

Better Health Plan for the West

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Logos



Mercy Health
Care first



Western Health



Partner Endorsement

The Better Health Plan for the West was endorsed by all of the partner organisations in September 2011.

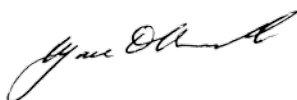
Brimbank City Council

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HealthWest

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Hume City Council

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ISIS Primary Care

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Mr Robert Croxford, CEO



Sunbury Community Health Centre

Mr Phillip Ripper, CEO



Western Melbourne Regional Development Australia*

Mr Bill Jaboor, Chair,
RDA Western Melbourne
Committee



Western Region Health Centre

Ms Lyn Morgain, CEO



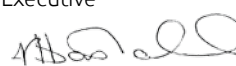
Central Highlands General Practice Network

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Djerriwarrh Health Services

Mr Bruce Marshall, Chief Executive



Hobsons Bay City Council

Mr Bill Jaboor, CEO



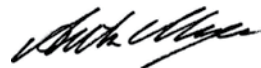
Impetus

Ms Carolyn Searle, Executive Officer



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Mr Anton Mayer, CEO



Melton Shire Council

Mr Kelvin Tori, CEO



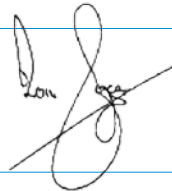
City of Moonee Valley

Mr Neville Smith, CEO



PivotWest

Mr Ross Joyce, CEO



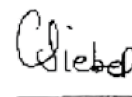
Western Health

Ms Kathryn Cook, Chief Executive



Westgate General Practice Network

Ms Corinne Siebel, CEO



Wyndham City Council

Ms Kerry Thompson, CEO



*Western Melbourne RDA incorporates the following LGAs and organisations:

LGAs: Brimbank, Hobsons Bay, Maribyrnong, Melton, Moonee Valley, Wyndham

Organisations: Leadwest, Matthews Steer Pty Ltd, Polar Cold Storage, Tweddle Child and Family Health Service, Victoria University

Executive Summary

The *Better Health Plan for the West* partnership has an historic opportunity to shape the way the local health services respond to the complex needs of one Australia's fastest growing and most diverse regions. The health providers in the west have a track record of collaborating together to develop and deliver new and innovative services. The *Better Health Plan for the West* presents the opportunity to build on this culture of dialogue and collaboration, and for the west to be a leader among regional health partnerships in Victoria.

The *Better Health Plan for the West* identifies an agreed set of key health issues and broad directions for future service delivery in the western metropolitan region for 2011 – 2021. All partners will be accountable for implementing this plan.

The oversight of this plan will evolve as the partnership moves from its current status as a loose and informal network, to a more formal arrangement with clear mutual responsibilities and expectations.

The *Better Health Plan for the West* was developed collaboratively across 7 months of multiple consultations with all partners, two externally facilitated workshops and extensive data analysis.

Context of this plan

In the first decade of this century, the population of Melbourne's western region increased by 29% from 719,326 to 927,464, an increase of 208,138¹. In 2009–2010, Wyndham and Melton were the two fastest growing LGAs in the country. The LGAs encompassed by this plan now account for 16.7% of the state's total population (ABS, 2010). Western Melbourne will continue to be one of the country's fastest growing regions over the next ten years. The region's population is set to exceed 1.1 million in 2021, an increase of 23% relative to 2011 population levels (DPCD, 2008).

The *Better Health Plan for the West* recognises that the demand for health services is determined by multiple factors. There is no doubt that the demand for health services in the west will continue to grow rapidly given the substantial increase in overall population size, the ageing population and increase in chronic disease. This growing demand is evidenced the Department of Health's forecast hospital bed need for the west.²

The west is also home to a highly diverse population. With the exception of Moorabool, each LGA has over a quarter of their population born overseas. Brimbank and Maribyrnong are particularly diverse, with 47% and 43% of their populations born outside Australia. 80,681 migrants arrived in the west from 2001 to 2011, 18% of whom were settled under the federal government's humanitarian migration stream.

The current capacity of health services in the west to meet current and future demand is limited. The acute public health services self-sufficiency levels of the Inner and Outer West planning areas are currently both below the Department's proposed benchmark level of 70%, at 54.6% and 60.5% respectively. This indicates that a significant proportion of this population are not accessing their health needs locally. The Inner and Outer West regions also have two of the lowest percentages of private hospital admissions at 30.2% and 25.9%. The Outer West has the lowest number of General Practices, dental services and pharmacies per capita of any of the regions in the *Metropolitan Health Plan*.

¹ The *Better Health Plan for the West* encompasses the following Local Government Areas: Brimbank, Hobsons Bay, Hume, Maribyrnong, Melton, Moonee Valley, Moorabool Shire and Wyndham. The Eastern and most densely part of the Moorabool LGA, which includes Bacchus Marsh, is an important part of the outer Western catchment for services in the west.

² The Department forecast a 17% and 61% increase in additional hospital beds required by 2022 for the Inner and Outer West planning areas respectively (Department of Health, 2011c).



Key themes

The key themes in this plan include:

- Providing consumers with the capacity and information to be **involved, engaged and to manage their own health and care**
- Designing programs that recognise **diverse consumer views** about how and when people decide to interact with health services
- Looking beyond the immediate role of individual partners in the continuum of care and taking a more **holistic view of consumer wellbeing**
- Working together more closely to **recruit, develop and share staff across the partnership**
- **Optimising current resources** through greater research and coordination and **attracting additional resources** through private investment
- Utilising **new and emerging e-health and communications technologies** in developing new models of care, improving health literacy and empowering consumers.

Health priorities

The implementation of the *Better Health Plan for the West* will initially be exemplified throughout three high priority health issues:

1. Mental health
2. Cardiovascular disease / Obesity / Diabetes
3. Cancer

These health issues were chosen for the following reasons:

1. Their local levels of prevalence and burden of disease are generally higher than the state average
2. They were identified as high priorities by stakeholders
3. There are high rates of co-morbidity between them.

The plan does not propose that the partners focus efforts exclusively on these outcomes. The three priorities are intended to provide an initial starting point when implementing the objectives and strategies of this plan.

Key initiatives

Key cross-partnership initiatives identified within the *Better Health Plan for the West* include:

Health literacy

- Develop a three year Health Literacy Plan that outlines a shared understanding of health literacy and clear roles for each partner
- Pool health promotion resources to deliver a regional health literacy program
- Establish a Western Diversity Advisory Committee.

Models of care

- Jointly identify cross partner models of care for the three priority health outcomes including the development of agreements to improve care coordination and continuity of care.

Human resources

- Increase medical, nursing and allied health under-graduate training opportunities in the west
- Work collaboratively across partners to jointly recruit, share and develop staff.

Service provision

- Jointly advocate for increased public health service capacity to meet current and future demand levels
- Encourage the development of health precincts that include private services
- Facilitate additional private hospital capacity in the region.

e-Health

- Ensure that the region is an early adopter under the roll-out of the National E-Health Strategy
- Develop a shared record 'repository' that will allow providers to see who is involved in the care of a consumer, and a summary of their clinical information
- Develop a "My Health Record" e-portfolio that allows consumers to track their own health.

Research

- Develop a "Joined Up" action based and outcomes focused research agenda for the west that is focused on the three priority health outcomes and will inform the development of models of care.

Partnership coordination

- Move the partnership from a loose network to one that has more formal mutual expectations and responsibilities
- Develop annual priority statements across partners and meet with the Department of Health to plan resource allocation.

Goal, objectives and health responsibilities

The overall goal of the *Better Health Plan for the West* is **healthy and engaged communities in the west**. This goal is supported by seven objectives.

The objectives and strategies within this plan are under-pinned by three agreed health priority areas.

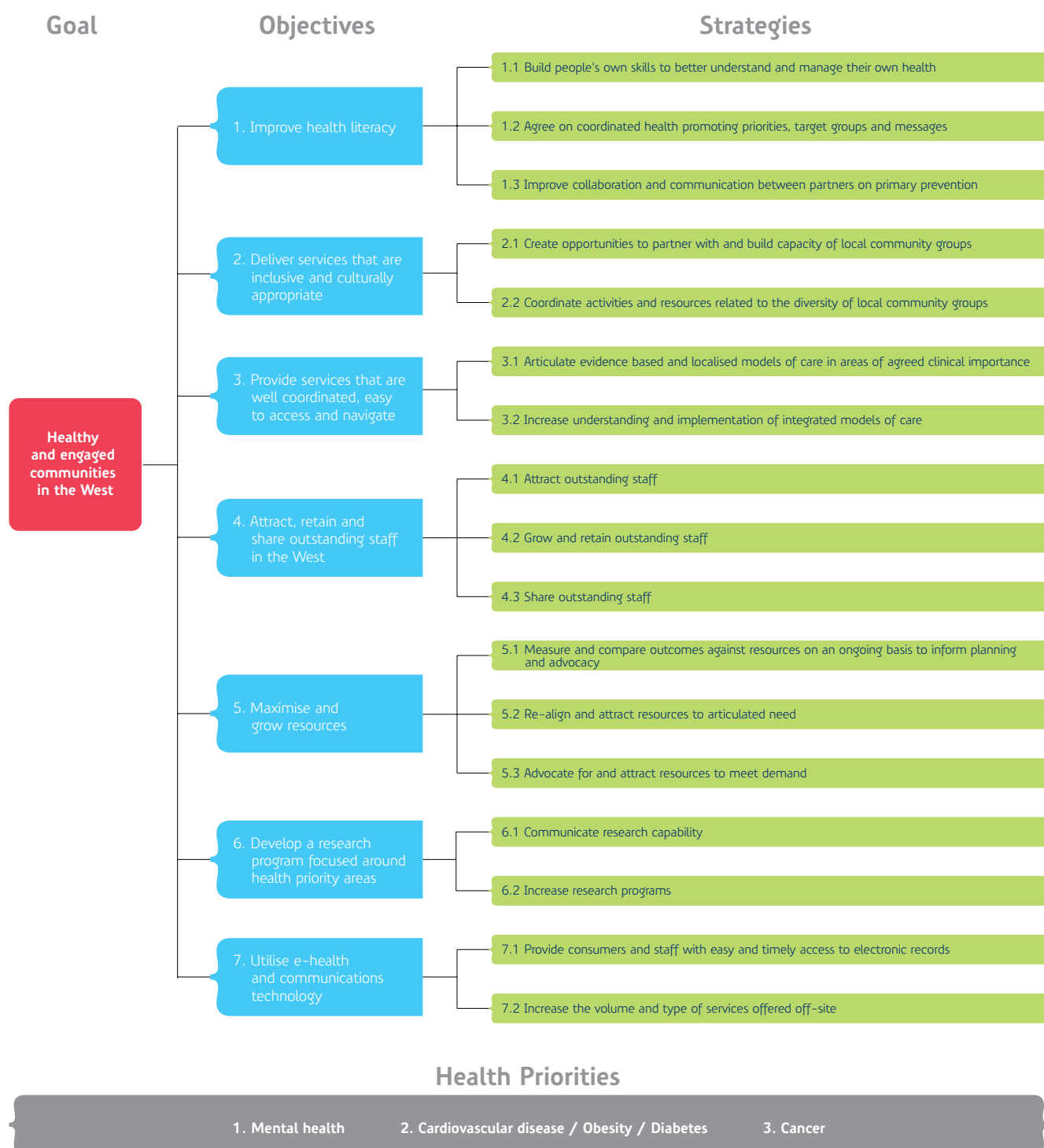


Figure 1: Overall goal, objectives, strategies and health priorities of the *Better Health Plan for the West*.

Introduction

Scope of this plan

The *Better Health Plan for the West* identifies an agreed set of key health planning issues and broad directions for future service delivery in the western metropolitan region for 2011 – 2021. The plan is also intended to identify:

- Synergies, opportunities and collaborative responsibilities
- Opportunities for improved coordination and integration of care across primary, community and acute settings
- New models of care including bed substitution models and better ways to engage consumers in their own care and enhance coordination between service providers.

The *Better Health Plan for the West* recognises that health and wellbeing are affected by a broad range of social determinants within the context of broad public policies and environmental influences, group and family influences and local community norms. These determinants include:

- Infrastructure that impacts on health (e.g. transport)
- Demographics
- Tertiary care efficiency.

These factors are acknowledged as important determinants, however the *Better Health Plan for the West* will focus on factors that are within the more immediate sphere of the partnership's control and influence.

Geographic scope

The *Better Health Plan for the West* encompasses health services provided across seven Local Government Areas (LGAs). These include Brimbank, Hobsons Bay, Hume, Maribyrnong, Melton, Moonee Valley, Moorabool and Wyndham.

In the first decade of this century, the population of Melbourne's western region increased by 29% from 719,326 to 927,464, an increase of 208,138³. In 2009–2010, Wyndham and Melton were the two fastest growing LGAs in the country. The LGAs encompassed by this plan now account for 16.7% of the state's total population (ABS, 2010).

Western Melbourne will continue to be one of the country's fastest growing regions over the next ten years. Demand for health services in the west will therefore continue to grow rapidly. The projected growth in the west relative to other parts of Melbourne is shown in Figure 2 on page 10.

³ The Better Health Plan for the West encompasses the following Local Government Associations: Brimbank; Hobsons Bay; Hume; Maribyrnong; Melton; Moonee Valley, Moorabool; and Wyndham.

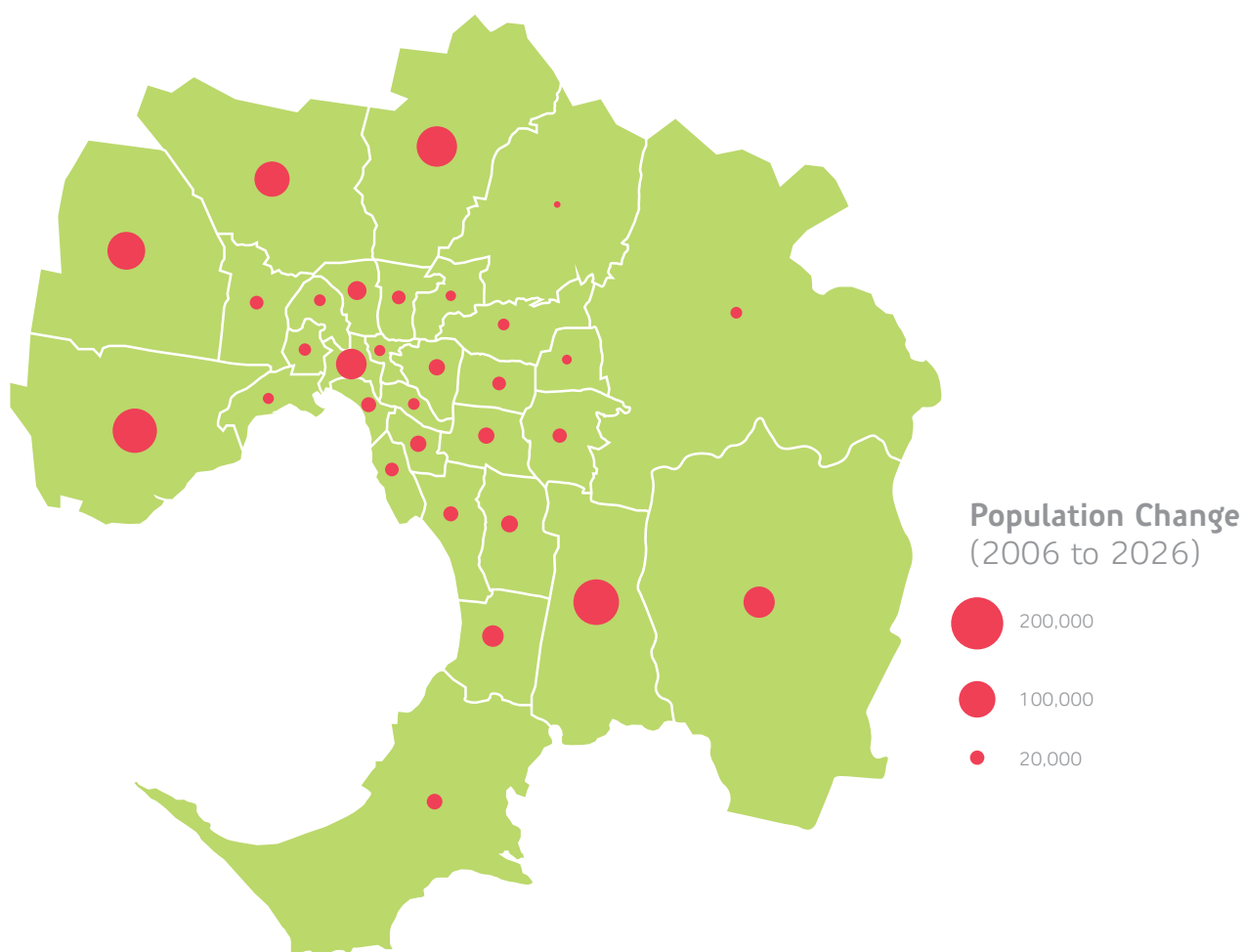


Figure 2: Projected population growth: Melbourne LGAs 2006–2026.

Source: Department of Planning and Community Development (2008)

The population in the west is also highly culturally and linguistically diverse. With the exception of Moorabool, each LGA had over a quarter of their population born overseas. Brimbank and Maribyrnong are particularly diverse, with 47% and 43% of their populations born outside Australia. 80,681 migrants arrived in the west from 2001 to 2011, 18% of whom were settled under the federal government's humanitarian migration stream.

Policy context

The *Better Health Plan for the West* was developed during a period that saw major health policy reforms and initiatives introduced at Commonwealth and state levels. The *Better Health Plan for the West* has focused on issues that can be managed locally.

Key initiatives and changes at the Commonwealth level included:

- The announcement of the first Medicare Locals in June 2011
- The signing of a new Council of Australian Government Heads of Agreement on Health Reform in February 2011 (COAG, 2011)

Key initiatives and changes at the state level included:

- The release of the *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan* in May 2011
- The release of the Victorian Public Health and Wellbeing Plan 2011–15 in 2011.

The *Better Health Plan for the West* aligns closely with the *Metropolitan Health Plan*, as shown by Figure 3 below.

The Victorian Department of Health is also scheduled to release the *Health Capital and Resources Plan 2012*.

Objectives of the Better Health Plan for the West

Priorities of the Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan

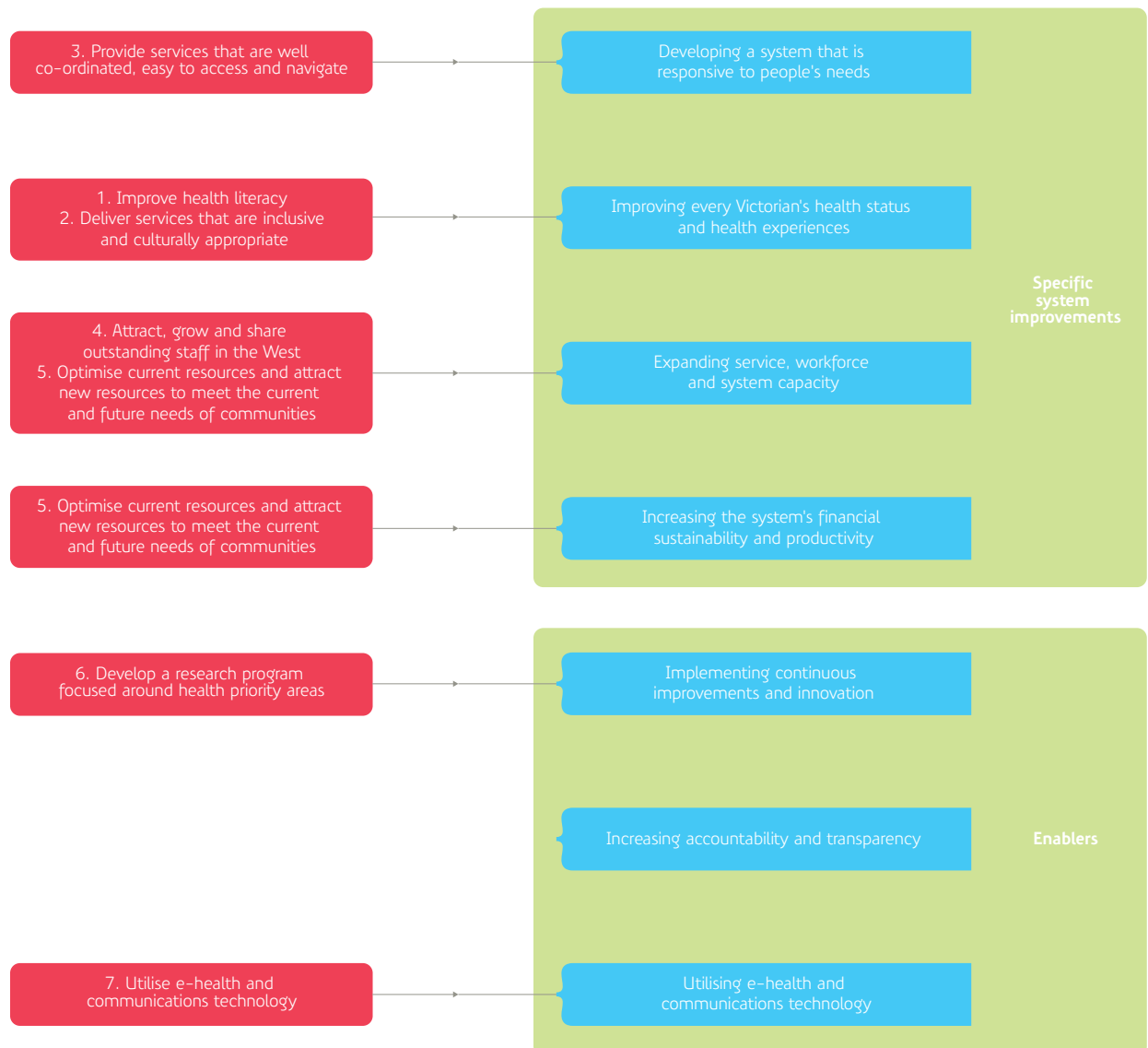


Figure 3: Alignment between the objectives of the Better Health Plan for the West and the priorities of the Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan.

Source: Department of Health (2011b)

Partners

The *Better Health Plan for the West* is a partnership of the following organisations.



The *Better Health Plan for the West* also includes Moorabool Shire. The eastern and most densely part of the Moorabool LGA, which includes Bacchus Marsh, is an important part of the outer western catchment for services in the west.

It is anticipated that the membership of the partnership will remain relatively static in the short term. The Medicare Locals in the west will be incorporated into the partnership as key partners as they come into operation.

How this plan was developed

The development of this plan was facilitated by external consultants The Nous Group. The *Better Health Plan for the West* was developed from December 2010 to June 2011. During this period The Nous Group undertook extensive consultation with all members of the partnership, facilitated two cross-partner workshops in March and May 2011, and conducted detailed data analysis.

The Future Of The West

Population growth in the west

The west of Melbourne will be one of the country's fastest growing regions over the next ten years. The nature of demand for health services will be complex and varied.

In the first decade of this century, the population of Melbourne's western region increased by 29% from 719,326 to 927,464, an increase of 208,138. The LGAs encompassed by this plan now account for 16.7% of the state's total population (ABS, 2010).

This growth in population can be largely attributed to rising housing prices over the same period, and relative affordability of houses in the west (Salt, 2010).

The region's population is projected to grow to 1,148,525 in 2021, an increase of 23% relative to 2011 population levels. Figure 4 below illustrates that this growth will be concentrated in the outer LGAs of the western region. This figure also shows that these LGAs will face the dual challenge of substantial growth and ageing populations over the next ten years.

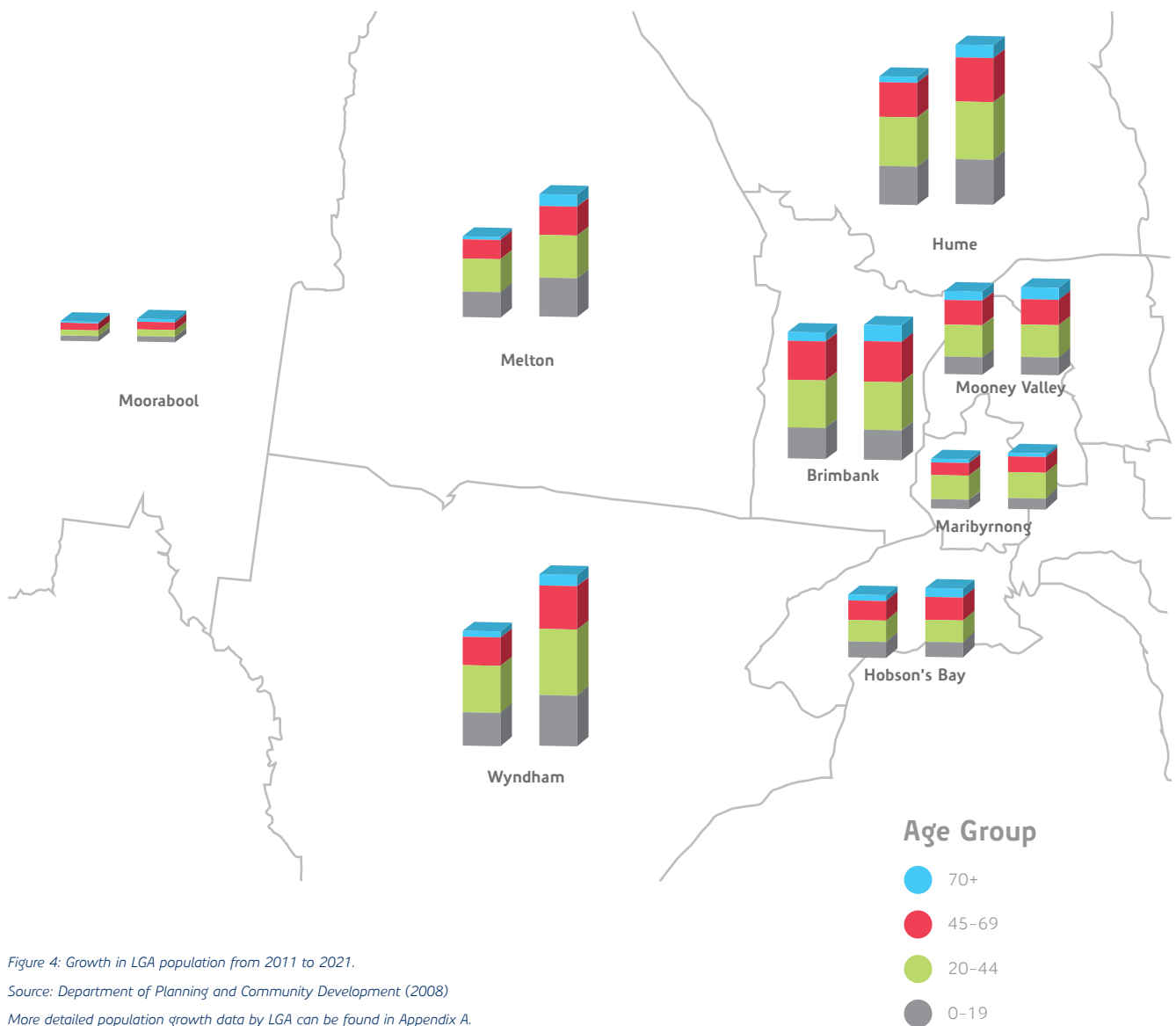


Figure 5 below shows that population growth in the west will continue to exceed the state average over the next ten years. As the current generation of home-buyers in the west age, this population growth will be particularly strong among age groups above 40 years old.

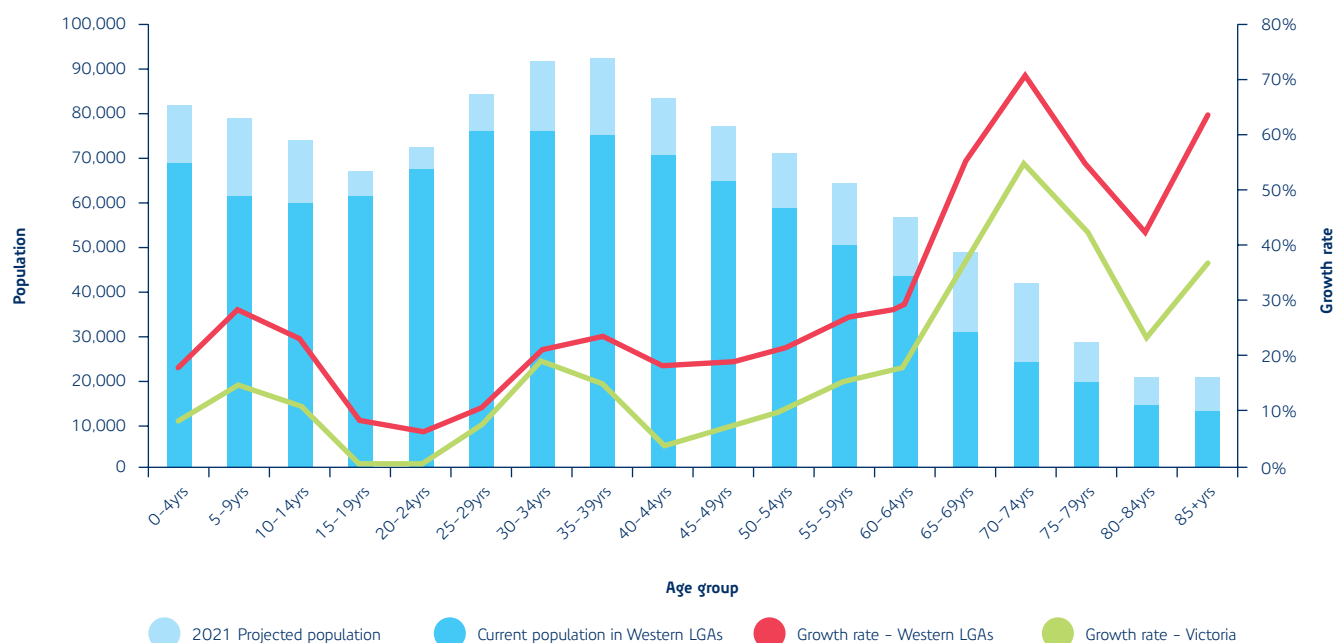


Figure 5: Population growth in the west 2011-2021.

Source: Department of Planning and Community Development (2008)

The ageing population in the west will result in increased pressure on acute and aged care services. Given the particular characteristics of the west's population, this will include higher demand for more complex aged care services as the impact of chronic disease in the middle years results in higher demand for health services in the older population. The growth in the young families will also put pressure on birthing services, maternal and child health and paediatric services.

Economic and social conditions in the west

The west is becoming more prosperous. Income growth is not uniform though, and there is a risk of entrenched socioeconomic disadvantage in the middle band of suburbs around Brimbank.

The socioeconomics of LGAs in the west are far from uniform and are rapidly evolving. The Centre for Strategic Economic Studies recently identified three broad trends driving socioeconomic change in west:

1. Rapid gentrification of established areas of the inner west –

Inner suburbs, particularly those with pre-WW2 housing stock, are experiencing rapid gentrification associated with modest population growth and more intensive land use.

2. Entrenched disadvantage in the middle west –

Large areas of middle western Melbourne – as well as some areas of outer western Melbourne – continue to lag behind the rest of Melbourne in terms of median incomes.

3. Rapid expansion in the Outer West –

New housing developments are reshaping large areas of the west. Different projects attract different cohorts of people. Property development companies are playing a large role in determining the overall socioeconomic trajectory of different areas of western Melbourne (Centre for Strategic Economic Studies, 2010).

Overall Objectives And Strategies

Objective 1: Improve health literacy

Empowering consumers to be involved, engaged and manage their health and care will be central to improving health outcomes in the west. Improving health literacy levels in the region requires innovative approaches to engage the diverse communities of the west. This will require consumer input into how services are delivered and careful consideration of how health related information is disseminated.

Education levels are an important determinant of health literacy. Research by the ABS in 2006 showed that in common with other literacy domains, people with higher formal educational attainment achieve higher levels of health literacy (ABS, 2006).

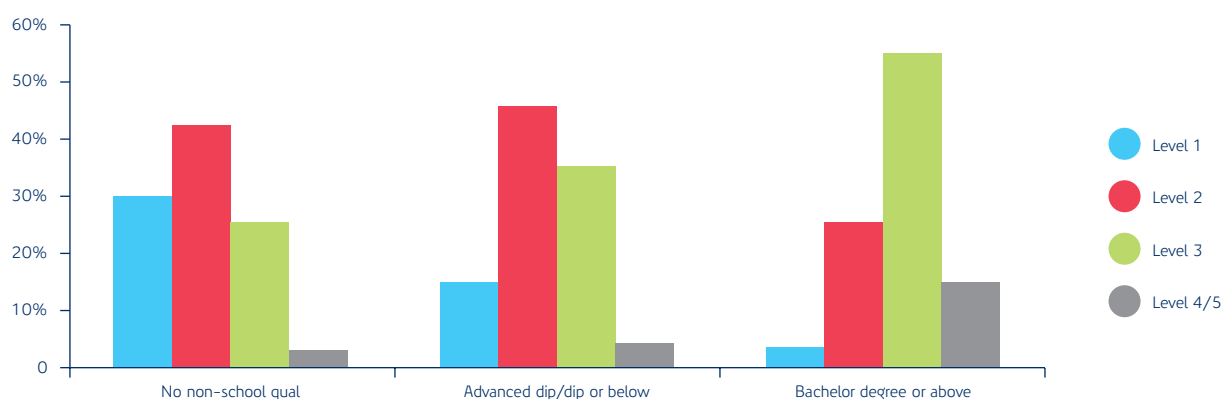


Figure 6: Health literacy by Level of highest non-school qualification.

Source: ABS (2006)

NOTE: Level 1 is the lowest level of health literacy and Level 5 is the highest. Skill Level 3 is regarded by the developers of the survey used by the ABS as the 'minimum required for individuals to meet the complex demands of everyday life and work in the emerging knowledge-based economy'

Education levels in the west are generally below state averages, as shown in Figure 7 below. The percentages of people with a Bachelor degree are below the state average across all LGAs (with the exception of Maribyrnong and Moonee Valley). Conversely, the percentages of people with lower level qualifications (such as certificates) are generally

above the state average. The relative disadvantage of the middle-west is further supported by the low levels of academic qualifications in the Brimbank and Hume LGAs. These below average education levels place residents in the west at risk of lower levels of health literacy.

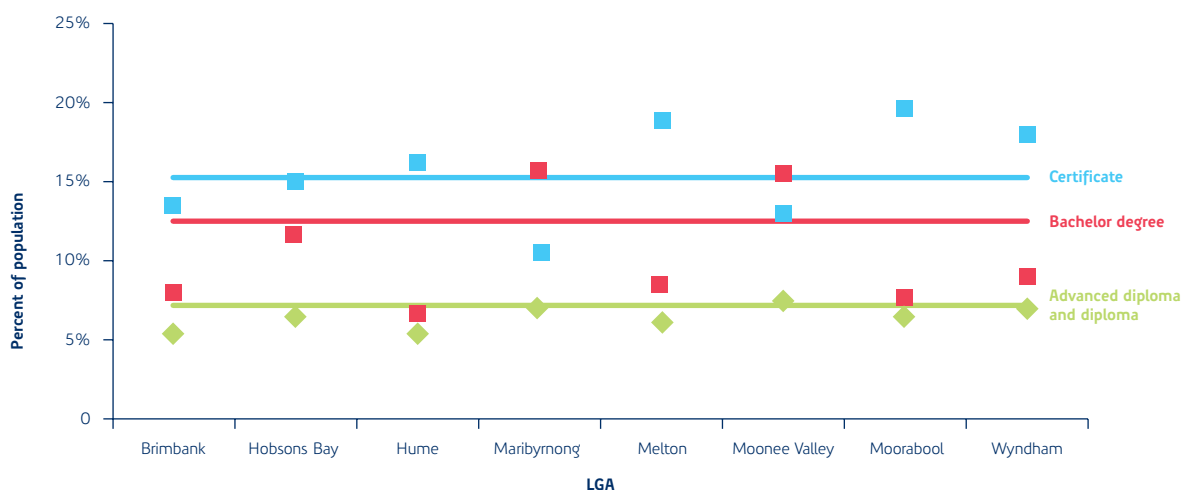


Figure 7: Education levels in the west vs. state average.

Source: ABS (2010)

The high proportion of CALD communities in the west where English may not be first language also increases the risk of low health literacy levels.

Lower Levels of health literacy can impact on the stage at which a consumer engages with the health system, and/or the types of conditions that they present with. Table 1 below shows a selection of avoidable mortalities across LGAs in the west over the period 2002 to 2006, which are higher than the state average, and typically have improved health outcomes when treated early.

Table 1: Selected avoidable mortalities by LGA from 2002 to 2006 – Standardised Rate per 100,000 persons

Condition	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Ischaemic Heart Disease	31.46	38.16	33.73	49.30	35.19	28.38	38.30	33.98	30.76
Lung cancer	28.07	21.20	23.69	30.25	24.88	19.26	16.76	24.86	21.12
Colorectal cancer	12.42	12.88	11.09	13.07	20.56	10.89	9.25	10.55	12.29
Diabetes	12.41	9.61	11.69	11.52	10.75	7.37	9.02	8.96	7.26
Breast cancer	7.81	9.70	7.88	6.34	4.73	7.58	9.04	7.73	9.52
Stroke	6.70	7.81	6.55	12.23	8.16	3.85	N/A	5.16	6.35
Chronic Obstructive Pulmonary Disease	5.71	9.00	10.27	10.37	7.55	6.42	8.19	8.45	7.70
Hepatitis and liver cancer	5.54	5.44	4.06	7.48	3.77	4.05	N/A	3.01	3.35
Stomach cancer	3.91	6.24	4.03	5.34	8.36	3.93	N/A	2.15	3.66
Oral cancers	2.60	3.72	3.08	3.27	N/A	0.94	N/A	3.04	2.23
Alcohol related conditions	2.23	7.19	4.50	8.07	3.49	3.50	5.73	3.98	4.22
Skin cancers	1.75	4.80	2.39	3.60	5.00	3.88	4.21	3.02	3.75

Source: Department of Health (2006c)

NOTE: Percentages greater than 1.5 times the state average are highlighted in red

What we will do

There is an opportunity for partners to work together more closely to develop innovative ways to encourage people to manage their own health. The partnership will tackle health literacy in two ways. From a client perspective improving health literacy means increasing the capacity of consumers to understand, engage with and manage their care. From a provider perspective, health literacy comes from increasing the capacity of health service providers to understand the health beliefs and frameworks of the clients they work with.

Strategy	How we will do this
1.1 Build people's own skills to better understand and manage their own health and build a proactive responsive service system	1.1.1 Implement a rolling health literacy training program across partners to increase service practitioners' knowledge of health literacy and health beliefs and how it affects different target groups 1.1.2 Create a shared organisational audit tool for health literacy 1.1.3 Develop a network of health literacy community leaders
1.2 Agree on coordinated health promoting priorities, target groups and messages	1.2.1 Establish a regional health literacy working group under the auspices of HealthWest 1.2.2 Develop a three year Health Literacy Plan that outlines a shared understanding of health literacy and clear roles for each partner, and plans for effective use of health promotion resources 1.2.3 Pool health promotion resources and deliver a regional health literacy program 1.2.4 Continue to build the capacity of health providers to effectively deliver consistent messages through appropriate communication channels 1.2.5 Promote community health screening programs (e.g. WMRDA Health Screening Kiosks) to develop health awareness
1.3 Improve collaboration and communication between partners on primary prevention	1.3.1 Conduct a review of the implementation and response to <i>Connectingcare – Health and Community Services Directory</i> ⁴ 1.3.2 Develop innovative ways to increase awareness of services provided by other partners based on lessons from the review

⁴ Connectingcare is a service directory and electronic referral system used by many organisations in the West.

Objective 2: Deliver services that are inclusive and culturally appropriate

The cultural and linguistic diversity of the west is a fundamental characteristic that will influence the delivery of future health services in the region. There will be ongoing demand for translation and interpreter services and future services will need to account for diverse community views about how and when to interact with the health services.

Cultural and linguistic diversity in the west

The proportion of people who speak a language other than English at home is higher than the state average for the majority of LGAs in the west. These proportions in Brimbank and Maribyrnong are higher than 40%, as shown below.

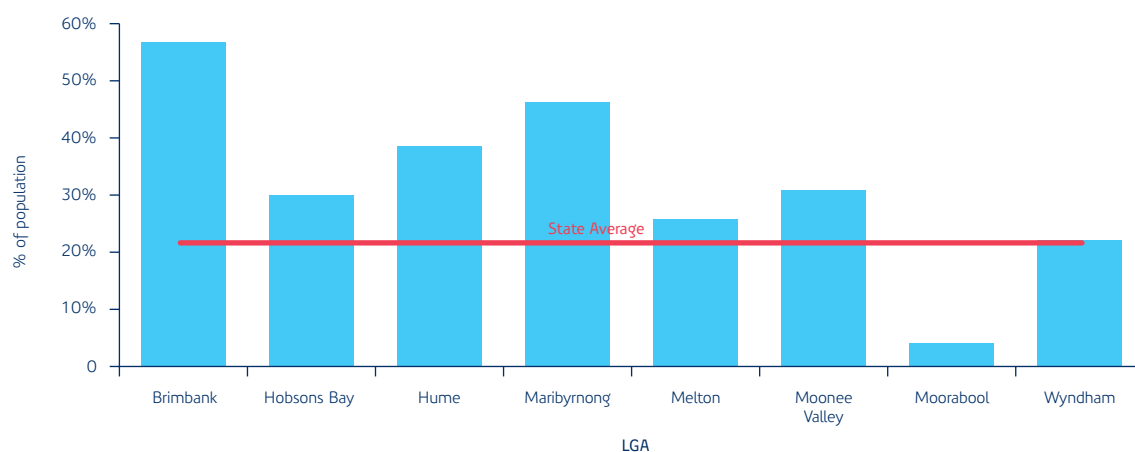


Figure 8: % of population that speaks a language other than English at home.

Source: ABS (2010)



Table 2 below shows the country of birth for populations in each LGA born outside Australia. LGAs with particular populations that are 1.5 times the state average are highlighted in red. The composition of Maribyrnong and Brimbank in particular reflect the changing face of migration to Australia over the past fifty years.

Table 2: Overseas born population: percentage of total population (2006)

Country of Birth	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Oceania and Antarctica	2	2	2	2	2	1	1	3	2
North-West Europe	3	7	4	4	5	4	7	6	6
Southern and Eastern Europe	18	11	8	9	8	12	2	7	6
North Africa and the Middle East	3	2	11	2	1	2	0	1	2
South-East Asia	14	5	3	14	4	3	0	4	4
North-East Asia	1	1	0	4	1	2	0	1	2
Southern and Central Asia	3	1	2	5	2	2	0	3	2
Americas	2	1	1	2	2	1	0	1	1
Sub-Saharan Africa	1	1	1	2	1	1	0	1	1
Total born overseas	47	31	31	43	26	28	12	27	25

Source: ABS, (2010)

NOTE: Percentages greater than 1.5 times the state average are highlighted in red

The Culturally and Linguistically Diverse (CALD) population of the west also has a high proportion of potentially vulnerable and high need consumers. Table 3 below shows that almost one-fifth of the arrivals in the west over the past ten years came under the Commonwealth Government's Humanitarian stream.

Table 3: Humanitarian settlements by LGA – Visas granted between January 2001 to January 2011

LGA	Humanitarian stream		Total settlers
	Number	% of total	
Brimbank	4,260	21%	20,244
Hobsons Bay	836	13%	6,285
Hume	4,108	30%	13,608
Maribyrnong	1,694	18%	9,407
Melton	525	10%	5,287
Moonee Valley	762	9%	8,870
Moorabool	6	2%	314
Wyndham	2,094	13%	16,666
Total	14,285	18%	80,681

Source: Department of Immigration and Citizenship (2011)

The west has a relatively small indigenous population, in line with the generally low numbers of indigenous people in the rest of the state.

Table 4: Estimated resident indigenous population in 2006

Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
0.4%	0.4%	0.7%	0.4%	0.7%	N/A	0.7%	0.7%	0.6%

Source: ABS (2011)

What we will do

The specific health needs of the west's diverse cultural communities are currently served by a myriad of ethnic community health groups, community outreach workers, and interpreting services across all of the partners. There is an opportunity for the partners to leverage off the unique strengths and specialised knowledge of each of these groups to deliver services that are more coordinated and efficient, and more carefully targeted.

Strategy		How we will do this	
2.1	Create opportunities to partner with and build capacity of local community groups	2.1.1	<p>Establish a Western Diversity Advisory Committee comprised of service providers, community, state and peak bodies. The committee will:</p> <ul style="list-style-type: none">• Improve community access to services• Facilitate community participation in planning activities• Build partnership opportunities
2.2	Coordinate activities and resources related to the diversity of local community groups	2.2.1	<p>The Western Diversity Advisory Committee will:</p> <ul style="list-style-type: none">• Develop an agreed set of culturally appropriate guidelines for working with diverse communities• Map existing resources and coordination mechanisms• Improving service co-ordination and delivery to diverse community groups• Minimising duplication of services and identifying gaps
		2.2.2	Establish a CALD resources internet portal

Objective 3: Provide services that are well coordinated, easy to access and navigate

Integrated models of care that support consumers across all aspects of the continuum are needed to improve health outcomes in the west. The partners have an opportunity to build upon existing models, research and service coordination to develop models of care around particular health outcomes that acts as exemplars of how the partners will work together to improve health outcomes in the west. This will require all partners to look beyond their immediate role in the continuum of care and take a more holistic view of consumer wellbeing.

Current context

The *Better Health Plan for the West* supports the Metropolitan Health Plan's argument that poor coordination between the services in the system can be costly for both individuals and the health care system. People whose chronic and complex conditions are not well managed often need to make more extensive use of hospitals. In the long-term, their health outcomes may be poorer, requiring increasing levels of health care to meet their needs.

With the increasing prevalence of chronic and complex diseases, future models of care will need to support an approach where multidisciplinary teams of medical, nursing, allied health and clinical support services are brought together to provide comprehensive care to meet the consumer's needs. Rather than current service models which are often specialty based, new teams will form around specific consumer conditions or streams of care.

New models will also need to support a workforce with more generalist skills to meet the growing burden of co-morbidity; there is likely to be more mixing of roles and the emergence of new workforce categories (Western Health, 2011).

What we will do

In the past few years, several projects have been initiated in the west that may support the development of region-wide models of care focused on specific issues. These initiatives include the Case-D, HARP and Healthy Communities, Healthy Lives projects⁵. There is an opportunity for the partners to develop more comprehensive models of care that that are grounded upon a solid research base.

Strategy	How we will do this
3.1 Articulate evidence based and localised models of care in areas of agreed clinical importance	<p>3.1.1 Research how consumers currently access and navigate services related to each of the three priority health outcomes:</p> <ol style="list-style-type: none">1. Mental health2. Cardiovascular disease / Obesity / Diabetes3. Cancer <p>3.1.2 Collate evidence bases for each outcome for the region (similar to the Case D study)</p>
3.2 Increase understanding and implementation of integrated models of care	<p>3.2.1 Over the next five years develop models of care for each of the priority health outcomes. This might mean expanding existing programs or developing new models</p> <p>3.2.2 Conduct a cost/benefit analysis of the change process and of each of the proposed models</p> <p>3.2.3 Identify barriers to integration and develop a long-term plan to address identified barriers with strategic investment</p> <p>3.2.4 Develop agreements between agencies to increase care coordination and continuity of care.</p>

⁵ Case D is a 12 month study currently being implemented by the regional Department of Health office in partnership with Melbourne University and health system stakeholders and PCPs in the Western and Northern regions. Case D is analysing the current pathways to care and the experiences of residents in the two regions with Type 2 Diabetes, including system capability and consumer outcomes.

The Western HARP program (Hospital Admission Risk Program) aims to reduce avoidable hospital admissions for targeted chronic disease groups. HARP targets people who have frequent presentations to Emergency Departments and/ or at risk of frequent presentations, with defined chronic diseases and complex needs. The Western HARP partners are guided by a Memorandum of Understanding and the Western HARP Statement of Intent.

Healthy Communities, Healthy Lives is three year old program adapted from the Expanded Chronic Care Model which was developed collaboratively by providers in the West. The first strategic priority (2009 to 2012) of the Healthy Communities, Healthy Lives initiative is type 2 diabetes.

Objective 4: Attract, grow and share outstanding staff in the west

The growing population in the west will require an increase in high-quality staff to provide the necessary health services. There is an opportunity for the partners to work together more closely to recruit, develop and share staff across all spectrums of care in one of the country's fastest growing and most diverse regions.

Current context

The west currently faces many of the same workforce-related challenges as other health providers across the metropolitan region. These include:

- High levels of rigidity and poor flexibility due to a complex range of rules, guidelines, regulations and agreements
- Difficulties in filling supply gaps quickly due to long lead times for training particularly in medicine and other highly developed specialty areas
- Out-dated workforce planning mechanisms and models that are insufficiently detailed and tied to professional silos

The west has a number of unique challenges when it comes to attracting and retaining a high quality health workforce.

- Untapped potential for university training in the region
- Limited private practice opportunities for medical staff due to a low number of private hospitals
- Limited research grants and opportunities when compared with other regions
- The historical trend of health professionals living in the east and bayside suburbs of Melbourne (as shown in the figures 9 to 11 below)

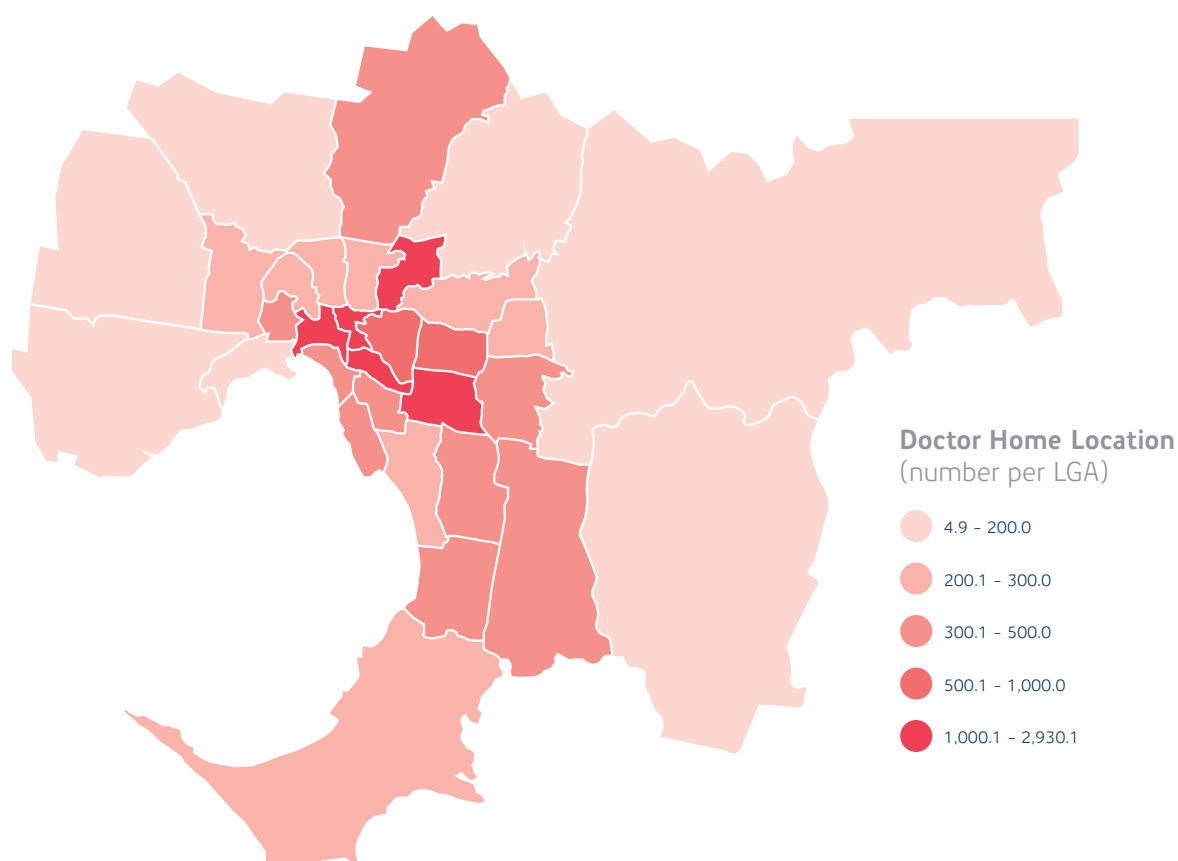


Figure 9: Current home locations of all registered medical practitioners.

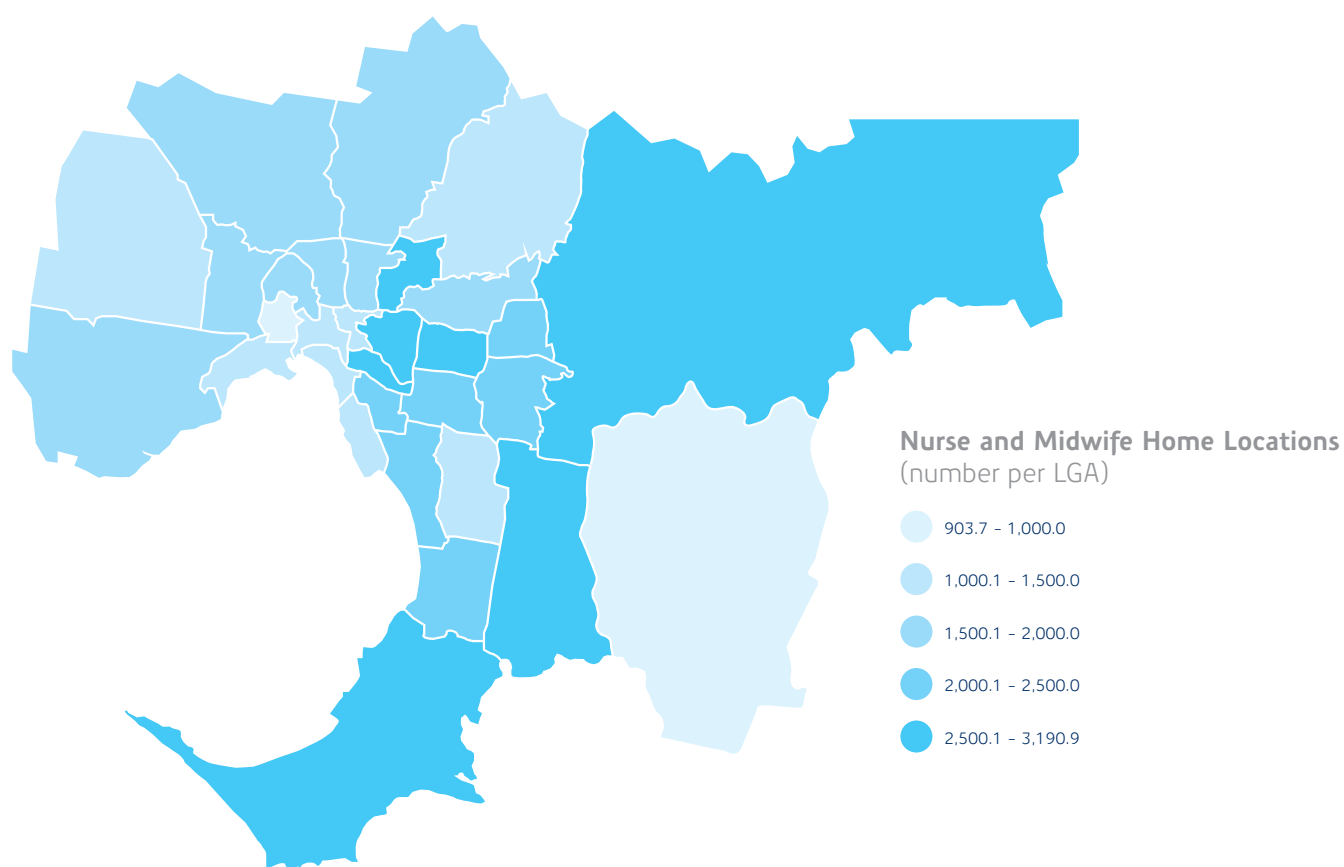


Figure 10: Current home locations of registered nurses and midwives.

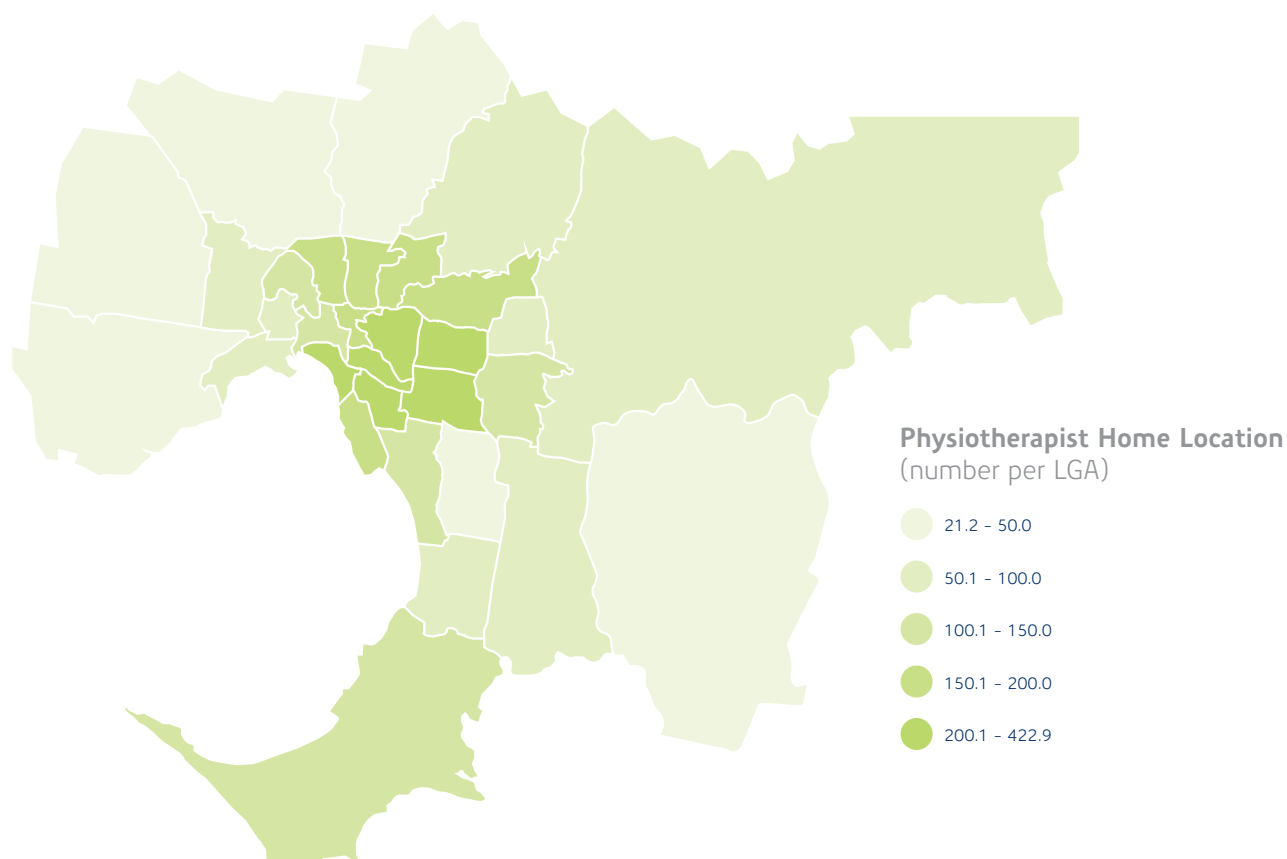


Figure 11: Current home locations of registered physiotherapists.

Source: Department of Health (2011c)

What we will do

In the short-term there are a number of areas where the combined scale of the partners could be used more effectively to recruit and develop staff. In the longer term, there are opportunities to further develop new and existing research and training opportunities to attract outstanding staff.

Strategy	How we will do this
4.1 Attract outstanding staff	<div>4.1.1 Work collaboratively across partners to jointly recruit and develop staff</div> <div>4.1.2 Develop jointly funded scholarships and incentives to train and work in the west</div> <div>4.1.3 Build a critical mass of specialists around agreed health priorities by strengthening existing and building new relationships with research institutes (similar to the model for the Western Centre for Health Research and Education at Sunshine Hospital)⁶</div> <div>4.1.4 Facilitate additional private sector capacity in the west.</div>
4.2 Grow and retain outstanding staff	<div>4.2.1 Increase medical, nursing and allied health under-graduate training opportunities in the west</div> <div>4.2.2 Coordinate career progression across sectors</div>
4.3 Share outstanding staff	<div>4.3.1 Implement cross-partnership rotations</div>



⁶ The Western Centre for Health Research and Education is a joint partnership between Western Health, The University of Melbourne and Victoria University.

Objective 5: Optimise current resources and attract new resources to meet the current and future needs of communities

The expansion of service capacity in the west has not matched the rapid population growth in west. In the current resource constrained climate, it will also be vital for partners to optimise current resources through greater research and coordination. There is also an opportunity to attract additional resources through private investment.

Current service capacity in the west

Current service capacity in the west is low relative to other parts of Melbourne as shown in Table 5 below. The Outer West in particular has the lowest number of General Practices, dental services, and pharmacies per capita of any of the regions in the Department of Health's Metropolitan Health Plan.

Table 5: Current service capacity, per 1000 people

	General practices	Dental services	Pharmacies
Inner East	0.56	0.40	0.30
Inner West	0.42	0.20	0.23
Inner North	0.37	0.31	0.19
Inner Southeast	0.35	0.29	0.24
Victoria	0.34	0.20	0.19
Northeast	0.33	0.20	0.23
Southeast	0.32	0.15	0.16
Outer Northwest	0.29	0.11	0.12
Peninsula	0.25	0.17	0.18
Outer East	0.24	0.14	0.15
Outer West	0.23	0.09	0.12

Source: Department of Health (2011c)

NOTE: This table does not include data from the Hume LGA. The Department of Health's Inner West planning area comprises the Hobsons Bay and Maribyrnong LGAs. The Outer West comprises the Brimbank, Melton, Moorabool and Wyndham LGAs.

The data presented below illustrates that there will be a clear need to expand existing service capacity in the region. At the acute end for example, Table 6 below shows that there is a sizeable increase in projected hospital admissions. Table 6 also illustrates that the percent of people admitted to private hospitals is well below the state average.

Table 6: Projected hospital utilisation

		Inner West	Outer West	VIC
Hospital admissions				
Current	Per 1000 people	418.8	389.1	422.0
	Percent private	30.2%	25.9%	37.8%
Projected (2021/22)	Per 1000 people	543.1	494.9	529.2
Difference	Per 1000 people	124.3	105.8	107.2

Source: Department of Health (2011c)

Table 7 below shows that there will be a significant increase in demand for additional hospital beds by 2022 particularly in the Outer West, based on the Department of Health's bed model.

Table 7: Modelled bed growth based on resident demand in each area profile (2009/10 – 2021/22)

Planning area	Additional beds required by 2022	Per cent growth 2010 – 2022	Annual growth 2010 – 2022
Inner West	66	17%	1.3%
Outer West	595	61%	4.1%

Source: Department of Health (2011c)

The public health services self-sufficiency levels of the Inner and Outer West planning areas are both below the Department of Health's proposed benchmark level of 70%⁷. The public self-sufficiency levels of the inner and outer west are 54.6% and 60.5% respectively.



⁷ Self-sufficiency refers to the ability of a service, within a particular area, to provide a minimum and appropriate level of service, both in amount and type, required by the local community. 70% is proposed as the level of self sufficiency required in an area to meet the minimum appropriate levels of services. Department of Health (2011c).

The level of service capacity and the pattern of consumers accessing services outside the region are also reflected in Figure 12 and Figure 13 below. These graphs demonstrate how total admissions and emergency department attendances at public hospitals in the west have not kept pace with population growth in the region.

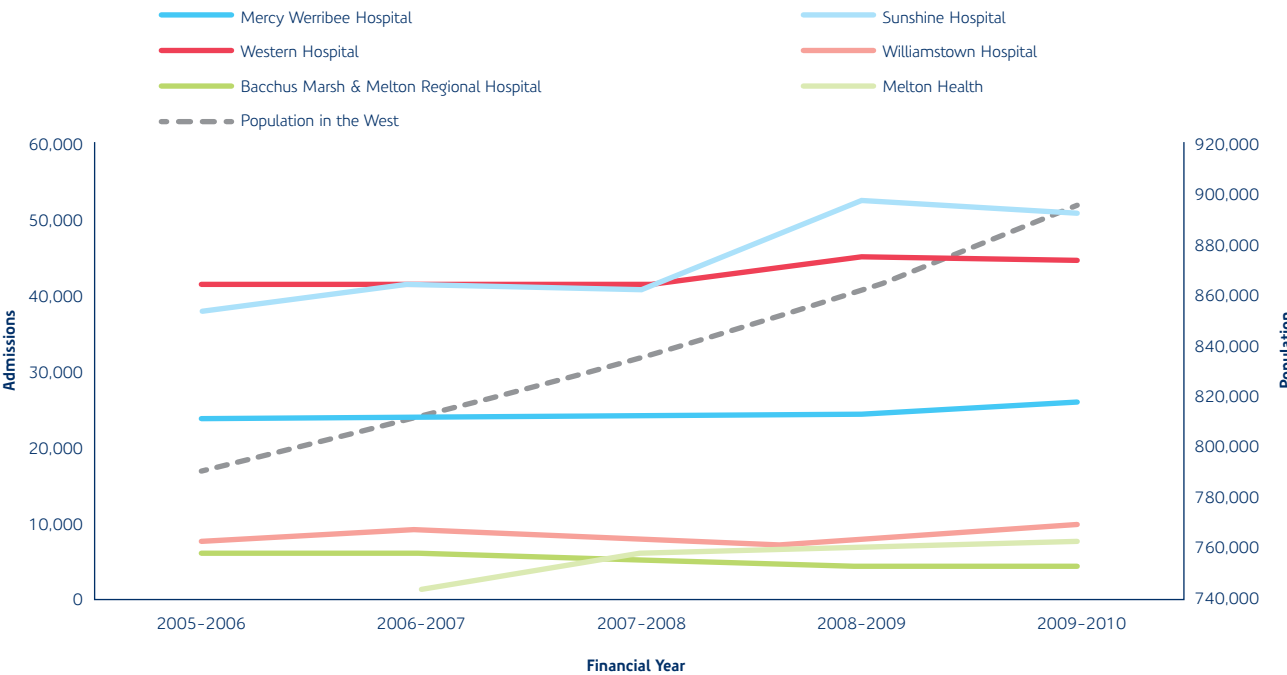


Figure 12: Total admissions in public hospitals in the West.
Source: Department of Health (2005-2010), Your hospitals: A report on Victoria's public hospitals

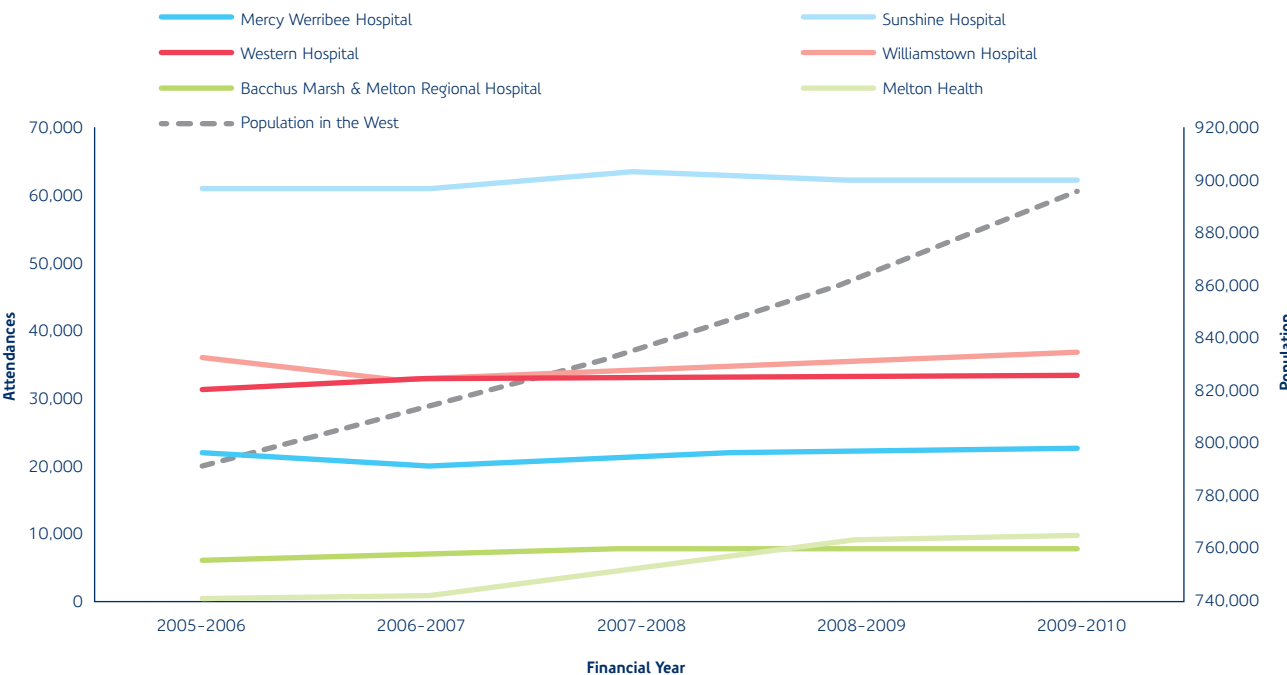


Figure 13: Emergency department attendances in public hospitals in the West.
Source: Department of Health (2005-2010), Your hospitals: A report on Victoria's public hospitals

Similarly, professional attendances at GP Networks in the west have not grown at the same rate as the region's population.

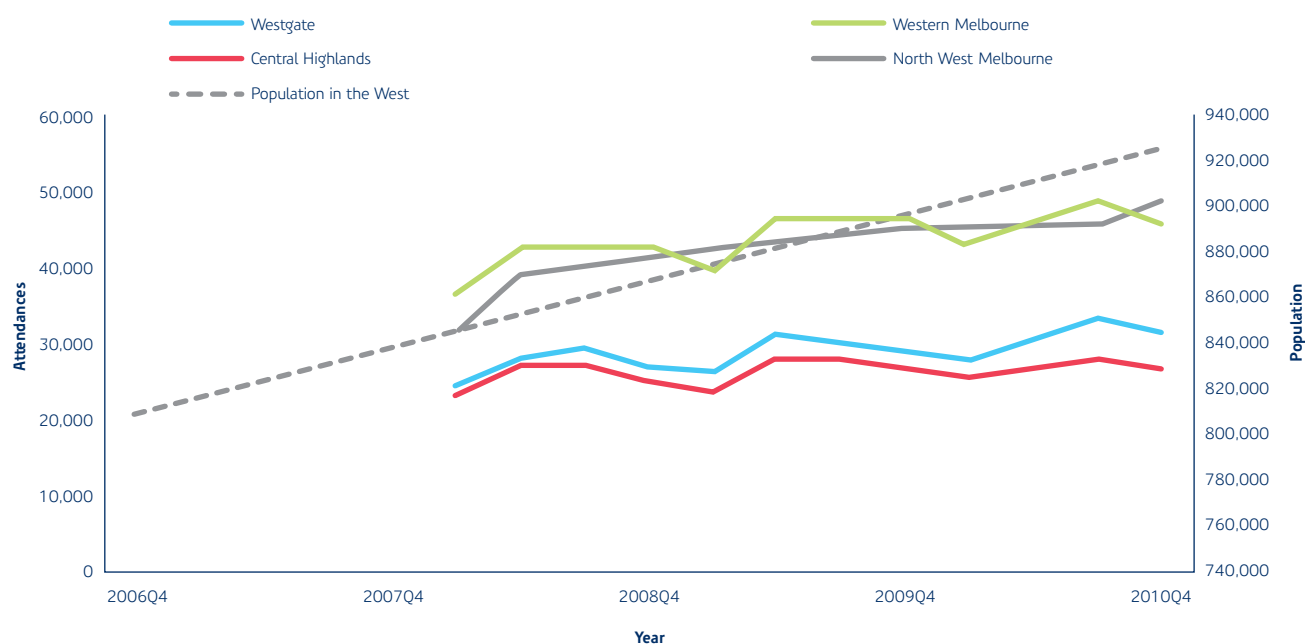


Figure 14: Professional attendance at GP Networks in the West.

Source: Medicare (2010)

What we will do

Meeting current and future demand in the west will require a mixture of optimising existing services and acquiring new capacity.

Strategy		How we will do this	
5.1	Measure and compare outcomes against resources on an ongoing basis to inform planning and advocacy for key resources	5.1.1	Measure the outcomes of services in the three priority health areas
5.2	Re-align and attract resources to articulated need	5.2.1	Develop annual priority statements across partners and meet with the Department of Health to plan resource allocation
5.3	Advocate for and attract resources to meet demand	5.3.1	Jointly advocate for increased publically funded health service capacity to meet current and future demand levels
		5.3.2	Promote the development of private services
		5.3.3	Facilitate additional private hospital capacity in the region.

Objective 6: Develop a research program focused around health priority areas

Current context

A well developed and executed research program will underpin all the objectives of the *Better Health Plan for the West*. The building blocks and opportunities to develop an outstanding research program are in already in place.

A well-coordinated and targeted research agenda will enable the implementation of the Plan by:

- Providing a robust evidence base for the development of new models of care and continuous improvement for existing models
- Attracting students and other researchers to the west to conduct applied research and combine research and practice
- Informing decision-making processes about the allocation of resources to different services approaches.

The west's demographic characteristics and the range of services provided through health agencies make it attractive to researchers who want to look at health issues in a complex and diverse environment.

There are already a number of pre-eminent researchers and clinicians working in the region. The opportunities for research in the west have significantly increased through the new Western Centre for Health Research and Education. This facility opened in early 2011 at Sunshine Hospital and is a partnership between Western Health, University of Melbourne, Victoria University, Victorian Government and the Australian Government.⁸



What we will do

Strategy	How we will do this
6.1 Communicate research capability	Through an outcomes focused research agenda:
	6.1.1 Hold regular forums that use the research outcomes for service system re-design, local planning and advocacy
	6.1.2 Identify regional research priorities and initiatives
6.2 Increase research programs	6.2.1 Identify research funding opportunities
	6.2.2 Increase the number of research grants obtained

⁸ This facility houses researchers undertaking programs into a range of diseases affecting the west.

Objective 7: Utilise e-health and communications technology

New and emerging e-health and communications technologies will be a critical factor in facilitating the objectives in this plan; particularly those related to health literacy and empowering our consumers, and developing new models of care.

Current context

The innovative use of technology will play a fundamental role in improving health outcomes in the west. As recognised in the National E-Health Strategy, there is a latent capacity in the health system represented by consumers themselves playing a more active role in the protection and management of their personal health outcomes (National E-Health and Information Principal Committee, 2008). The clever use of technology can empower consumers in the west and facilitate increases in health literacy.

New technologies will also allow providers in the west to deliver services as efficiently as possible. Information sharing, for clinicians as well as for individual health care users, is currently made difficult by the diversity of information management systems between the state, Commonwealth and private health sectors.

The impediments to sharing information can create risks of error, inefficiency, and potential disparities in consumers' outcomes. Limitations in the timely electronic movement of clinical information may mean that the key information about a consumer whose risks have been identified in one setting may not always be transferred to other settings. Difficulties in obtaining information can mean that up-to-date evidence and best practice approaches do not always influence either clinicians' decisions or consumers' choices about how to manage their health (Department of Health, 2011b).



What we will do

There are already a number of innovative e-health initiatives currently in the region including Djerriwarrh Health Services' comprehensive electronic health records and automated queue management system. There are several other proposed initiatives such as Western Health's new model of care which proposes e-health initiatives to provide decentralised community based care where it is safe and efficient to do so. The west is therefore in a good position to expand the existing uses of e-health in the region and become an early adopter under the National E-Health Strategy.

Comparatively low complexity and cost initiatives using existing platforms can enable the sharing of health records among providers and the possession of consolidated data by consumers.

Strategy		How we will do this	
7.1	Provide consumers and staff with easy and timely access to electronic records	7.1.1	Establish a Western Data Working Group that will: <ul style="list-style-type: none">• Develop a shared record 'repository' that will allow providers to see who is involved in the care of a consumer, and a summary of their clinical information• Develop agreed consumer consent protocols
		7.1.2	Develop a "My Health Record" e-portfolio for health that allows consumers to track their own health
7.2	Increase the volume and type of "off-site" services provided in community settings	7.2.1	Advocate for the up-dating of funding criteria to reflect clinical innovations now available through video conferencing
		7.2.2	Introduce clinical video conferencing

Future Health Priorities

The communities in the west have particular health needs that reflect the relative prevalence and burden of disease of certain health outcomes. This plan identifies three largely inter-related outcomes where prevalence levels are likely to remain above state levels for the foreseeable future: 1 Mental health; 2. Cardiovascular disease / Obesity / Diabetes; and 3. Cancer. The plan does not recommend an exclusive focus on these outcomes in the longer term. The priorities are intended to provide an initial starting point when implementing the objectives and strategies of this plan.

Table 8 below shows the prevalence⁹ and incidence of particular health across each LGA in the west. Percentage for particular LGAs that exceed the state average by more than 25% are highlighted in red.

Table 8: Percentage of prevalence and incidence of conditions in western LGA populations

Health Outcome	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Asthma									
Prevalence of current asthma (2008)	11.9	11.5	12.8	6.4	11.3	10.3	11.7	12.2	10.7
Cancer									
Malignant cancers diagnosed each year per capita (2007) ¹⁰	0.4	0.5	2.6	0.5	0.3	0.5	0.6	0.4	0.4
Cardiovascular disease									
Prevalence of cardiovascular disease (2001)	1.8	2.3	2.3	2.7	1.3	1.2	1.5	1.2	2.1
Communicable diseases									
Prevalence of infectious diseases (2001)	3.3	3.6	3.1	3.7	3.1	4.0	3.3	3.1	3.6
Diabetes									
Prevalence of type 2 diabetes (2008)	6.7	3.2	8.5	5.5	9.3	3.1	5.0	4.3	4.8
Mental health									
High (22–29) and very high (30–50) levels of psychological distress (2008) ¹¹	16.7	10.9	19.2	13.9	15.5	10.3	14.1	8.7	11.4
Proportion of persons who sought professional help for a mental health problem in the last 12 months	7.8	13.0	11.6	11.1	12.1	12.0	10.1	10.3	11.4

⁹ Prevalent cases are those people who at any point in time during that year had the condition regardless of when it first affected the individual.

¹⁰ This includes cases diagnosed over the period from 2003 to 2007.

¹¹ Based on Kessler 10 Psychological Distress Scale (K10).

Table 8: Percentage of prevalence and incidence of conditions in western LGA populations (continued)

Health Outcome	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Musculoskeletal conditions									
Prevalence of Musculoskeletal diseases (2001)	3.1	3.4	2.6	4.3	2.5	4.0	2.8	2.6	3.5
Oral health									
Prevalence of oral health (2001)	48.4	52.0	48.0	52.8	49.6	56.4	49.1	48.2	52.5
Obesity									
BMI ≥ 30.0 (Males)	23.3	18.0	26.8	13.0	22.5	23.2	26.9	23.9	17.3
BMI ≥ 30.0 (Females)	18.4	13.7	20.1	10.2	24.5	12.3	22.5	18.9	16.1

Sources: Department of Health (Vic.) (2001), Department of Health (Vic.) (2008a), Cancer Council Victoria (2011)

The projected prevalence rates of a number of these conditions are shown in Figure 15 below.

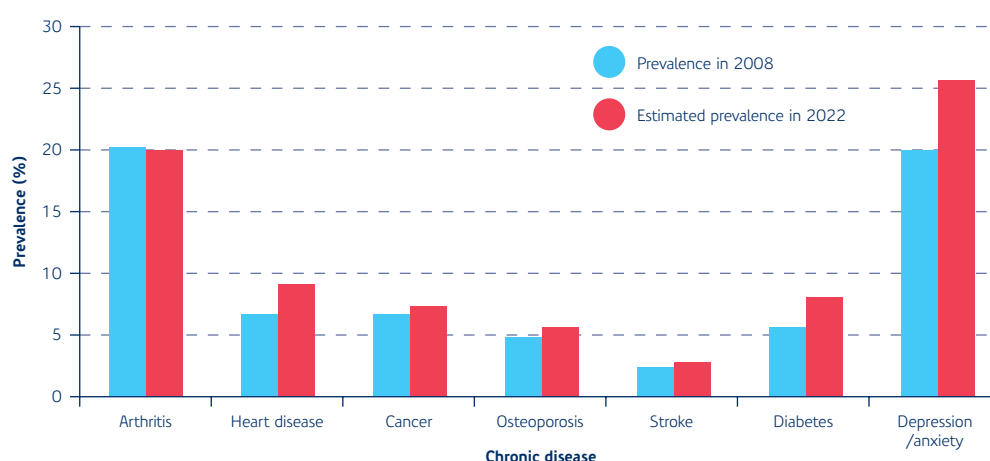


Figure 15: Projected prevalence of selected chronic diseases in Victoria 2022.

Source: Department of Health (Vic.) (2011)

The implementation of the *Better Health Plan for the West* will be centred around the following three health priorities:

1. Mental health
2. Cardiovascular disease / Obesity / Diabetes
3. Cancer

These priorities were chosen for the following reasons:

- Their local levels of prevalence and burden of disease are generally higher than the state average
- They were identified as high priorities by stakeholders in the initial round of consultations
- There are high rates of co-morbidity between them

The selection of these three priorities does not in any way detract from the importance of services designed to address the other health priorities.

Appendix B provides a more detailed analysis of the local prevalence of the three health priorities by LGA.

How We Will Work Together

Partnership governance

The *Better Health Plan for the West* partnership is currently a loose and informal network. It is the intention of the partners that the partnership will move in the short term along the partnership continuum towards more formal coordinating and cooperating type arrangements (see Figure 16: The partnership continuum). The evolution of the partnership will also be influenced by the introduction of Medicare Locals in the region.¹²



Networking	Sharing of information Low effort and commitment Little or no risk
Co-ordinating	More formal understanding Medium effort and commitment
Co-operating	Longer term Requires significant amounts of time High levels of trust
Collaborating	Long-term Formal agreements Memoranda of Understanding (MOU) Shared control over programs and activities Pooling of resources and governance arrangements High risks and reward

Figure 16: The partnership continuum

Adapted from: Himmelman (2001)

Accountability

All of the partner organisations will be responsible for implementing the actions of the *Better Health Plan for the West*.

¹² The timing of this was not known during the development of this Plan.

Health planning principles

The work of the partnership will be guided by the following principles:

We will work with our consumers:

- In partnership to help them to understand and act on their own health status across all rungs of the participation ladder¹³

We will deliver services:

- Acknowledging health inequalities and with a health equity approach
- At the most consumer friendly, responsive and cost effective delivery point
- Locally accessible wherever possible
- Through more centrally available tertiary services in the region

We will work together by:

- Leveraging existing resources
- Maximising technology to improve communication between providers
- Recognising the unique contributions of each partner and defining roles and responsibilities

We will plan for future services by:

- Seeking and endeavouring to secure resources that are commensurate with need
- Maintaining a clear view of expanding services to complement each other
- Ensuring that services are flexible and sustainable
- Taking a service system approach
- Being informed by robust evidence bases
- Understanding the important role of prevention and early intervention

¹³ The three categories of rungs from bottom to top are: 1. nonparticipation (manipulation and therapy); 2. Degrees of tokenism (informing, consultation and placation); 3. Degrees of citizen power (delegated power and citizen control) (Arnstein, 1969).

Appendix A – Demographic Data

Table 9: Project population growth by LGA 2011 – 2021

Age group	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moorabool	Moonee Valley	Wyndham	VIC
0-4yrs	-2%	0%	22%	5%	32%	7%	-2%	40%	9%
5-9yrs	-3%	5%	24%	15%	66%	15%	-1%	64%	15%
10-14yrs	-7%	2%	12%	10%	75%	0%	-2%	62%	12%
15-19yrs	-11%	-10%	6%	-7%	57%	-12%	-11%	33%	0%
20-24yrs	-6%	2%	7%	-8%	26%	8%	-1%	21%	0%
25-29yrs	1%	15%	16%	-8%	2%	17%	13%	26%	7%
30-34yrs	8%	13%	32%	8%	14%	18%	18%	39%	19%
35-39yrs	6%	-6%	27%	28%	38%	12%	4%	49%	15%
40-44yrs	-5%	-15%	9%	25%	71%	-3%	-12%	55%	3%
45-49yrs	-2%	-5%	10%	25%	76%	-6%	-6%	53%	6%
50-54yrs	1%	5%	29%	18%	51%	6%	1%	51%	10%
55-59yrs	2%	24%	44%	23%	32%	13%	5%	63%	15%
60-64yrs	7%	27%	39%	42%	46%	16%	13%	58%	18%
65-69yrs	39%	37%	53%	46%	123%	50%	28%	87%	37%
70-74yrs	68%	40%	76%	9%	166%	108%	26%	115%	55%
75-79yrs	51%	15%	72%	-21%	177%	85%	14%	100%	43%
80-84yrs	41%	12%	72%	-40%	151%	44%	11%	90%	23%
85+yrs	65%	44%	99%	-14%	163%	54%	27%	100%	36%
Grand Total	5%	7%	24%	11%	51%	14%	5%	50%	14%

Source: Department of Planning and Community Development (Vic.) (2008)

Appendix B – Prevalence And Burden Of Disease In The West

Mental health

The prevalence of people experiencing high and very high levels of psychological distress is higher than the state average across the majority of LGAs in the west. Figure 17 shows that prevalence levels are particularly high in Hume and Brimbank.

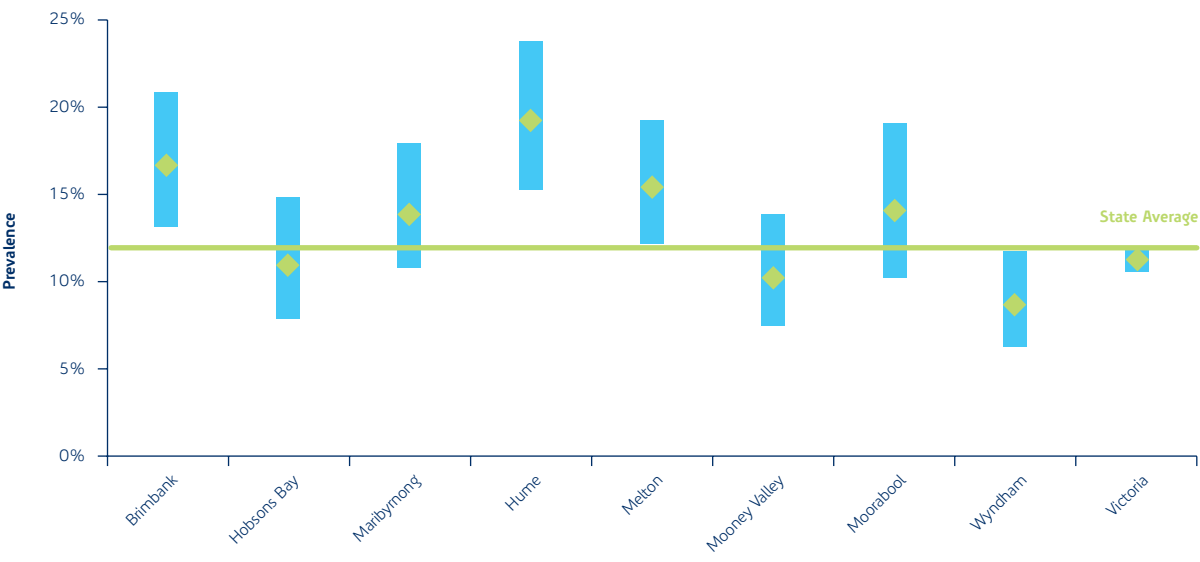


Figure 17: Prevalence of people with high & very high levels of psychological distress by LGA. *

Source: Department of Health (Vic.) (2008a)

* Based on Kessler 10 Psychological Distress Scale (K10). High is (22-29)

Figure 18 shows the proportion of people who sought professional help for a mental health problem in 2007. It is notable that Brimbank had the lowest levels of people seeking professional help, despite having a high prevalence of people with high and very high levels of psychological distress.

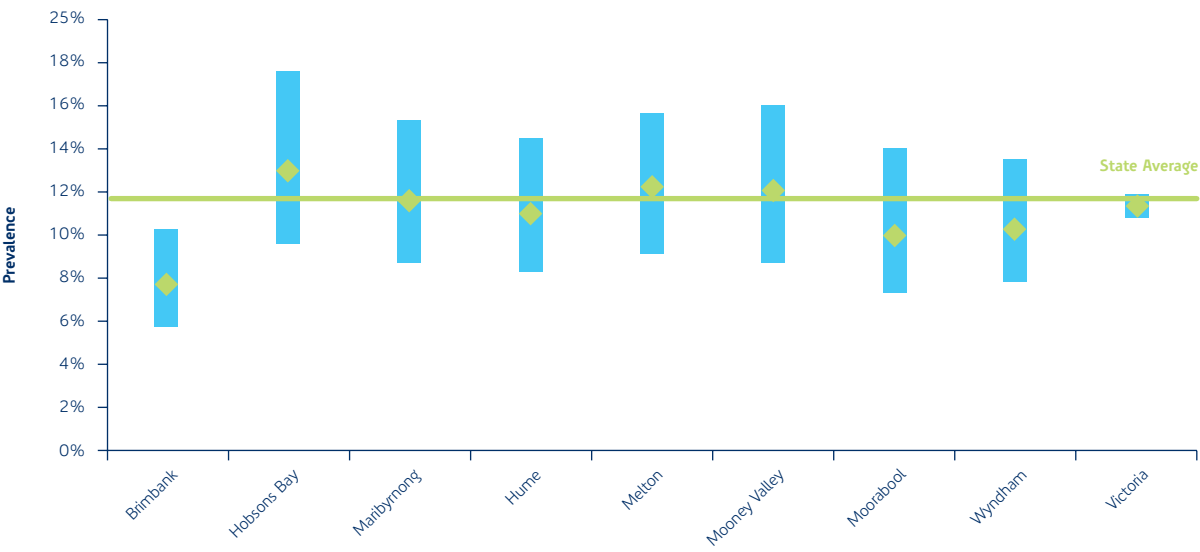


Figure 18: Proportion of persons who sought professional help for a mental health problem in the last 12 months by LGA.

Source: Department of Health (Vic.) (2008a)

Note: Upper and lower confidence intervals of 95% are displayed on the above graph

The Disability Adjusted Life Years (DALY¹⁴) for mental disorders per 1,000 people in the west is shown below. DALY rates for depression for both males and females were particularly high relative to the state averages.

Table 10: Disability Adjusted Life Years for mental disorders per 1,000 by LGA – Males (2001)

Mental disorder	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Alcohol abuse/dependence	1.8	1.6	1.8	2.0	1.5	1.6	1.1	1.6	1.6
Heroin abuse/dependence	1.7	1.2	2.0	2.4	1.2	1.5	1.2	1.5	1.5
Schizophrenia	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7
Depression	6.3	6.7	6.4	6.1	6.7	6.7	5.3	6.7	5.9
Bipolar disorder	1.0	0.7	1.0	1.2	0.8	0.8	0.8	0.8	0.7
Social phobia	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Generalised anxiety disorder	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7
Borderline personality disorder	1.2	1.4	1.5	1.2	1.5	1.8	1.8	1.7	1.5
Total	20.8	19.8	21.5	22.2	19.8	20.7	18.4	20.7	19.6

Source: Department of Health (Vic.) (2001a)

Table 11: Disability Adjusted Life Years for mental disorders per 1,000 by LGA – Females (2001)

Mental disorder	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Alcohol abuse/dependence	0.4	0.4	0.4	0.3	0.4	0.4	0.2	0.4	0.4
Heroin abuse/dependence	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.4
Schizophrenia	1.3	1.3	1.3	1.4	1.3	1.3	1.3	1.3	1.3
Depression	8.6	7.7	8.0	9.0	7.7	6.9	6.4	6.9	7.1
Bipolar disorder	1.0	0.7	0.9	1.0	0.7	0.8	0.5	0.9	0.8
Social phobia	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Generalised anxiety disorder	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4
Borderline personality disorder	1.9	1.4	1.8	2.2	1.4	1.5	1.2	1.7	1.6
Total	21.6	20.0	21.0	22.5	20.0	19.5	18.2	19.7	19.7

Source: Department of Health (Vic.) (2001a)

¹⁴ Disability Adjusted Life Years (DALY) is a measure of overall disease burden expressed as the number of years lost due to ill-health, disability or early death. DALY = Years of Life Lost (YLL) + Years Lived with Disability (YLD).

Cardiovascular disease / Obesity / Diabetes

Cardiovascular disease

The prevalence of cardiovascular disease in the west was below the state average in 2001, with the exception of residents in Maribyrnong and Hobsons Bay.

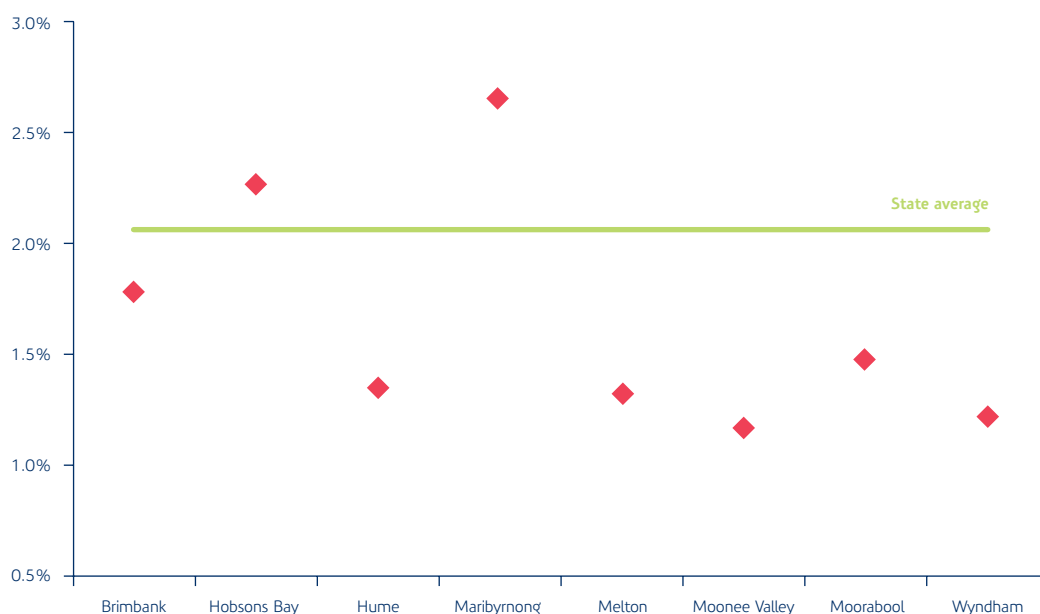


Figure 19: Prevalence of cardiovascular disease by LGA.

Source: Department of Health (Vic.) (2001a)

The Disability Adjusted Life Years for cardiovascular disease per 1,000 people in the west are shown below. Brimbank, Hume, Maribyrnong and Moorabool all have DALY rates for males for cardiovascular disease above the State average.

Table 12: Disability Adjusted Life Years for cardiovascular disease per 1,000 by LGA – Males (2001)

Cardiovascular disease	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Ischaemic heart disease	15.2	14.3	15.1	15.6	14.4	14.4	15.0	14.7	14.9
Stroke	6.4	6.5	6.2	6.2	6.5	6.2	6.0	6.2	6.2
Inflammatory heart disease	1.1	0.9	1.1	1.2	0.9	1.0	1.1	1.0	1.0
Other cardiovascular disease	0.9	0.9	0.9	0.9	0.9	1.0	1.1	1.1	1.0
Total	25.8	24.4	25.8	26.5	24.5	25.0	25.8	25.4	25.5

Source: Department of Health (Vic.) (2001a)

Table 13: Disability Adjusted Life Years for cardiovascular disease per 1,000 by LGA – Females (2001)

Cardiovascular disease	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Ischaemic heart disease	10.5	10.4	10.4	10.5	10.5	10.1	10.3	10.1	10.5
Stroke	7.4	7.9	7.3	7.1	7.8	7.5	7.2	7.4	7.8
Inflammatory heart disease	0.6	0.6	0.7	0.6	0.5	0.7	0.7	0.6	0.7
Other cardiovascular disease	1.1	1.1	1.2	1.2	1.1	1.2	1.4	1.1	1.3
Total	21.8	22.3	21.5	21.4	22.3	21.4	22.2	21.2	22.4

Source: Department of Health (Vic.) (2001a)

Obesity

The prevalence levels of obesity among both males and females in the west are above the state average across all LGAs, with the exception of Maribyrnong. Obesity prevalence was particularly high in Hume and Moorabool.

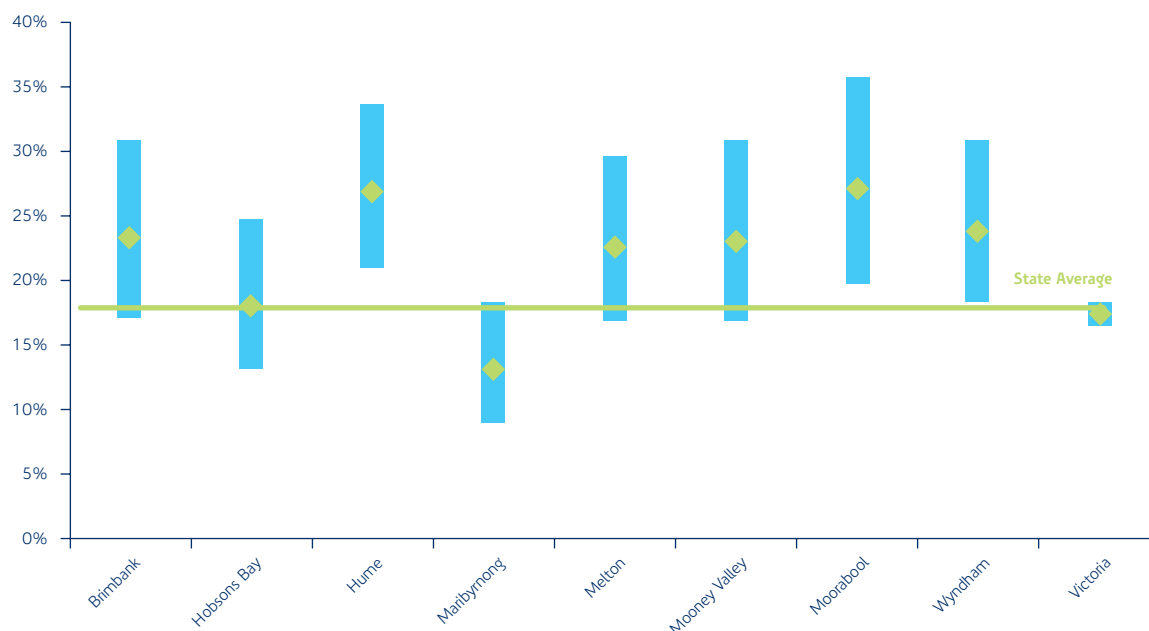


Figure 20: Prevalence of Obesity by LGA (Males). *

Source: Department of Health (Vic.) (2008a)

Note: Upper and lower confidence intervals of 95% are displayed on the above graph

* Obesity is defined as having a body mass index (BMI) that is ≥ 30.0 .

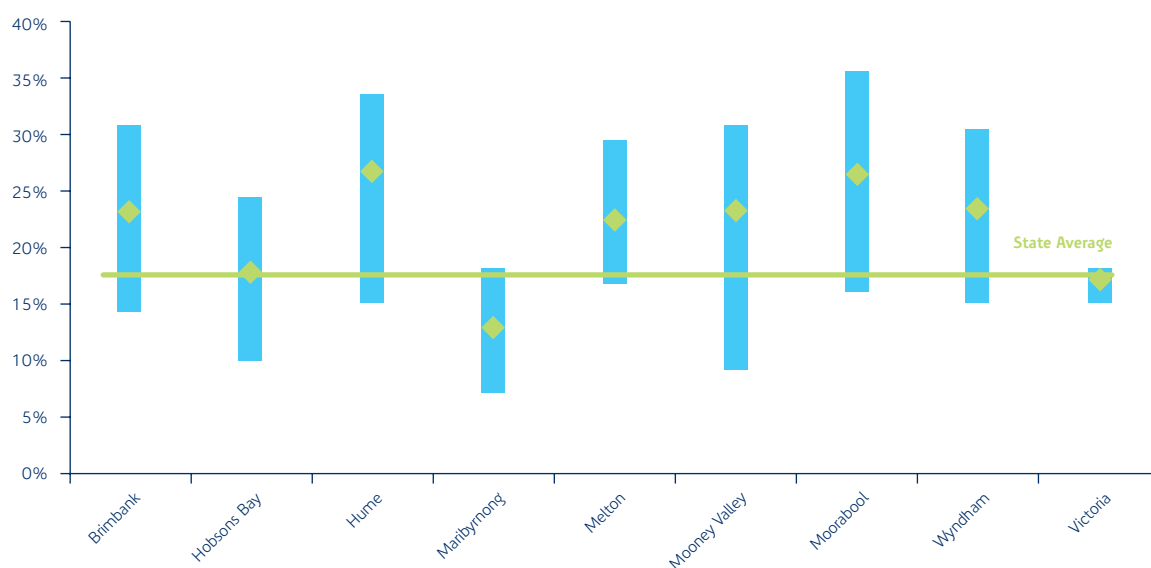


Figure 21: Prevalence of Obesity by LGA (Females).*

Source: Department of Health (Vic.) (2008a)

Note: Upper and lower confidence intervals of 95% are displayed on the above graph

* Obesity is defined as having a body mass index (BMI) that is ≥ 30.0 .

Diabetes

The west has prevalence levels of Type 2 diabetes above the State average.

Figure 22 shows that levels are particularly high in Brimbank, Hume and Melton.

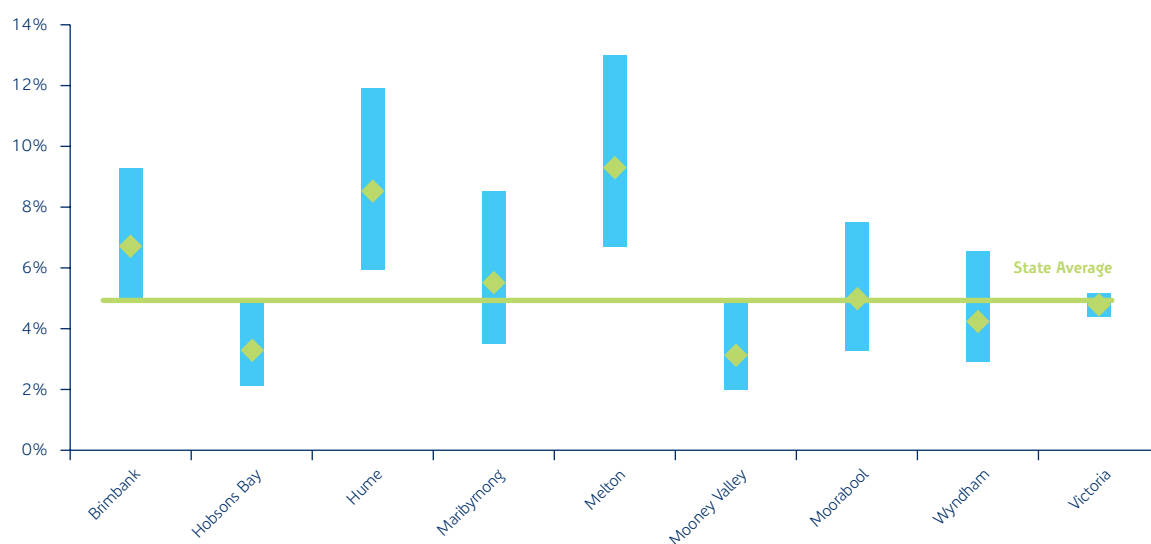


Figure 22: Prevalence of Type 2 Diabetes by LGA.

Source: Department of Health (Vic.) (2008a)

Note: Upper and lower confidence intervals of 95% are displayed on the above graph

Cancer

The DALY rates for malignant cancers in 2001 across each LGA are shown below:

Table 14: Disability Adjusted Life Years for malignant cancers per 1,000 by LGA – Males (2001)

DALY Rates for Males (2001)	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Mouth and oropharynx cancers	1.1	1.0	1.1	1.2	1.0	1.0	1.1	1.0	1.0
Cancer oesophagus	0.8	0.8	0.9	0.8	0.7	1.0	1.3	1.0	1.0
Cancer stomach	1.5	1.4	1.2	1.4	1.4	0.9	1.0	0.9	1.1
Cancer colon/rectum	4.1	3.7	4.3	4.5	3.7	4.0	4.7	4.1	4.2
Cancer pancreas	1.2	1.2	1.2	1.2	1.2	1.2	1.4	1.2	1.3
Cancer lung	6.9	6.6	6.5	6.8	6.8	6.2	5.8	6.4	6.0
Melanoma	0.6	0.7	0.9	0.7	0.6	1.1	1.2	1.0	1.1
Cancer prostate	4.6	4.9	4.4	4.3	5.0	4.4	5.1	4.3	4.8
Cancer kidney	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8
Cancer brain	1.0	1.0	1.1	1.1	1.0	1.0	1.4	1.0	1.2
Lymphoma	1.2	1.0	1.3	1.4	1.0	1.2	1.5	1.2	1.3
Leukaemia	1.0	0.9	1.0	1.1	0.9	1.0	1.1	1.0	1.1
Other malignant cancers	1.4	1.5	1.3	1.3	1.5	1.3	1.2	1.2	1.3
Total	26.2	25.5	26	26.6	25.6	25.1	27.6	25.1	26.2

Source: Department of Health (Vic.) (2001a)

Table 15: Disability Adjusted Life Years lost due to malignant cancers per 1,000 by LGA – Females (2001)

DALY Rates for Females (2001)	Brimbank	Hobsons Bay	Hume	Maribyrnong	Melton	Moonee Valley	Moorabool	Wyndham	VIC
Mouth and oropharynx cancers	0.4	0.4	0.4	0.3	0.4	0.5	0.6	0.5	0.5
Cancer oesophagus	0.4	0.5	0.3	0.3	0.5	0.4	0.5	0.4	0.4
Cancer stomach	0.8	0.7	0.8	0.9	0.7	0.7	0.5	0.7	0.7
Cancer colon/rectum	3.2	3.1	3.3	3.4	3.1	3.2	3.9	3.2	3.5
Cancer pancreas	1.0	1.0	1.1	1.1	0.9	1.1	1.2	1.1	1.1
Cancer lung	3.9	3.8	3.7	3.8	3.9	3.5	3.6	3.5	3.6
Melanoma	0.4	0.5	0.4	0.4	0.5	0.5	0.8	0.4	0.6
Cancer breast	6.4	6.7	6.2	6.2	6.7	6.0	6.2	5.6	6.6
Cancer ovary	1.5	1.6	1.4	1.4	1.6	1.5	1.5	1.5	1.5
Cancer prostate	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cancer kidney	0.7	0.7	0.5	0.5	0.8	0.6	0.6	0.6	0.5
Cancer brain	0.8	0.8	0.8	0.8	0.8	0.9	0.9	0.9	0.9
Lymphoma	1.1	1.2	1.1	1.1	1.2	1.2	1.0	1.1	1.2
Leukaemia	0.7	0.8	0.8	0.7	0.8	0.8	0.8	0.8	0.8
Other malignant cancers	1.0	0.9	1.0	1.0	0.9	0.9	1.1	0.8	1.0
Total	22.3	22.7	21.8	21.9	22.8	21.8	23.2	21.1	22.9

Source: Department of Health (Vic.) (2001a)

The total malignant cancers diagnosed each year over the period 2003 to 2007 across each LGA are shown below:

Table 16: Total malignant cancers diagnosed each year over the period 2003 to 2008 by LGA

	Male	Female	Total	All persons
LGA				% of LGA population
Brimbank	363	304	668	0.4%
Hobsons Bay	237	186	423	0.5%
Hume	297	241	538	0.4%
Maribyrnong	149	128	277	0.4%
Melton	129	107	237	0.3%
Moonee Valley	316	253	569	0.5%
Moorabool	76	53	129	0.5%
Wyndham	205	176	381	0.3%
VIC	14,462	11,429	25,891	

Source: Cancer Council Victoria (2011)



Appendix C – REFERENCES

- ABS (2006), *4233.0 Health Literacy, Australia*
- ABS (2009), *3218.0 Regional Population Growth, Australia*
- ABS (2010a), *1379.0.55.001 National Regional Profile, Brimbank (C), 2005–2009*
- ABS (2010b), *1379.0.55.001 National Regional Profile, Hobsons Bay (C), 2005–2009*
- ABS (2010c), *1379.0.55.001 National Regional Profile, Hume (C), 2005–2009*
- ABS (2010d), *1379.0.55.001 National Regional Profile, Maribyrnong (C), 2005–2009*
- ABS (2010e), *1379.0.55.001 National Regional Profile, Melton (S), 2005–2009*
- ABS (2010f), *1379.0.55.001 National Regional Profile, Moorabool (S), 2005–2009*
- ABS (2010g), *1379.0.55.001 National Regional Profile, Victoria, 2005–2009*
- ABS (2010h), *1379.0.55.001 National Regional Profile, Wyndham (C), 2005–2009*
- ABS (2011), *3218.0 – Regional Population Growth, Australia, 2009–10*
- Arnstein, S (1969), 'A ladder of citizen participation', *Journal of the American Institute of Planners* 35(4), pp216–224.
- Bennett, K. (2009), *Diabetes in Western Metropolitan Melbourne*
- Cancer Council Victoria (2011), *Victorian Cancer Registry*
- Centre for Strategic Economic Studies (2010), *Updating Melbourne's West*.
- COAG (2011), *Heads of Agreement – National Health Reform*
- Department of Health (Vic.) (2001), *Burden of Disease study*
- Department of Health (Vic.) (2006a), *Your hospitals: A report on Victoria's public hospitals – January to June 2006*
- Department of Health (Vic.) (2006b), *Your hospitals: July to December 2005*
- Department of Health (Vic.) (2006c), *Victorian Health Information Surveillance System*
- Department of Health (Vic.) (2007), *Your hospitals: July 2006 to June 2007*
- Department of Health (Vic.) (2008a), *Victorian Population Health Survey report 2008*
- Department of Health (Vic.) (2008b), *Your hospitals: July 2007 to June 2008*
- Department of Health (Vic.) (2009), *Your hospitals: July 2008 to June 2009*
- Department of Health (Vic.) (2010a), *Your hospitals: July 2009 to June 2010*
- Department of Health (Vic.) (2010b), *North and West metropolitan region health status: Summary profile*
- Department of Health (Vic.) (2011a), *Health Status Atlas*
- Department of Health (Vic.) (2011b), *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan*
- Department of Health (Vic.) (2011c), *Metropolitan Health Plan: Technical Paper May 2011*
- Department of Human Services (Vic.) (2009), *Primary health care in Victoria: A discussion paper*
- Department of Immigration and Citizenship (2011), *Settlement Reporting*
- Department of Planning and Community Development (Vic.) (2008), *Victoria in the Future*
- Himmelman A. (2001), 'On coalitions and the transformation of power relations', *American J of Community Psychology* 29(2)
- Medicare Australia (2010), *Divisions of General Practice Statistics*
- National E-Health and Information Principal Committee (2008), *National E-Health Strategy*
- Salt, B. (2010), *The Rise and Rise of Melbourne's West*
- Western Health (2011), *The Western Health Model of Care – Summary Report*



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