and Health Service Use. Canberra, Queensland University of Technology & Australian Institute of Health and Welfare.
Laplagne, P., M. Glover et al (2007). Effects of Health and Education on Labour Force Participation, Staff Working Paper. Melbourne, Productivity Commission.
[72] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[73] VicHealth (2005). Health Inequalities: A Position Paper for VicHealth
[74] Cutler, D., Lleras-Muney, A. 2007, 'Education and Health', National Poverty Center, Gerald R. Ford School of Public Policy, University of Michigan.
[75] Feinstein, Leon, et al. 2006, 'What are the effects of education on health?', Report on Measuring the Effects of Education and Health and Civic Engagement, Proceedings of the Copenhagen Symposium, OECD, Copenhagen
[76] Turrell, G., L. Stanley et al (2006). Health Inequalities in Australia: Morbidity, Health Behaviours, Risk Factors and Health Service Use. Canberra, Queensland University of Technology & Australian Institute of Health and Welfare.

[77] Stanwick, J., K. Ong et al (2006). Vocational education and training, health and wellbeing: Is there a relationship? Adelaide, National Centre for Vocational Education Research.
[78] Laplagne, P., M. Glover et al (2007). Effects of Health and Education on Labour Force Participation, Staff Working Paper. Melbourne, Productivity Commission.
[79] World Health Organization, Health Impact Assessment; Social Determinants of Health; accessed on 30/11/2016
[80] Galobardes B, Shaw M, Lawlor DA, Lynch JW & Smith GD 2006. Indicators of socioeconomic position. Journal of Epidemiology and Community Health 60(1):7–12 and 60(2):95–101.
[81] Mathers CD & Schofield DJ 1998. The health consequences of unemployment: the evidence. Medical Journal of Australia 168(4):178–82.
[82] Dooley D, Fielding J & Levi L 1996. Health and unemployment. Annual Review of Public Health 17:449–65.
[83] World Health Organization 2003, Diet, nutrition and the prevention of chronic disease: Report of a joint WHO/FAO expert consutlation, World Health Organization, Geneva.
[84] National Health and Medical Research Council (NHMRC) 2013, Australian Dietary Guidelines, NHMRC, Canberra.
[85] Australian Institute of Health and Welfare (AHW) 2016, Australian burden of disease study: Impact and causes of illness and death in Australia 2011, Australian Burden of Disease Study series no. 3, AIHW cat. no. BOD 4, Canberra, AIHW.
[86] World Health Organization (WHO) 2011, Global health risks: Mortality and burden of disease attributable to selected major risks, WHO, Geneva.
[87] Australian Institute of Health and Welfare (AHW) 2016, Australian burden of disease study: Impact and causes of illness and death in Australia 2011, Australian Burden of Disease Study series no. 3, AIHW cat. no. BOD 4, Canberra, AIHW.
[88] National Health and Medical Research Council (NHMRC) 2013, Australian Dietary Guidelines, NHMRC, Canberra.
[89] Malik, VS, Popkin, BM, Bray, GA, Després, JP & Hu, FB 2010, 'Sugar-sweetened beverages, obesity, type 2 diabetes mellitus, and cardiovascular disease risk', Circulation, vol. 121, no. 11, pp. 1356–64.
Woodward-Lopez, G, Kao, J & Ritchie, L 2011, 'To what extent have sweetened beverages contributed to the obesity epidemic?', Public Health Nutrition, vol. 14, no. 3, pp. 499–509.
[90] Brindal, E, Mohr, P, Wilson, C & Wittert, G 2008, 'Obesity and the effects of choice at a fast food restaurant', Obesity Research & Clinical Practice, 2(2), pp. 111–17.
[91] Rosenheck, R., 2008, 'Fast food consumption and increased caloric intake: A systematic review of a trajectory towards weight gain and obesity risk', Obesity Reviews, 9(6), pp. 535–547.
[92] Lim, S.S., Vos, T., Flaxman, A.D., Danaei, G., Shibuya, K., AdairRohani, H., AlMazroa, M.A., Amann, M., Anderson, H.R., Andrews, K.G. and Aryee, M., 2012. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. The lancet, 380(9859), pp.2224-2260.
[93] Department of Health 2014, Australia's physical activity and sedentary behaviour guidelines, Australian Government, Canberra.
Cadilhac, DA, Cumming, TB, Sheppard, L, Pearce, Dc, Carter, R & Magnus, A 2011, 'The economic benefits of reducing physical inactivity: An Australian example', Int J Behav Nutr Phys Act, 8, 99.
[94] Department of Health 2014, Australia's physical activity and sedentary behaviour guidelines, Australian Government, Canberra.
[95] Cadilhac, DA, Cumming, TB, Sheppard, L, Pearce, Dc, Carter, R & Magnus, A 2011, 'The economic benefits of reducing physical inactivity: An Australian example', Int J Behav Nutr Phys Act, 8, 99.
[96] Dunstan, DW, Barr, ELM, Healy, GN, Salmon, J, Shaw, JE, Balkau, B, Magliano, DJ, Cameron, AJ, Zimmet, PZ, Owen, N 2010, 'Television viewing time and mortality: The Australian diabetes, obesity and lifestyle study (AusDiab)', Circulation, 121, 384–391.
[97] Pearson, N & Biddle, SJ 2011, 'Sedentary behavior and dietary intake in children, adolescents, and adults. A systematic review', Am J Prev Med, 41, 178–88.
Grontved, A & Hu, F 2011, 'Television viewing and risk of type 2 diabetes, cardiovascular disease, and all-cause mortality: A meta-analysis', JAMA, 305, 2448–55.
Lynch, BM 2010, 'Sedentary behavior and cancer: A systematic review of the literature and proposed biological mechanisms', Cancer Epidemiol Biomarkers Prev, 19, 2691–709.
Thorp, AA, Owen, N, Neuhaus, M & Dunstan, DW 2011, 'Sedentary behaviors and subsequent health outcomes in adults: A systematic review of longitudinal studies, 1996–2011', American Journal of Preventive
[98] Australian Institute of Health and Welfare, 2005, States & Territories GRIM (General Record of Incidence of Mortality) Books, AIHW, Canberra.

[99] Staples, M, Elwood, M, Burton, R, Williams, J, Marks, R & Giles, G, 2006, 'Nonmelanoma skin cancer in Australia: The 2002 national survey and trends since 1985', Medical Journal of Australia, vol. 184, pp. 6–10
[100] Australian Institute of Health and Welfare, 2005, Health system expenditures on cancer and other neoplasms in Australia 2000-01, cat. no. HWE 29, Australian Institute of Health and Welfare, Canberra.
[101] Cancer Council Victoria 2011, SunSmart, www.cancervic.org.au/preventingcancer/be-sunsmart
[102] SunSmart 2012, Shade policy background information sheet, www.sunsmart.com.au/workplaces_and_local_government/in_local_government
[103] DoHA (Department of Health and Ageing) 2015c, National Cervical Screening Program, viewed 6 August 2015,
[104] DoHA (Department of Health and Ageing) 2015a, National Bowel Cancer Screening Program, viewed 6 August 2015,.
[105] AIHW (Australian Institute of Health and Welfare) 2014b, Cancer in Australia: an overview 2014, cancer series no. 90, cat. no. CAN 88, AIHW, Canberra.
[106] Breastscreen Victoria 2015, Breastscreen Victoria the facts, viewed 6 August 2015, .
[107] Access Economics 2010, Clear focus: the economic impact of vision loss in Australia in 2009, an overview of the report prepared for Vision 2020 Australia by Access Economics Pty Limited, Access Economics, Melbourne.
[108] PHCAG (Primary Health Care Advisory Group) 2015. Better outcomes for people with chronic and complex health conditions through primary health care: discussion paper. August 2015. Canberra: Primary Health Care Advisory Group.
[109] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[110] Van Doorslaer E, Masseria C, Koolman X, et al. (2006). Inequalities in access to medical care by income in developed countries. Canadian Medical Association Journal, 174(2), 177-183.
[111] Clinical Epidemiology & Health Service Evaluation Unit. (2009). Potentially preventable hospitalisations: A review of the literature and Australian policies. Melbourne: Melbourne Health.
[112] Black D. (1980). Inequalities in Health: Report of a Research Working Group (The Black Report). London: Department of Health and Social Services, UK Government
[113] Page A, Ambrose S, Glover J, et al. (2007). Atlas of avoidable hospitalisations in Australia: Ambulatory care-sensitive conditions. Public Health Information Development Unit, University of Adelaide [Electronic Version]. Retrieved 27 May 2010.
Australian Institute of Health and Welfare. (2009). Australian hospital statistics 2007-08. Health services series no. 33. Cat. no. HSE 71. Canberra: AIHW.
[114] Australian Institute of Health and Welfare. (2009). Australian hospital statistics 2007-08. Health services series no. 33. Cat. no. HSE 71. Canberra: AIHW.
[115] Turrell G, Oldenburg BF, Harris E, et al. (2004). Utilisation of general practitioner services by socio-economic disadvantage and geographic remoteness. Australian and New Zealand Journal of Public Health, 28(2), 152-158.
[116] Furler JS, Harris E, Chondros P, et al. (2002). The inverse care law revisited: Impact of disadvantaged location on accessing longer GP consultation times. MJA, 177(2), 80-83.
[117] Furler JS, Harris E, Chondros P, et al. (2002). The inverse care law revisited: Impact of disadvantaged location on accessing longer GP consultation times. MJA, 177(2), 80-83.
[118] Wilkinson D, Symon BG. (2000). Inequitable distribution of general practitioners in Australia: estimating need through the Robin Hood index. Australian and New Zealand Journal of Public Health, 24(1), 71-75.
[119] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[120] AIHW 2015a. Australia's hospitals 2013–14: at a glance. Health services series no. 61. Cat. no. HSE 157. Canberra: AIHW.
[121] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[122] Australian Housing and Urban Research Institute (2001). Do housing conditions impact on health inequalities between Australia's rich and poor?
[123] World Health Organization 1997, The World Health Report 1997. Conquering suffering Enriching humanity. Report of the Director-General, Geneva.
[124] Best, R. (1999) Health inequalities: the place of housing. In: Inequalities in health: the evidence. The evidence presented to the Independent Inquiry into Inequalities in Health
[125] Australian Housing and Urban Research Institute (2001). Do housing conditions impact on health inequalities between Australia's rich and poor?
[126] Homelessness Australia (2016). Homelessness and Poverty Fact Sheet.
[127] St Vincent's Mental Health Service & Craze Lateral Solutions. (2005). Homelessness and mental health linkages: Review of national and international literature

[128] Australian Housing and Urban Research Institute (2001). Do housing conditions impact on health inequalities between Australia's rich and poor?
[129] Best, R. (1999) Health inequalities: the place of housing. In: Inequalities in health: the evidence. The evidence presented to the Independent Inquiry into Inequalities in Health
[130] National Health Care for the Homeless Council (2011). Homelessness & Health: What's the Connection?
[131] National Health Care for the Homeless Council (2011). Homelessness & Health: What's the Connection?
[132] National Health Care for the Homeless Council (2011). Homelessness & Health: What's the Connection?
[133] World Health Organization (1998). Social determinants of health: The solid facts, Wilkinson, R. & Marmot, M. (eds), World Health Organization, Europe.
[134] Homelessness Australia (2016). Homelessness and Poverty Fact Sheet.
[135] Homelessness Australia (2016). Homelessness and Poverty Fact Sheet.
[136] Homelessness Australia (2013). Homelessness and Women Fact Sheet.
[137] Access Economics 2008, The growing cost of obesity in 2008: Three years on, Diabetes Australia, Access Economics, Canberra.
Colagiuri, S, Lee, CM, Colagiuri, R, Magliano, D, Shaw, JE, Zimmet, PZ & Caterson, ID 2010, 'The cost of overweight and obesity in Australia', Med J Aust, 192, 260–4.
[138] Overweight and obesity, Australian Institute of Health and Welfare, viewed 21/11/2016
[139] National Health and Medical Research Council (NHMRC) 2013, Australian Dietary Guidelines, NHMRC, Canberra.
[140] AIHW (Australian Institute of Health and Welfare) 2015, Australian Burden of Disease Study: fatal burden of disease 2010, cat. no. BOD 1, AIHW, Canberra.
[141] AIHW (Australian Institute of Health and Welfare) 2014, Australia's health 2014, cat. no. AUS 178, AIHW, Canberra.
[142] AIHW (Australian Institute of Health and Welfare) 2015, 1 in 5 Australians affected by multiple chronic diseases, viewed 24 September 2015, .
[143] AIHW (Australian Institute of Health and Welfare) 2015, 1 in 5 Australians affected by multiple chronic diseases, viewed 24 September 2015, .
[144] Pitts, M, (2005). 'Introduction: sexual health for all?'. In Sexual health: an Australian perspective. M Temple-Smith & S. Gifford (eds). IP Communications: Melbourne.
Taylor, E, (2011). Social determinants of sexual and reproductive health. Women's Health West: Melbourne.
Skinner, R, Hickey, M, (2003). Current priorities for adolescent sexual and reproductive health in Australia. Medical Journal of Australia 179:158-161.
[145] Singh, S, Darroch, J, Ashford, L, Vlassoff, M, (2009). Adding It Up: The costs and benefits of investing in family planning and maternal and newborn health. Guttmacher Institute and UN Population Fund: New York. http://www.guttmacher.org/pubs/FB-AIU-summary.pdf [viewed 28 August 2013]
Vlassoff, M, Singh, S, Darroch, J, Carbone, E, Bernstein, S, (2004). Assessing costs and benefits of sexual and reproductive health interventions. Occasional Report No. 11. Guttmacher Institute: New York. http://www.guttmacher.org/pubs/2004/12/20/or11.pdf [viewed 29 August 2013]
Jacobsen, V, Mays, N, Crawford, R, Annesley, B, Christoffel, P, Johnston, G, Durbin, S, (2002). Investing in well-being: an analytical framework. New Zealand Treasury Working Paper 02/23. New Zealand Treasury: Wellington. http://www.treasury.govt.nz/publications/research-policy/wp/2002/02-23/twp02-23.pdf
[146] Friedli, L 2009, Mental health, resilience and inequalities, World Health Organization Europe Regional Office, Copenhagen.
[147] Weinberg, M, Franklin, C & Tomyn, AJ 2016, Resilience indicators research: A review, Victorian Health Promotion Foundation, Melbourne.
[148] Friedli, L 2009, Mental health, resilience and inequalities, World Health Organization Europe Regional Office, Copenhagen.
[149] Barry, MM 2009, 'Addressing the determinants of positive mental health: Concepts, evidence and practice', International Journal of Mental Health Promotion, vol. 11, no. 3, pp. 4–7
Huppert, FA & So, TTC 2013, 'Flourishing across Europe: Application of a new conceptual framework for defining wellbeing', Social Indicators Research, vol. 110, no. 3, pp. 837–861.
[150] Australian Bureau of Statistics (ABS) 2001, 'Chapter 4: Health - defining health' in Measuring wellbeing: Frameworks for Australian social statistics, 2001, ABS cat. no. 4160.0, ABS, Canberra.
Mead, R & Cummins, R 2010, What makes us happy? Ten years of the Australian Unity Wellbeing Index, Australian Unity, Deakin University, Melbourne.
[151] World Health Organization (WHO) 2014, Mental health: A state of well-being, viewed 16 May 2016, www.who.int/features/factfiles/mental_health/en/.
[152] Department of Health and Human Services 2016, Victorian Population Health Survey 2014: Health and wellbeing, chronic conditions, screening and eye health, State Government of Victoria, Melbourne.

[153] Office for National Statistics 2016, Social Capital across the UK: 2011–2012, Office for National Statistics, London.
Australian Bureau of Statistics 2007, National survey of mental health and wellbeing: Summary of results, 2007, Australian Bureau of Statistics, Canberra.
beyondblue 2016, Depression and anxiety in gay, lesbian, bisexual, transgender and intersex people, beyondblue, Melbourne.
[154] WHO (World Health Organization) 2015, Mental health, viewed 1 September 2015,.
[155] DHS (Department of Human Services) 2005, Victorian Burden of Disease Study: mortality and morbidity in 2001, State Government of Victoria, Melbourne.
[156] Clarke DM 2009, 'Depression and physical illness: more complex than simple comorbidity', Medical Journal of Australia, vol. 190, supplement 7, pp. S52–S53.
Clarke DM, Currie KC 2009 'Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence', Medical Journal of Australia, vol. 190, supplement 7, pp. S54–S60.
[157] DHS (Department of Human Services) 2005, Victorian Burden of Disease Study: mortality and morbidity in 2001, State Government of Victoria, Melbourne.
[158] Department of Health, Victoria 2012, Municipal public health and wellbeing planning: Having regard to climate change
[159] Department of Health, Victoria 2012, Municipal public health and wellbeing planning: Having regard to climate change
[160] Horton, G., and McMichael, T. Climate Change Health Check 2020, Report prepared by Doctors for the Environment for the Climate Institute, April 2008.
[161] Horton, G., and McMichael, T. Climate Change Health Check 2020, Report prepared by Doctors for the Environment for the Climate Institute, April 2008. 5 Horton, G.,
[162] Victorian Government Department of Human Services, January 2009 Heatwave in Victoria: An assessment of health impacts, 2009, Melbourne.
[163] Myers, S. Global environmental change: the Threat to human health, Worldwatch Report 181, November 2009.
[164] Horton, G., and McMichael, T. Climate Change Health Check 2020, Report prepared by Doctors for the Environment for the Climate Institute, April 2008.
[165] Nicholls, N. Climate science: how the climate is changing and why (and how we know it), Discussion Paper, National Climate Change Adaptation Facility, August 2009.
[166] The Lancet, Executive Summary, Health and Climate Change Series, November 2009.
[167] City of Port Phillip, Waste Management And Resource Recovery Plan 2009-2014
[168] Clean Up Australia, 2015, Recycling Fact Sheet
[169] The Lancet, Executive Summary, Health and Climate Change Series, November 2009.
[170] World Health Organisation (2011). Health in the green economy: health co-benefits of climate change mitigation – transport sector.
[171] World Health Organization, 2011. Air quality and health: fact sheet no. 313. Geneva.
[172] Krzyzanowski M, Kuna-Dibbert B, Schneider J. (2005). Health effects of transport-related air pollution. Copenhagen, World Health Organization
[173] Peden M et al. (2004). World report on road traffic injury prevention. Geneva, World Health Organization
[174] World Health Organization, 2011. Air quality and health: fact sheet no. 313. Geneva.
[175] Peden M et al. (2004). World report on road traffic injury prevention. Geneva, World Health Organization
[176] Kenworthy J, Laube F. (2002). Travel demand management: the potential for enhancing urban rail opportunities and reducing automobile dependence in cities. World Transport Policy & Practice, 2002, 8(3):20–36.
[177] World Health Organization (2009). Interventions on diet and physical activity: what works: summary report. Geneva.
[178] Berglund B, Lindvall T, Schwela DH, (1999). Guidelines for community noise. Geneva, World Health Organization, 1999.
Moudon AV. (2009). Real noise from the urban environment: how ambient community noise affects health and what can be done about it. American Journal of Preventive Medicine, 37(2):167–171.
Babisch W. (2008). Road traffic noise and cardiovascular risk. Noise Health, 10(38):27–33.
[179] World Health Organisation (2011). Health in the green economy: health co-benefits of climate change mitigation – transport sector.
[180] World Health Organisation (2011). Health in the green economy: health co-benefits of climate change mitigation – transport sector.
[181] Appleyard D, Lintell M. (1972). The environmental quality of city streets: the residents' viewpoint. Journal of the American Planning Association, 38(2):84–101.

Leyden KM. (2003). Social capital and the built environment: the importance of walkable neighborhoods. Am J Public Health, 93(9):1546–51.
[182] Collison D, Dey C, Hannah G & Stevenson L 2007. Income inequality and child mortality in wealthy nations. Journal of Public Health 29(2):114–7. Marmot M 2006. Health in an unequal world. Clinical Medicine 6(6):559–72
[183] Yu P 2008. Mortality of children and parental disadvantage. Paper presented at Australian Social Policy Research Conference Sydney, 11–13 July, 2007.
[184] Ministerial Council on Drug Strategy, National Drug Strategy 2010-15
[185] Australian Institute of Health and Welfare (2012). A picture of Australia's children 2012. Cat. no. PHE 167. Canberra: AIHW.
[186] DEETYA (Australian Government Department of Employment, Education, Training and Youth Affairs) 1998. Literacy for all: the challenge for Australian schools. Commonwealth literacy policies for Australian schools. Australian schooling monograph series no. 1/1998. Canberra: DEETYA.
[187] OECD 2010b. The OECD Programme for the International Assessment of Adult Competencies (PIAAC). France: OECD.
[188] Australian Institute of Health and Welfare (AIHW) 2009, A picture of Australia's children 2009, Cat. no. PHE 112, Canberra. <http://www.aihw.gov.au/publications/index.cfm/title/10704>
National Health and Medical Research Council (NHMRC) 2003, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, , viewed June 25, 2009.
[189] Australian Institute of Health and Welfare (AIHW) 2009, A picture of Australia's children 2009, Cat. no. PHE 112, Canberra. <http://www.aihw.gov.au/publications/index.cfm/title/10704>
National Health and Medical Research Council (NHMRC) 2003, Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers, , viewed June 25, 2009.
[190] Horta BL, Bahl R, Martines JC & Victora CG 2007, Evidence on the long-term effects of breastfeeding : systematic review and meta-analyses Geneva : World Health Organization,
[191] Productivity Commission (PC) 2009, Paid Parental Leave: Support for Parents with Newborn Children, Productivity Commission Inquiry Report, No. 47, , viewed June 26, 2009.
[192] Australian Institute of Health and Welfare (2012). A picture of Australia's children 2012. Cat. no. PHE 167. Canberra: AIHW.
[193] Department of Education and Training, Victoria, Maternal and Child Health, viewed on 24/11/16 <http://www.education.vic.gov.au/childhood/professionals/health/Pages/maternalchildhealth.aspx>
[194] Australian Institute of Health and Welfare, Immunisation viewed 24/11/16 <http://www.aihw.gov.au/child-health/system-performance/#immunisation>
[195] Australian Institute of Health and Welfare, Learning and Development: Literacy, viewed on 24/11/16 <http://www.aihw.gov.au/child-health/learning-and-development/#literacy>
[196] Lamont A (2010). Effects of child abuse and neglect for adult survivors. NCPC Resource Sheet, April 2010. Melbourne: Australian Institute of Family Studies.
[197] Eckersley R (2008). Never better–or getting worse? The health and wellbeing of young Australians. Canberra: Australia21.
[198] WHO 2010. Young people: health risks and solutions. Fact sheet no. 345.
[199] Muir K, Mullan K, Powell A, Flaxman S, Thompson D & Griffiths M (2009). State of Australia's young people: a report on the social, economic, health and family lives of young people. Canberra: Department of Education, Employment and Workplace Relations and the Social Policy Research Centre, University of New South Wales.
[200] Muir K, Mullan K, Powell A, Flaxman S, Thompson D & Griffiths M (2009). State of Australia's young people: a report on the social, economic, health and family lives of young people. Canberra: Department of Education, Employment and Workplace Relations and the Social Policy Research Centre, University of New South Wales.
[201] Australian Institute of Health and Welfare (2011). Young Australians: their health and wellbeing
[202] Australian Institute of Health and Welfare (2011). Young Australians: their health and wellbeing
[203] Australian Institute of Health and Welfare (2011). Young Australians: their health and wellbeing
[204] Eckersley R (2008). Never better–or getting worse? The health and wellbeing of young Australians. Canberra: Australia21.
[205] Bhatia SK & Bhatia SC 2007. Childhood and adolescent depression. American Family Physician 75(1):73–80.
[206] NPHP 2004. The National Injury Prevention and Safety Promotion Plan: 2004-2014. Canberra: NPHP.
[207] Moran P, Coffey C, Mann A, Carlin JB & Patton GC 2006. Personality and substance use disorders in young adults. British Journal of Psychiatry 188:374–9.
[208] Sales JM & DiClemente RJ 2010. Research facts and findings. New York: ACT for Youth Center of Excellence

[209] Klein JD & Committee on Adolescence 2005. Adolescent pregnancy: current trends and issues. Pediatrics 116:281–6.
[210] Holt EM, Steffen LM, Moran A, Basu S, Steinberger J, Ross JA et al. 2009. Fruit and vegetable consumption and its relation to markers of inflammation and oxidative stress in adolescents. Journal of the American Dietetic Association 109(3):414–21.
[211] Varni JW, Limbers CA & Burwinkle TM 2007. Impaired healthrelated quality of life in children and adolescents with chronic conditions: a comparative analysis of 10 disease clusters and 33 disease categories/ severities utilizing the PedsQL™ 4.0 Generic Core Scales. Health and Quality of Life Outcomes 5(43):1–15.
[212] AIHW 2008e. Cancer in Australia: an overview, 2008. Cat. no. CAN 42. Canberra: AIHW
[213] Australian Institute of Health and Welfare (2011). Young Australians: their health and wellbeing
[214] Australian Institute of Health and Welfare, Ageing. http://www.aihw.gov.au/ageing/. Viewed 18/11/2016
[215] ABS 2013. Australian Health Survey: Updated Results, 2011–2012. Cat. no. 4364.0.55.003 Canberra: ABS.
[216] Australian Institute of Health and Welfare, Ageing. http://www.aihw.gov.au/ageing/. Viewed 18/11/2016
[217] AIHW 2014. Australia's health 2014. Australia's health no. 14. Cat. no. AUS 178. Canberra: AIHW.
[218] ABS 2015. Causes of Death, Australia, 2013. Cat. no. 3303.0. Canberra: ABS.
[219] Australian Institute of Health and Welfare, Ageing. http://www.aihw.gov.au/ageing/. Viewed 18/11/2016
[220] AHMAC (Australian Health Ministers' Advisory Council) 2015. Aboriginal and Torres Strait Islander Health Performance Framework: 2014 report. Canberra: AHMAC.
[221] AIHW 2015a. Aboriginal and Torres Strait Islander Health Performance Framework 2014 report: detailed analyses. Cat. no. IHW 167. Canberra: AIHW.
[222] Ministerial Council on Drug Strategy, National Drug Strategy 2010-15
[223] Ministerial Council on Drug Strategy, National Drug Strategy 2010-15
[224] Australian Bureau of Statistics 2015, 4430.0 - Disability, Ageing and Carers, Australia: Summary of Findings
[225] Australian Institute of Health and Welfare (2016). Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[226] Australian Institute of Health and Welfare (2016). Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[227] Australian Institute of Health and Welfare (2016). Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[228] Australian Institute of Health and Welfare (2016). Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[229] Australian Institute of Health and Welfare (2016). Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[230] Australian Research Centre in Sex, Health and Society, La Trobe University, note 7, p 46.
[231] Beyond Blue, (2012). In my shoes: Experiences of discrimination, depression and anxiety among gay, lesbian, bisexual, trans and intersex people, pp 1-2.
[232] Markus, A & Dharmalingham, A, 2008, Mapping social cohesion: The Scanlon Foundation surveys, Monash Institute for the Study of Global Movements, Monash University, Melbourne.
[233] VicHealth, 2009, Building on our strengths: A framework to reduce race-based discrimination and support diversity in Victoria, Victorian Health Promotion Foundation, Melbourne.
[234] AIHW 2010a. Australia's health 2010. Australia's health series no. 12. Cat. no. AUS 122. Canberra: AIHW.
[235] AIHW 2010a. Australia's health 2010. Australia's health series no. 12. Cat. no. AUS 122. Canberra: AIHW.
[236] AIHW 2010a. Australia's health 2010. Australia's health series no. 12. Cat. no. AUS 122. Canberra: AIHW.
[237] Commonwealth of Australia; Department of Health and Ageing (2009). Development of a new national Women's Health Policy; consultation discussion paper
[238] Australian Bureau of Statistics (2016). Gender Indicators, Australia, August 2016
[239] Commonwealth of Australia; Department of Health and Ageing (2009). Development of a new national Women's Health Policy; consultation discussion paper
[240] Commonwealth of Australia; Department of Health and Ageing (2009). Development of a new national Women's Health Policy; consultation discussion paper
[241] State of Victoria (Department of Premier and Cabinet) 2016. Safe and Strong: A Victorian Gender Equality Strategy
[242] State of Victoria (Department of Premier and Cabinet) 2016. Safe and Strong: A Victorian Gender Equality Strategy

[243] State of Victoria (Department of Premier and Cabinet) 2016. Safe and Strong: A Victorian Gender Equality Strategy
[244] Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. The Burden of Disease and Injury in Australia 2003
[245] State of Victoria (Department of Premier and Cabinet) 2016. Safe and Strong: A Victorian Gender Equality Strategy
[246] State of Victoria (Department of Premier and Cabinet) 2016. Safe and Strong: A Victorian Gender Equality Strategy
[247] State of Victoria (Department of Premier and Cabinet) 2016. Safe and Strong: A Victorian Gender Equality Strategy
[248] State of Victoria (Department of Premier and Cabinet) 2016. Safe and Strong: A Victorian Gender Equality Strategy
[249] World Health Organization, 2001 Madrid Statement Mainstreaming gender equity in health: the need to move forward.
[250] Health Canada, Health Canada's Gender-based Analysis Policy, Publications Health Canada, Canada 2000, at http://www.hc-sc.gc.ca/hl-vs/women-femmes/gender-sexe/policy-politique-eng.php
[251] Doyal L. Payne S. Cameron A 2003 Promoting gender equality in health, University of Bristol.
[252] Homelessness Australia (2012) About Homelessness
[253] Australian Housing and Urban Research Institute (2001). Do housing conditions impact on health inequalities between Australia's rich and poor?
[254] Australian Housing and Urban Research Institute (2001). Do housing conditions impact on health inequalities between Australia's rich and poor?
[255] Homelessness Australia (2016). Homelessness and Poverty Fact Sheet.
[256] St Vincent's Mental Health Service & Craze Lateral Solutions. (2005). Homelessness and mental health linkages: Review of national and international literature
[257] Australian Housing and Urban Research Institute (2001). Do housing conditions impact on health inequalities between Australia's rich and poor?
[258] Best, R. (1999) Health inequalities: the place of housing. In: Inequalities in health: the evidence. The evidence presented to the Independent Inquiry into Inequalities in Health
[259] World Health Organization (1998). Social determinants of health: The solid facts, Wilkinson, R. & Marmot, M. (eds), World Health Organization, Europe.
[260] Australian Bureau of Statistics, 2004, Household and family projections: Australia 2001–2006, cat. no. 3236.0, ABS, Canberra.
[261] Cornwell, E & Waite, L, 2009, 'Social disconnectedness, perceived isolation, and health among older adults', Journal of Health & Social Behaviour, vol. 50, no. 1, pp. 31–48.
[262] Friedli, L 2009, Mental health, resilience and inequalities, World Health Organization Europe Regional Office, Copenhagen.
Baumeister, RF & Leary, MR 1995, 'The need to belong: Desire for interpersonal attachments as a fundamental human motivation', Psychological Bulletin, 117, 497–529.
Hart, J, Shaver, PR & Goldenberg, JL 2005, 'Attachment, self-esteem, worldviews, and terror management: Evidence for a tripartite security system'. Journal of Personality and Social Psychology, 88, 999–1013.
[263] Robinette, JW, Charles, ST, Mogle, JA, & Almeida, DM 2013, 'Neighborhood cohesion and daily well-being: Results from a diary study', Social Science & Medicine, vol. 96, pp. 174–82.
[264] Strahilevitz, L 2003, Social norms from close-knit groups to loose-knit groups, University of Chicago Law Review, vol. 70, no. 1, pp. 359–72.
[265] Office for National Statistics 2016, Social capital across the UK: 2011 to 2012, Office for National Statistics, London.
[266] Markus, A & Dharmalingham, A, 2008, Mapping social cohesion: The Scanlon Foundation surveys, Monash Institute for the Study of Global Movements, Monash University, Melbourne.
[267] VicHealth, 2009, Building on our strengths: A framework to reduce race-based discrimination and support diversity in Victoria, Victorian Health Promotion Foundation, Melbourne.
[268] Department of Health and Human Services 2016, Victorian Population Health Survey 2014: Health and wellbeing, chronic conditions, screening and eye health, State Government of Victoria, Melbourne.
[269] DHS (Department of Human Services) 2005, Victorian Burden of Disease Study: mortality and morbidity in 2001, State Government of Victoria, Melbourne.
[270] Clarke DM 2009, 'Depression and physical illness: more complex than simple comorbidity', Medical Journal of Australia, vol. 190, supplement 7, pp. S52–S53.
Clarke DM, Currie KC 2009 'Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence', Medical Journal of Australia, vol. 190, supplement 7, pp. S54–S60.
[271] Friedli, L 2009, Mental health, resilience and inequalities, World Health Organization Europe Regional Office, Copenhagen.

[272] Weinberg, M, Franklin, C & Tomyn, AJ 2016, Resilience indicators research: A review, Victorian Health Promotion Foundation, Melbourne.
[273] Friedli, L 2009, Mental health, resilience and inequalities, World Health Organization Europe Regional Office, Copenhagen.
[274] Reavley, N, Bassilios, B, Ryan, S, Schlichthorst, M & Nicholas, A 2015, Interventions to build resilience among young people: a literature review, Victorian Health Promotion Foundation, Melbourne.
Tollit, M, McDonald, M, Borschmann, R, Bennett, K, von Sabler, M & Patton, G 2015, Epidemiological evidence relating to resilience and young people: a literature review, Victorian Health Promotion Foundation, Melbourne.
[275] Baum, FE, Ziersch, AM, Zhang, G & Osborne, K 2009, 'Do perceived neighbourhood cohesion and safety contribute to neighbourhood differences in health?', Health & Place, vol. 15, no. 4, pp. 925–34.
[276] Cubbin, C, Pedregon, V, Egerter, S & Braveman, P 2008, Where we live matters for our health: Neighborhoods and health. Issue brief 3: Neighbourhoods and health, Robert Wood Johnson Foundation, San Francisco.
[277] Stafford, M, Chandola, T & Marmot, M 2007, 'Association between fear of crime and mental health and physical functioning', American Journal of Public Health, vol. 97, no. 11, pp. 2076–81.
[278] UN Women 2015, A Framework to underpin action to prevent violence against women, UN Women, New York.
Webster, K 2016, A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women (ANROWS Compass, 07/2016), Australia's National Research Organisation for Women's Safety Limited (ANROWS), Sydney.
[279] Webster, K 2016, A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women (ANROWS Compass, 07/2016), Australia's National Research Organisation for Women's Safety Limited (ANROWS), Sydney.
[280] Australian Bureau of Statistics (ABS) 2013, Personal safety, Australia, 2012, ABS cat. no. 4906.0, viewed 18 May 2016, www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4906.0Main+Features12012.
[281] PricewaterhouseCoopers Australia (PwC) 2015, A high price to pay: The economic case for preventing violence against women, PricewaterhouseCoopers, Sydney.
[282] Webster, K 2016, A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women (ANROWS Compass, 07/2016), Australia's National Research Organisation for Women's Safety Limited (ANROWS), Sydney.
[283] Rehm, J, Baliunas, D, Borges, GL, Graham, K, Irving, H, Kehoe, T, Parry, CD, Patra, J, Popova, S, Poznyak, V, Roerecke, M, Room, R, Samokhvalov, AV & Taylor, B 2010, 'The relation between different dimensions of alcohol consumption and burden of disease: An overview', Addiction, vol. 105, no. 5, pp. 817–43.
[284] Laslett, AM, Room, R, Ferris, J, Wilkinson, C, Livingston, M & Mugavin, J 2011, 'Surveying the range and magnitude of alcohol's harm to others in Australia', Addiction, vol. 106, no. 11, pp. 1603–11.
[285] Collins, D & Lapsley, H 2008, The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05, Department of Health, Canberra.
[286] Australian Institute of Health and Welfare (AIHW) 2014, National Drug Strategy Household Survey detailed report: 2013, Drug statistics series no. 28, AIHW cat. no. PHE 183, AIHW, Canberra.
[287] AIHW (Australian Institute of Health and Welfare) 2012. Risk factors contributing to chronic disease. Cat. no. PHE 157. Canberra: Australian Institute of Health and Welfare.
[288] Australian Institute of Health and Welfare 2016, Australian burden of disease study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4, AIHW, Canberra.
[289] Banks, E, Joshy, G, Weber, M, Liu, B, Grenfell, R, Egger, S, Paige, E, Lopez, A, Sitas, F & Beral, V 2015, 'Tobacco smoking and all-cause mortality in a large Australian cohort study: Findings from a mature epidemic with current low smoking prevalence', BMC Medicine, 13, 38.
[290] National Rural Health Alliance (NRHA) 2012. Illicit drug use in rural Australia. Fact sheet 33, June 2012. Canberra. Viewed 5 June 2014.
[291] Australian Institute of Health and Welfare (AIHW) 2016. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. Cat. no. BOD 4. Canberra: AIHW.
[292] Access Economics 2008, The growing cost of obesity in 2008: Three years on, Diabetes Australia, Access Economics, Canberra.
Colagiuri, S, Lee, CM, Colagiuri, R, Magliano, D, Shaw, JE, Zimmet, PZ & Caterson, ID 2010, 'The cost of overweight and obesity in Australia', Med J Aust, 192, 260–4.
[293] AIHW (Australian Institute of Health and Welfare) 2015, Australian Burden of Disease Study: fatal burden of disease 2010, cat. no. BOD 1, AIHW, Canberra.

[294] AIHW (Australian Institute of Health and Welfare) 2014, Australia's health 2014, cat. no. AUS 178, AIHW, Canberra.
[295] World Health Organization 2003, Diet, nutrition and the prevention of chronic disease: Report of a joint WHO/FAO expert consutlation, World Health Organization, Geneva.
[296] National Health and Medical Research Council (NHMRC) 2013, Australian Dietary Guidelines, NHMRC, Canberra.
[297] Department of Health 2014, Australia's physical activity and sedentary behaviour guidelines, Australian Government, Canberra.
Cadilhac, DA, Cumming, TB, Sheppard, L, Pearce, Dc, Carter, R & Magnus, A 2011, 'The economic benefits of reducing physical inactivity: An Australian example', Int J Behav Nutr Phys Act, 8, 99.
[298] Department of Health 2014, Australia's physical activity and sedentary behaviour guidelines, Australian Government, Canberra.
[299] Cadilhac, DA, Cumming, TB, Sheppard, L, Pearce, Dc, Carter, R & Magnus, A 2011, 'The economic benefits of reducing physical inactivity: An Australian example', Int J Behav Nutr Phys Act, 8, 99.
[300] Dunstan, DW, Barr, ELM, Healy, GN, Salmon, J, Shaw, JE, Balkau, B, Magliano, DJ, Cameron, AJ, Zimmet, PZ, Owen, N 2010, 'Television viewing time and mortality: The Australian diabetes, obesity and lifestyle study (AusDiab)', Circulation, 121, 384–391.
[301] Pitts, M, (2005). 'Introduction: sexual health for all?'. In Sexual health: an Australian perspective. M Temple-Smith & S. Gifford (eds). IP Communications: Melbourne.
Taylor, E, (2011). Social determinants of sexual and reproductive health. Women's Health West: Melbourne.
Skinner, R, Hickey, M, (2003). Current priorities for adolescent sexual and reproductive health in Australia. Medical Journal of Australia 179:158-161.
[302] Singh, S, Darroch, J, Ashford, L, Vlassoff, M, (2009). Adding It Up: The costs and benefits of investing in family planning and maternal and newborn health. Guttmacher Institute and UN Population Fund: New York. http://www.guttmacher.org/pubs/FB-AIU-summary.pdf [viewed 28 August 2013]
Vlassoff, M, Singh, S, Darroch, J, Carbone, E, Bernstein, S, (2004). Assessing costs and benefits of sexual and reproductive health interventions. Occasional Report No. 11. Guttmacher Institute: New York. http://www.guttmacher.org/pubs/2004/12/20/or11.pdf [viewed 29 August 2013]
Jacobsen, V, Mays, N, Crawford, R, Annesley, B, Christoffel, P, Johnston, G, Durbin, S, (2002). Investing in well-being: an analytical framework. New Zealand Treasury Working Paper 02/23. New Zealand Treasury: Wellington. http://www.treasury.govt.nz/publications/research-policy/wp/2002/02-23/twp02-23.pdf
[303] PHCAG (Primary Health Care Advisory Group) 2015. Better outcomes for people with chronic and complex health conditions through primary health care: discussion paper. August 2015. Canberra: Primary Health Care Advisory Group.
[304] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.
[305] Van Doorslaer E, Masseria C, Koolman X, et al. (2006). Inequalities in access to medical care by income in developed countries. Canadian Medical Association Journal, 174(2), 177-183.
[306] Clinical Epidemiology & Health Service Evaluation Unit. (2009). Potentially preventable hospitalisations: A review of the literature and Australian policies. Melbourne: Melbourne Health.
[307] Black D. (1980). Inequalities in Health: Report of a Research Working Group (The Black Report). London: Department of Health and Social Services, UK Government
[308] Page A, Ambrose S, Glover J, et al. (2007). Atlas of avoidable hospitalisations in Australia: Ambulatory care-sensitive conditions. Public Health Information Development Unit, University of Adelaide [Electronic Version]. Retrieved 27 May 2010.
Australian Institute of Health and Welfare. (2009). Australian hospital statistics 2007-08. Health services series no. 33. Cat. no. HSE 71. Canberra: AIHW.
[309] Australian Institute of Health and Welfare. (2009). Australian hospital statistics 2007-08. Health services series no. 33. Cat. no. HSE 71. Canberra: AIHW.