

Primary Health Branch report

2007-08

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Director's foreword

I am pleased to present the *Primary Health Branch report 2007–08*. This report provides an overview of activities delivered by a range of primary health agencies funded by the branch and also details the branch's achievements against its five stated aims for 2007–08.

The vision of the Primary Health Branch is to improve the health and wellbeing of Victorians, particularly those with or at risk of poorer health status, by developing strong, effective modern primary health care services as part of Victoria's health care system.

To achieve this vision, the branch set the following aims for 2007–08.

1. Strengthen, expand and integrate the primary health care service system
2. Better connect primary health care services with acute and residential care to support substitution and diversion
3. Expand service options and access to information to support self-management, primary, secondary and tertiary prevention and integrated health promotion
4. Improve the performance, quality and safety of state funded primary health care services
5. Value and improve consumer and carer participation in all primary health programs as a key aspect of continuous improvement of primary health care services.

As part of this work, the branch developed and released several policy frameworks and continued to support program development. Key policies released in 2007–08 included the *Towards a demand management framework for community health services*, *Working with general practice: Department of Human Services position statement and resource guide*, and the *Statewide service coordination survey*.

This report also provides an account of the services funded by the branch. In this year, the branch supported the delivery of 2,123,149 occasions of service to the Victorian community, comprising 952,545 Community Health individual and group contacts, 798,435 Dental Health visits and 372,169 calls to NURSE-ON-CALL.

I would like to thank those people who are delivering Victoria's primary health care services. The achievements of 2007–08 continue to form a strong foundation for the health of Victorians.



Janet Laverick
Director Primary Health
Rural and Regional Health and Aged Care Services Division
Department of Human Services

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About the Primary Health Branch

Vision

The vision of the Primary Health Branch is to improve the health and wellbeing of Victorians, particularly those with or at risk of poorer health status, by developing strong, effective modern primary health care services as part of Victoria's health care system.

Approach

The Primary Health Branch works with the broader primary health sector and research community to maximise knowledge related to national and international evidence and practice in primary and community-based health care. This knowledge is used to inform the development of policy and programs and to support the implementation of best practice in the sector.

To achieve this, the Primary Health Branch fosters a positive work environment that promotes the Department of Human Services values, develops the potential of staff and encourages open communication, feedback, collaboration and innovation.

Responsibilities

The Primary Health Branch is responsible for statewide policy development, planning, funding and monitoring of primary health programs and initiatives. This includes:

- funding primary health services such as community health, dental health and health promotion
- liaising with the Commonwealth Government and general practice to develop a coordinated and effective primary health care system
- developing strategies to improve the integration of the primary health care sector and the interface between the primary health care sector and the acute health care sector
- developing the capacity of the primary health sector to respond to chronic disease.

2007–08 branch aims

To achieve its vision, the Primary Health Branch aims to:

1. strengthen, expand and integrate the primary health care service system
2. better connect primary health care services with acute and residential care to support substitution and diversion
3. expand service options and access to information to support self-management, primary, secondary and tertiary prevention and integrated health promotion
4. improve performance, quality and safety of state-funded primary health care services
5. value and improve consumer and carer participation in all primary health programs as a key aspect of continuous improvement of primary health care services.

Key policies

The efforts of the Primary Health Branch are guided by the key Victorian Government and department policies listed below.

Victorian Government policies

At the highest level of Victorian social policy, the work of the Primary Health Branch is guided by *Growing Victoria Together* and *A Fairer Victoria*.

Growing Victoria Together

Growing Victoria Together commits the Victorian Government to high quality, accessible health and community services and a vision for Victoria to 2010 and beyond.

The specific goal of providing high quality, accessible health and community services will be measured by improvements in the health of Victorians, improvements in the wellbeing of young children, reduced emergency, elective and dental waiting times, and increased consumer confidence in health and community services.

A Fairer Victoria

A Fairer Victoria establishes a framework to address disadvantage by developing and implementing innovative approaches to service delivery. The current priorities include:

- ‘Getting the best start’: early years support for children and families most at risk.
- ‘Improving education and helping people into work’: reducing educational inequality, supporting young people at risk and reducing barriers to workforce participation.
- ‘Improving health and wellbeing’: reducing health inequalities and promoting wellbeing.
- ‘Developing liveable communities’: strengthening neighbourhoods and local communities.

Department policies

In addition, based on the objectives outlined in the *Departmental plan 2007–08*, the Primary Health Branch has developed several key policies and strategies to foster the development of the primary health care sector in Victoria.

Departmental plan 2007–08

The Department of Human Services Plan for 2007–08 sets out the State Government’s key policy directions in human services, the challenges facing the department and details the priorities to continue to build a high performing human services system.

The mission of the department is to protect and enhance the health and wellbeing of all Victorians, emphasising vulnerable groups and those most in need. To achieve this, its key objectives are:

1. building sustainable, well managed and efficient human services
2. providing timely and accessible human services
3. improving human service safety and quality
4. promoting least intrusive and earliest effective care
5. strengthening the capacity of individuals, families and communities
6. reducing inequalities through improving health and wellbeing, particularly for disadvantaged people and communities.

Community health services—creating a healthier Victoria

Community health services—creating a healthier Victoria sets out a ten-year vision for community health services to expand their role as a platform for community-based health care.

Working with general practice: Department of Human Services position statement and resource guide

This policy articulates the vision of the collaborative interface between general practice and the Department of Human Services and provides a framework for a strong, coordinated and consistent approach to underpin collaborative work with the general practice sector into the future.

Primary care partnerships strategy

The *Primary care partnerships strategy* was initiated in 2000 to improve the health and wellbeing of people using primary health care services and to reduce avoidable use of hospital, medical and residential services.

Improving Victoria's oral health

Improving Victoria's oral health outlines six strategic developments or major projects required to maintain and improve the oral health of all Victorians.

Care in your community: a planning framework for integrated ambulatory health care policy

The framework sets out a consistent approach to the development of an integrated health care system, building on existing strengths and trends in health care provision.

Chronic disease management program guidelines for primary care partnerships and community health services

A chronic disease management approach aims to demonstrate improved health outcomes and quality of life for people with chronic disease.

Service delivery and partners

The Primary Health Branch continues to manage service delivery and new primary health initiatives through strong relationships with the primary health sector, as well as other key partners including the ambulatory, acute and post acute health sectors, aged care services, mental health services, local government, Divisions of General Practice and researchers.

The Primary Health Branch, with support from Department of Human Services regional offices, funds the delivery of primary health programs in the areas of:

- community health
- dental health
- health services for homeless youth
- refugee health
- child health
- early intervention in chronic disease
- diabetes self-management
- NURSE-ON-CALL
- general practice engagement
- Aboriginal health

For more information on the programs funded by the Primary Health Branch, refer to the *Primary Health Branch policy and funding guidelines, 2007–08 update*.

For a comprehensive list of key stakeholders and partners, refer to the *Appendix: Primary Health Branch service delivery partners*.

Branch structure

In 2007–8, the Primary Health Branch continued to examine opportunities to modify work practices to reduce duplication and optimise the use of available resources, including staff skills.

Primary health programs

Primary health programs focused on the development, funding and accountability of key programs such as Dental Health, Community Health, Innovative Health Services for Homeless Youth, Aboriginal Health Promotion and Chronic Care Partnerships and the Family and Reproductive Rights Education Program.

Primary health integration

Primary health integration focused on the development of key programs and strategies targeted towards the integration of the primary health care sector. This includes the *Primary care partnerships strategy*, the integrated chronic disease program, NURSE-ON-CALL and general practice initiatives.

Strategy, research and communication

Strategy, research and communication aimed to bring together cross-program policy development, corporate response coordination, communication and consumer engagement strategies with service development activities such as workforce strategies and service delivery planning.

Performance, reporting and monitoring

Performance, reporting and monitoring focused on the coordination and development of data management, program performance monitoring and program budgeting.

Highlights of 2007–08

New initiatives

The Primary Health Branch developed a number of key policies and strategies in 2007–08, including the *Working with general practice: Department of Human Services position statement and resource guide*, *Towards a demand management framework for community health services* and the *Statewide service coordination survey*.

Working with general practice: Department of Human Services position statement and resource guide

Launched in December 2007, *Working with general practice: Department of Human Services position statement and resource guide* presents a department-wide commitment to improving the way the department works with practitioners in general medical practice. The statement and guide recognise that successful partnerships between state-funded services and general practice are integral to the provision of coordinated care and result in more integrated service delivery and better health outcomes.

The position statement was developed primarily for departmental staff and as a guide for state-funded agencies and the general practice sector. It outlines a vision for a robust and effective collaborative interface between general practice and the department and:

- highlights opportunities to further align Victorian and Commonwealth government agendas for health care
- identifies actions to further the department's contribution to better collaboration with the general practice sector.

The resource guide provides practical information for departmental staff and other service providers committed to better engagement with general practitioners over various state health initiatives.

Towards a demand management framework for community health services

Towards a demand management framework for community health services sets out a framework for Victoria's community health services to better deliver the right care, at the right time, to the people who most need it.

Developed in consultation with the community health sector, it articulates a consistent demand management model and aims to:

- improve the consistency of practices in measuring and managing demand
- support and improve fair and equitable access to services
- provide improved access to services for clients.

The document provides tools for prioritising clients requiring services and identifies systems and strategies to manage clients throughout their health care journey. The framework addresses issues including waiting list definition and the prioritisation and management of branch-funded allied health, counselling and nursing services. It also surveys a range of strategies for more effectively managing those clients who are already in the system to help provide timely and appropriate care.

A related document, the *Waiting time measurement within community health services: practice guidelines*, contains revised practice guidelines and updates the methodology of measuring client waiting times for community health services across Victoria. This provides the consistency essential for developing good practice strategies for managing high demand.

Statewide service coordination survey

Service coordination aims to place consumers at the centre of service delivery to facilitate access to services, opportunities for early intervention, health promotion and improved health and care outcomes.

The statewide service coordination survey was a component of the *Continuous improvement framework*—a tool developed by primary care partnership member agencies to monitor service coordination implementation for quality improvement, planning and reporting purposes.

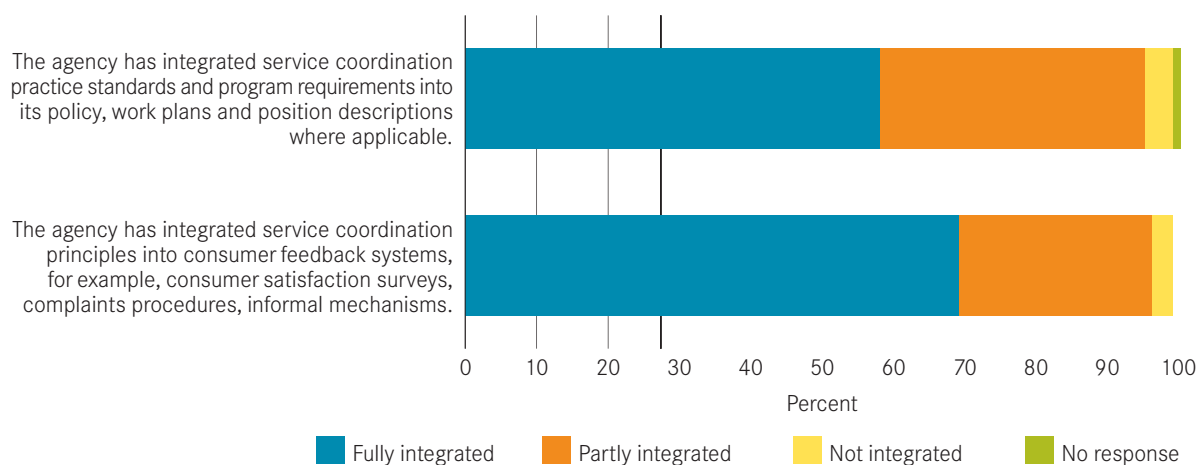
The survey, to be conducted annually, consisted of thirteen questions based on parts of the *Continuous improvement framework*. The areas covered by the survey include initial contact, initial needs identification, assessment, care planning, referral, and privacy and consent.

The results of the inaugural survey indicated mature levels of service coordination implementation in most of the areas covered by the survey.

Table 1 Responses to the service coordination survey by program

Program	Total responses
Admitted patients	16
Hospital Admission Risk Program (HARP)	26
Emergency services (including 24 hour emergency respite support)	10
Post acute	24
Sub acute	14
Palliative care	14
Outpatients	13
Allied health	34
Aged care assessment	40
Home and Community Care (HACC)	189
Homelessness assistance	12
Long-term housing assistance	4
Dental services	11
Community health	83
Ambulance services	1
Child protection and family services	20
Disability services	51
Drugs services	17
Early years services	14
Mental health	32
Youth justice services	11

Figure 1 Levels of service integration (sample of statewide response)



Particular areas of consistent practice include:

- obtaining client consent for disclosure of information
- responding to urgent and routine referrals
- monitoring clients between referrals
- providing referral feedback.

These areas are vital to achieve efficient sharing of client health and care information, effective coordination of services and preventing clients from ‘slipping between the gaps’. The results are an indication of the impact of seven years of service system reforms led by primary care partnerships and the maturity of the services to support changed practice. Results also demonstrate how primary care partnerships have grown to include a broader range of partners to meet the full needs of their clients.

Meeting branch aims

Aim 1: Strengthen, expand and integrate the primary health care service system

A strong, effective and integrated primary health care system is increasingly seen as important, in Australia and internationally, to tackle the challenges facing health care.

In addition, the life-course approach is playing an important role in understanding population health and wellbeing. This perspective views health as the product of risk behaviours, protective factors and environmental agents that we encounter throughout our entire lives and that have cumulative, additive and even multiplicative impacts on specific outcomes.

Community-based, primary health care seeks to protect, promote and develop the health of defined communities. By addressing and managing individual and population health problems at an early stage, the need for more complex care later in life is reduced. At the other end of the health care continuum, primary health care services can support rehabilitation and care at home.

► Branch achievements

Increased access to primary health services through service models, resources and policies that complement and supplement Medicare Benefit Schedule funded services

- **Development of the *Working with general practice: Department of Human Services position statement and resource guide***, which articulates the department's vision for a strengthened collaborative interface and provides practical information for departmental staff engaging with general practice. For more information, see **New initiatives**.
- **The Medicare Benefits Schedule Project**, which commenced with a summary of Medicare Benefits Schedule (MBS) items and their potential to support client care for those community health services seeking to expand their range of services through the MBS. An industry forum was also held to give practice examples and advice to the sector.

Integrated oral health within the primary health system

- **Implementation of *Integrated oral health services: a step in the right direction***, which is a key strategic development under *Improving Victoria's oral health*.

Snapshot: Integrated oral health services: a step in the right direction

Integrating oral health services is a key Victorian Government policy objective that aims to achieve:

- better continuity of care for patients through the public oral health system
- increased participation rates among high-needs groups
- improved access for families
- greater patient satisfaction
- enhanced staff satisfaction.

Integration is a significant change that will make a lasting, positive impact on the Victorian community. However, transferring a large number of services to local community health services is a major business process requiring effective change management. Critical success factors included having a vision for integrated oral health services, consistent leadership, establishment of multi-skilled teams and use of team building interventions, a flexible approach, due diligence and realistic timeframes.

From experiences so far, integration is achieving measurable benefits for clients and dental staff. There have been additional benefits for the entire community health services sector through advancing overall integration. *Integrated oral health services: a step in the right direction* contributes to extending those benefits and making the change successful.

Embedded service coordination across the human services system

- **Development of the statewide *Victorian service coordination practice manual* by the sector**, which ensures the widest applicability of the practice standards to different sectors.
- **Continued improvement of service coordination tool templates** to better meet the needs of a broader range of programs including palliative care and child and family services.
- **Continued implementation of the care planning project and implementation of strategies to engage general practitioners.** The project aimed to promote consistent care planning practice across and within agencies through primary care partnerships.

Snapshot: Electronic referral taking off

Electronic referral (e-referral) supports client health and care information to be shared electronically, securely and with client consent, via computers rather by phone, fax or mail. A client's individual health and care information is recorded and shared in a standard way—using the service coordination tool templates—and can then be shared securely between authorised services.

According to feedback from service providers, using the service coordination tool templates as part of e-referral can halve the time taken to make a referral (when compared with the time taken to refer using phone, fax or mail services). In addition, e-referral enables multiple referrals—an increasingly common requirement for consumers with complex needs—to be made more quickly.

Ann-Marie Decker, Eastern Health's Emergency Care Coordinator, is a great advocate for e-referral: "E-referral, and the agreed common practices that underlie it, has supported us to link in more strongly with other services," she says. "When we e-refer we know that we will get good quality and quick referral feedback and as a result we feel confident to refer more broadly than before. We love it!"

Building blocks for e-referral

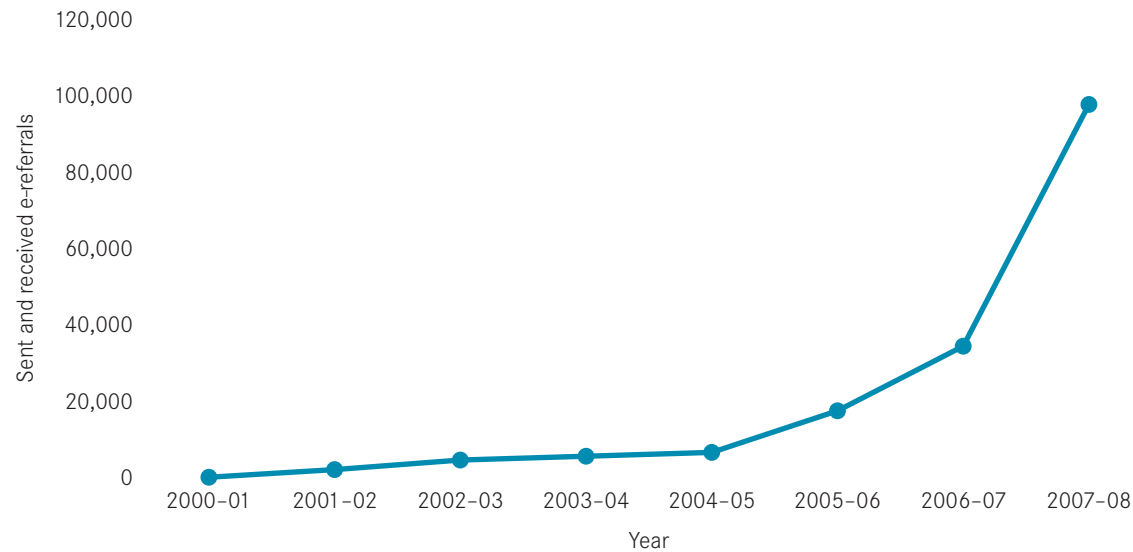
Primary care partnership member agencies and the Department of Human Services have worked together to put in place the building blocks needed to enable e-referral. For example:

- member agencies have agreed to statewide standards for service coordination practices
- more than 450 agencies now use the service coordination tool templates electronically to document consumer information, screen for unmet needs and provide quality referrals
- client management software vendors are provided with resources that enable consistent implementation of the service coordination tool templates in an electronic environment
- agencies are able to access information about other services quickly and effectively using the department's Human Services Directory.

Future of e-referral

The Primary Health Branch is working across the department, and nationally, to further develop the standards and infrastructure that support e-referral in Victoria in line with the national e-health agenda.

Figure 2 Sent and received e-referrals by financial year



Developed partnerships and alignment between programs and services

- **Facilitation of partnerships between Aboriginal Community Controlled Health Organisations and community health services**, as part of the ongoing implementation of the Aboriginal Health Promotion and Chronic Care Partnership initiatives.
- **Continued contribution to the Department of Justice problem gambling initiative.** This includes funding of \$0.7 million per annum over three years to enhance connections between problem gambling services and other human services through primary care partnerships.

► Future directions

Projects for 2008-09 include:

- finalisation and implementation of the latest version of the service coordination tool templates (SCTT 2009)
- continued implementation of the oral health service planning framework for all catchments
- development of a resource that assists general practices in community health services to improve their sustainability
- continued development of strategies and resources that assist effective engagement with general practice and other private health practitioners.

Aim 2: Better connected primary health care services with acute and residential care to support substitution and diversion

Victoria has a well established primary health sector, with strong partnerships with other health and human services. The sector is advanced in providing integrated and coordinated care, particularly for those with chronic and complex conditions, and providing vulnerable groups with access to services. Partnerships with hospitals, population health services, specialist health and other human service sectors are an important part of the primary health care system, which cannot operate in isolation. Importantly, partnership approaches enable seamless care pathways, effective population health action and better use of available resources.

Key challenges facing the health system include the growing incidence of chronic and complex conditions and avoidable hospital admissions. People with chronic and complex conditions need to have well planned, integrated care in a community setting that supports their capacity to self-manage and reduces avoidable hospital admissions. Core actions for change include the implementation of better integrated chronic disease management to reduce hospital use and a focus on the delivery of outcomes.

► Branch achievements

Increased links between primary and acute services to maximise capacity and access

- **Improved coordination of services between the acute and primary health sectors**, through the inclusion of acute program areas in the development of the revised service coordination tool templates.
- **Consultations with the Metropolitan Health and Aged Care Services Division to develop *Towards a demand management framework for community health services***, which helped ensure the division and its stakeholders were informed of improvements in community health demand management and understood the process to refer clients.
- **The reduction of demand on hospital emergency departments through NURSE-ON-CALL**, which enabled the Victorian public to call directly for around-the-clock access to general health advice and information. As a result of the service, just over one in five callers who had planned to ring an ambulance or go to an emergency department were advised they could manage their condition at home.

Snapshot: NURSE-ON-CALL

NURSE-ON-CALL, launched on 4 June 2006, enables the Victorian public to call directly for around-the-clock access to general health advice and information. The service, staffed by registered nurses, is available from any landline in Victoria for the cost of a local call (higher for mobiles).

NURSE-ON-CALL has been well received by Victorians and significantly improved the health outcomes of a number of callers.

- In 2007–08, 34,890 callers indicated that they would manage their health problem at home with self-care, however, 679 of these (or 2 per cent) required transfer to an ambulance.
- Conversely, for the same period only about 3 in 10 callers who had planned to ring an ambulance (3,209 callers) or go to an emergency department (37,174 callers) had conditions requiring transfer to 000 and presentation to the emergency department.

The Minister for Health, Mr Andrews, agreed NURSE-ON-CALL had helped save hospital resources, with hospitals diverting more than 46,900 calls to the service in 2007–08.

“That represents more than 7,800 hours of time—or 326 days—that hospital nurses would otherwise have spent speaking to these patients,” he said.

Results from the customer satisfaction surveys continue to reveal very positive outcomes:

- 99.6 per cent of respondents satisfied with the service they received.
- 98.6 per cent of respondents felt that NURSE-ON-CALL was a valuable step in accessing health assistance and advice.
- 97.7 per cent of respondents stated they would use the service again.

Area-based planning trials across Victoria

- **Successful completion of three area-based planning trials**, forming part of the *Care in your community: a planning framework for integrated ambulatory health care policy* implementation process.

Snapshot: Completion of the planning trials

The trials, undertaken by the department's Primary Health Branch and Metropolitan Health and Aged Care Division, were completed on 31 July 2007. The trials aimed to implement the objectives and processes stated in the department's *Care in your community: a planning framework for integrated ambulatory health care policy* paper.

This policy seeks to refocus the health system to provide the most effective mix of hospital and community-based integrated care services to better meet future community needs. It established principles to guide the government, health care providers and members of the community as they shape the future of health services in Victoria.

The trials were held at:

- Southern Metropolitan Region: South East planning area (covering the local government areas of Greater Dandenong, Casey and Cardinia)
- Eastern Metropolitan Region: Outer East planning area (covering the local government areas of Knox, Maroondah and Yarra Ranges)
- Gippsland Region: (covering a regional area including the towns of East Gippsland, Baw Baw, LaTrobe, Bass Coast, South Gippsland and Wellington) under the direction of the Gippsland Health Services Partnership.

An independent evaluation of the trials found that integrated area-based planning was a sound approach which had attracted a high level of engagement from service providers, carers and consumers. Further, the report found that area-based planning networks achieved consensus on a range of service issues consistent with the policy framework.

► Future directions

Projects for 2008–09 include:

- review of partnership arrangements between primary and acute health to maximise service capacity and access
- continued development of NURSE-ON-CALL services, including the extension of the service to mental health and chronic disease management
- strengthened relationships and referral pathways between the Hospital Admission Risk Program (HARP) and the Early Intervention in Chronic Disease Initiative.

Aim 3: Expand service options and access to information to support integrated health promotion, self-management and primary, secondary and tertiary prevention

State-funded primary health care provides significant access to health services for the most vulnerable groups in the community. It is essential that these services focus on prevention, integrated health promotion, early intervention, self-management and wellness in order to prevent or slow progression of ill health and maximise each individual's health potential and the health of communities.

► Branch achievements

Improved prevention and management of chronic disease and expanded service options

- **The Kid's Life! obesity program**, which is currently in its initial stages and aims to support parents with young children who are overweight or obese to make healthy lifestyle changes.

Developed integrated and coordinated chronic disease initiatives

- **The implementation of Early Intervention in Chronic Disease and Diabetes Self Management initiatives**, which provided additional service hours to people with chronic disease and drives internal systems change to support proactive, planned, managed care.

Snapshot: Improvements in chronic disease care

The Early Intervention in Chronic Disease initiative provided approximately 3,000 Victorians with a range of chronic disease services over 2007–08.

Early Intervention in Chronic Disease is a Primary Health Branch initiative that invests in community health services and primary care partnerships, with Divisions of General Practice as key partners, to improve the care of people with chronic disease.

Local needs, local priorities

Programs funded by the initiative are responding to local needs by targeting specific medical conditions, such as Type 2 diabetes, heart disease and respiratory diseases; and developing systems to improve chronic disease care for vulnerable groups.

Leading system-wide change

The Early Intervention in Chronic Disease initiative is leading broad change across organisations in reorientating their practice to facilitate a more coordinated, proactive and client-centred approach to support the needs of people with chronic disease. Models of care are underpinned by the Wagner Chronic Care Framework, which is a quality improvement framework to drive change.

New and innovative models of care are facilitating a seamless journey through the service system for clients and carers. The first phase of the Early Intervention in Chronic Disease program evaluation has demonstrated that work is progressing across the following components of care:

- targeting those at greatest need within the community
- providing initial needs identification and prioritisation to ensure timely access to services
- providing comprehensive assessment that identifies the medical, physical, social, cultural and psychological dimensions of need, lifestyle and complication risks and capacity for improved self-management
- providing coordinated care planning that includes working with general practitioners

- providing multidisciplinary and clinical care (including allied health and nursing services and group programs) that is evidence-based and supports self-management
- linking clients to psychosocial support
- linking clients to other services including community resources
- providing review and recall for proactive care.

The role of primary care partnerships in driving broader service system change has focused on improving coordinated care planning, communication, information sharing and referral between health care providers, with a focus on general practice as central to a person's care. In primary care partnerships where this work has progressed, outcomes include:

- the development of referral and feedback protocols, agreed care pathways and increased use of relevant MBS items
- an increase in clients receiving care plans (and taking an active part in their development)
- increased communication and information sharing between service providers
- increased coordination of self-management support programs.

Improved capacity of primary care partnerships and community health services to work with partners to support health promotion and early intervention

- **The improved capacity for primary care partnerships to plan and implement evidence-based integrated health promotion and early intervention**, facilitated by the provision of accessible information resources such as case studies and websites.
- **Development of improved integrated health promotion performance measures for all funded agencies including primary care partnerships.** This forms part of the follow-up to the Auditor General's report on health promotion.
- **An updated evidence-based guide to oral health promotion**, developed as part of the branch's work to integrate oral health promotion with other primary health promotion activities.
- **An increased future capacity of primary care partnerships and community health services to address the mental health impacts of drought in rural communities** through the dissemination of findings and examples of good practice from the *Tackling mental health drought response* evaluation.
- **A statewide mapping of self-management across primary care partnership catchments** to provide the department, primary care partnerships and agencies with a greater understanding of the capacity within the current system and to provide self-management support, as well as the barriers and enablers in building this capacity.

Snapshot: Responding to the mental health impacts of drought

From October 2006 to 2008, the Victorian Government has provided \$9.2 million of non-recurrent funding to address the mental health impacts of drought.

The funding has provided for a range of initiatives targeted at the areas most severely affected by drought including:

- drought counselling services through community health and family services
- workforce development for counsellors in the pragmatic 'no bull' approach to work constructively with farming communities
- mental health first aid training for community members
- sustainable farm families program aimed at improving the health and wellbeing of farming families
- locally planned coordination of services and health promotion through primary care partnerships.

Snapshot: The primary care partnership integrated health promotion strategy evaluation

The evaluation examined the role of partnerships and how they have contributed to successful integrated health promotion planning, implementation and evaluation for the agencies in three key domains:

- the underlying partnership model and integrated planning approaches
- integrated health promotion capacity building
- benefits, outcomes and continual improvement.

Agency participation

Data was collected using a variety of methods and more than 100 member agencies contributed to the evaluation. This included 80 participants from a cross-section of member agencies who provided information during nine focus groups with the primary care partnership sample group; data provided on long-form questionnaires which were completed by 66 agencies and data provided on short-form questionnaires which were completed by 36 agencies.

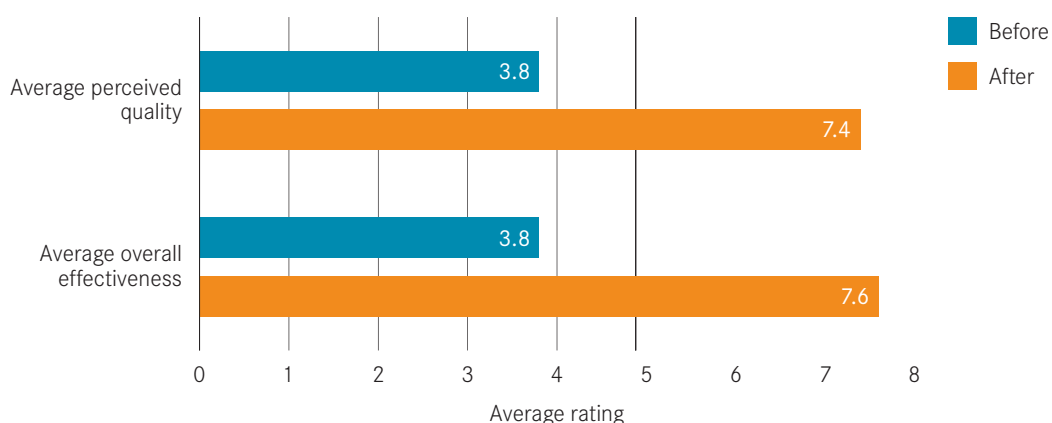
Integrated health promotion through primary care partnerships is valued and effective

The evaluation found clear evidence of the success of the partnership approach for improving integrated health promotion. A significant increase in the overall quality and effectiveness of integrated health promotion from before the introduction of the Primary Care Partnership Integrated Health Promotion Strategy to the current time was evident (see below).

Key findings are that the primary care partnership approach to integrated health promotion has clearly:

- demonstrated an improvement in integrated planning
- demonstrated an increase in organisational capacity for health promotion
- demonstrated economic and other benefits to member agencies
- contributed to healthier communities.

Figure 3 Overall effectiveness and perceived quality of integrated health promotion before and after the primary care partnership integrated health promotion strategy



► Future directions

Projects for 2008–09 include:

- further development of NURSE-ON-CALL and other information strategies to maintain health
- improvements to the prevention and management of chronic disease, with a focus on diabetes
- workforce development to support service system improvements for people with chronic disease
- continued use of industry advisors to support primary care partnerships progress work around integrated chronic disease management
- improvements in the capacity of primary care partnerships and community health services to provide and support health promotion and early intervention programs, with a focus on children and disadvantaged groups
- completion of the review of the 'Tackling mental health' drought response initiatives
- further development of the Kids Life! program
- development of a telephone self-management service model.

Aim 4: Improve performance, quality and safety of state-funded primary health care services

State-funded primary health services currently provide services to approximately 7 per cent of the Victorian population, particularly to those who are the most disadvantaged. Improvements in effectiveness and efficiency aim to increase the proportion of the population able to receive services from both public and privately funded primary health care providers functioning as components of an integrated primary health system.

Critical to the success of any changes to improve the primary health care system is the capacity to ensure access to an appropriate practitioner anywhere in Victoria. The workforce of the future needs to be adaptable, innovative, flexible, able and prepared to work across traditional boundaries, and open to developing new roles and skills.

► Branch achievements

Greater consistency and improved clinical governance of state-funded primary health services

- **Support for the continued implementation of the Clinical Governance in Community Health work plan.** This includes the completion of guidelines and resources for clinical supervision and clinical risk management, a pilot of draft clinical indicators and training to board members of independent agencies.
- **The improved governance of primary care partnerships** through the development and delivery of workshops on strengthening partnerships in regions and the commencement of a review of governance arrangements with primary care partnership chairs.
- **The improved governance of community health services** through a range of activities, as outlined in the **Snapshot**.
- **The improved quality of counselling services in community health** through the introduction of the single-session model.
- **Support for improvements in clinical governance through a consumer opinion survey and the introduction of Quality of Care reports.** Both activities reinvigorate the focus on consumers, carers and community in service planning, design, delivery and evaluation.

Snapshot: Primary Health Branch support for improved governance of community health services

Examples of the branch's work to improve the governance of community health services include:

- support for independent community health services to produce Quality of Care reports
- collaboration with the Victorian Managed Insurance Authority and the Victorian Healthcare Association to pilot and implement training in clinical risk management to all community health services
- encouragement for community health centre board members to attend targeted professional development workshops
- support for the Bridging Clinical Risk Management Project in Eastern Metropolitan Region to identify and address interagency clinical risk in the Hospital Admission Risk Programs (HARP).

The Primary Health Branch is being assisted by the Victorian Health Boards Governance Program provided by the Nous Group. The training brings together board members from across all health sectors, enhancing the knowledge of the broader health system and the contributions of each sector.

Improved demand management for primary health services

- **Development of consistent demand measurement across community health services** following a review of the *Waiting time measurement within community health services practice guidelines*.
- **Implementation of the Demand Management Framework**, which forms part of the 2007–08 publication *Towards a demand management framework for community health services*.

Improved funding and accountability systems for primary health programs

- **Implementation of a revised branch funding approach**, which is used to fund allied health, counselling, nursing and health promotion services.
- **Ongoing development of and improvement to program planning, reporting and evaluation frameworks**, as outlined in the **Snapshot**.
- **Continued improvements to data reporting and quality** through the ongoing development of a data quality framework, a new data reporting and verification system in the Rural and Regional Health and Aged Care Services Division data repository and a new incident information system.

Snapshot: Improvements to planning, reporting and evaluation frameworks for Primary Health Branch funded programs

The branch continued to develop and improve program planning, reporting and evaluation frameworks for:

- primary care partnerships through feedback to regions and primary care partnerships from a statewide analysis of the *2006–09 Primary care partnership community health plans*
- agencies participating in the Early Intervention in Chronic Disease initiative through statewide evaluation and sector consultation to inform the development of a new reporting and monitoring framework. This framework provides client and agency level data for accountability and service planning and aligns with other chronic disease management data collections
- Aboriginal health promotion and chronic care agencies through the development of a reporting framework based on biannual regional reports, client and service quarterly reporting and local and statewide evaluations
- general practitioners in community health services projects through the development of an improved reporting template and monitoring framework
- Divisions of General Practice Victoria through a renegotiated work plan incorporating key performance indicators linked to funding
- community health, dental health and primary care partnerships through the development of health promotion performance indicators
- NURSE-ON-CALL through ongoing contract management and performance monitoring
- agencies accessing language services through monthly data collection, with the aim of gauging demand and using opportunities to expand the service
- primary care partnerships and funded agencies participating in the development of improved integrated health promotion performance measures that will inform the collection of evidence-based data from 2009 onwards.

Strengthened primary health workforce

- **Support for workforce development in community health services**, including training for child health teams, the development of the community health teaching and research project and the identification of minimum qualification and professional development standards for counsellors.
- **Initiation of a workforce development program for primary care partnership staff, member agencies and relevant departmental staff**, which included regional sessions focusing on strengthening partnerships.
- **The provision of further professional development to refugee health nurses** and community health nurses to strengthen the refugee health program.

Snapshot: Community health student placements

Community health services accept students from a large range of undergraduate and postgraduate courses for placements, including medicine, nursing, speech therapy, dietetics, podiatry, counselling, occupational therapy, physiotherapy, health promotion, audiology, welfare and social work.

Student Placement Project for Community Health Services

The Primary Health Branch and the Service and Workforce Planning Branch funded an initiative to improve the capacity of community health services to increase and improve the quality of their student placement numbers.

Upper Hume Community Health Service and Doutta Galla Community Health Service were selected to develop a sustainable sub-regional student placement coordination model, able to be replicated in other locations.

First stage tasks included data collection on placement activity, developing solutions to identified barriers to placement expansion in community health services, and exploring ways to reimburse community health service staff time for placement planning and supervision. Second stage work will include the development of a statewide training strategy for student placement supervision.

The development of closer partnerships and more robust relationships between neighbouring community health services, TAFE colleges and private registered training organisations will be crucial to the success of the project.

► Future directions

Projects for 2008–09 include:

- greater consistency and improved clinical governance of state-funded primary health services through the delivery of further clinical governance training to community health service board members, CEOs and managers and an exploration of stronger clinical leadership capacity in the sector
- an improved funding and reporting process for community dental services, including the development of a new dental data set and the implementation of outcomes from the oral health funding review
- better demand management for primary health services following the evaluation of the Demand Management Framework priority tools
- a primary health workforce development plan
- testing of the new data reporting and verification system in the Rural and Regional Health and Aged Care Services Division data repository
- completion of the review of primary care partnership governance and accountability arrangements
- workforce development opportunities to build the capacity of the sector to provide evidence-based integrated chronic disease management.

Aim 5: Value and improve consumer and carer participation in all primary health programs as a key aspect of continuous improvement of primary health care services

Consumers of primary health services have a right to safe, high quality and appropriate health care, to have the opportunity to set goals for their care in dialogue with clinicians, and to the provision of information to participate in decisions about their care.

Systematic mechanisms to enable maximum consumer, carer and community participation in service planning, development, delivery and review are critical to building a strong person-centred primary health care system. Improving capacity and practices that support such participation need to be built into these activities at every level.

► Branch achievements

Developed service systems that encourage consumers to actively participate in their wellbeing

- **An interagency care planning framework**, which was developed by the branch to support consumers and carers to participate in their health care.

Encouraged feedback from consumers and carers

- **Further facilitation of consumer, carer and community participation** by engaging the Australian Institute of Primary Care to provide advice on how the branch can strengthen consumer, carer and community engagement in the primary health sector.
- **Management of the consumer, carer and community advisory committee**, which provides advice to the branch on policy and program development.
- **A revised approach to consumer satisfaction surveys** was developed and implemented in the *2007–08 Primary Health Care Consumer Opinion Survey*.

Snapshot: Primary Health Care Consumer Opinion Survey results

The Primary Health Care Consumer Opinion Survey aimed to assist in evaluating and improving services to consumers at community health centres by asking them about their level of satisfaction on three main domains:

- satisfaction with centre environment
- satisfaction with service provision
- degree to which special needs are met by the community health centre.

The survey targets services that are funded by the Primary Health Branch, such as audiology, counselling/social work, dietetics, nursing, occupational therapy, physiotherapy, podiatry and speech therapy/pathology.

Aggregated results of the survey showed that:

- over 90 per cent of community health clients were either very satisfied (49.1 per cent) or satisfied with services received
- over 90 per cent of users were either very satisfied (32.5 per cent) or satisfied with the centre's environment.

► Future directions

Projects for 2008–09 include:

- commencement of stage 2 of the care planning project to ensure that consumers and carers are supported as partners in their health care
- implementation of the recommendations of the Australian Institute of Primary Care review of branch strategies to engage consumers, carers and the community in the planning and delivery of primary health services
- development of a strategy for ensuring consumer and carer input into the work of the branch
- development of service systems to encourage clients to actively participate in their health and wellbeing.

Primary health services

Overview of primary health services

The Primary Health Branch is responsible for funding a number of services across Community Health, Dental Health and the NURSE-ON-CALL service.

For more information on the programs funded by the Primary Health Branch, refer to the *Primary Health Branch policy and funding guidelines, 2007–08 update*.

Primary health programs

Community Health

Community Health programs improve the health and wellbeing of Victorians and reduce demand for more specialised medical and acute hospital services.

Funded services include approximately 100 community health services across Victoria, women's health services, family planning services and some statewide specialist services (including the Victorian Foundation for the Survivors of Torture, International Diabetes Institute, Centre for Adolescent Health and Centre for Culture Ethnicity and Health).

Dental Health

Public dental services are provided in dental clinics that are located in community health services. In some cases, dental care is provided by private clinicians through voucher schemes.

Dental Health Services Victoria is responsible for the delivery of public dental services through the Royal Dental Hospital Melbourne and the purchase of services through community health services under conditions set by the department.

NURSE-ON-CALL

NURSE-ON-CALL is a telephone health line providing Victorians with immediate, expert health information and advice 24 hours a day, 7 days a week. It also offers other health-related information, such as details of local health services and the numbers of other phone help lines.

Service outputs and trends

Funding

In 2007–08, \$314.5 million was allocated to primary and dental health services.

Table 2 Funding for primary health services 2007–08¹

Outputs	Total output cost \$ million
Community health care	176.5
Dental services	138.0
Total	314.5

Service outputs and trends

Service outputs

In 2007–08, a total of 2,123,149 occasions of service were delivered through agencies funded by Community Health, Dental Health and NURSE-ON-CALL programs.

- The total number of occasions of service for Community Health programs (952,545 contacts) includes service provided to individuals, organisations and groups for direct care and health promotion activity.
- The total number of Dental Health occasions of service (798,435 visits) includes general dental and denture care services.
- The total number of NURSE-ON-CALL occasions of service (372,169 calls) includes calls for triage, referral, health education and general information.

Table 3 Occasions of service by program area 2007–08²

Program area	Number of occasions of service
Community Health	897,055 contacts 55,490 groups
Dental Health	798,435 visits
NURSE-ON-CALL	372,169 calls

Service trends

- The visits to dental clinics increased 5 per cent on 2006–07.
- There was an 11 per cent decrease in calls for the NURSE-ON-CALL service on 2006–07. The higher number of calls in 2006–07 (418,000 calls) is correlated with an intense statewide marketing campaign following the service launch in June 2006.

Clients

In 2007–08, the Primary Health Branch delivered services to 477,107 clients in Community Health³ and Dental Health services.

- There was a 1 per cent increase in the number of Community Health registered clients on 2006–07.
- There was a 7 per cent increase in clients of dental public services on 2006–07. This is due to the integration of school and community dental clinics in 2007–08, which resulted in a change in reporting and counting rules. From 1 July 2007, the data reflects all clients and visits to public dental services, not just those to community dental clinics.

Table 4 Clients of Community Health and Dental Health 2006–07 and 2007–08⁴

Program area	Clients	Client activity
Community Health	156,187	614,112 contacts
Dental Health	320,920	798,435 visits
NURSE-ON-CALL	N/A	372,169 calls

² Data sources: Community Health—Primary Health Performance database (including health promotion activity); Dental Health—Dental Health program database; NURSE-ON-CALL—NURSE-ON-CALL reports.

³ For Community Health programs the figures refer to registered clients.

⁴ Data sources: Community Health—Primary Health Registered clients database (including health promotion activity); Dental Health—Dental Health program database; NURSE-ON-CALL—NURSE-ON-CALL reports.

Service use

Primary health programs

Community Health

This information combines all reported data for 2007–08 from the following Primary Health Branch programs:

- Aboriginal Health Promotion and Chronic Care Partnership
- Community Health
- Diabetes Self Management
- Early Intervention in Chronic Disease
- Family and Reproductive Rights Education
- Family Planning
- Innovative Health Services for Homeless Youth
- Women’s Health.

Occasions of service by service type and region

The Community Health programs delivered 897,055 occasions of service in 2007–08. The majority of these services were nursing (23.5 per cent) and counselling/casework (21.0 per cent).

Table 5 Occasions of service to individuals by service type 2007–08⁵

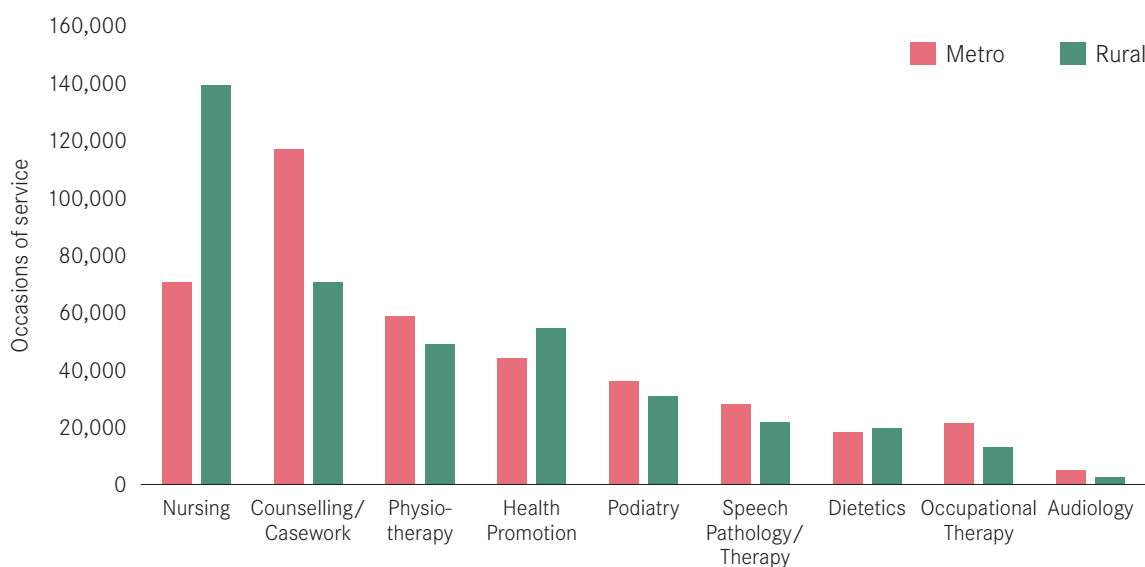
Service type	%
Nursing	23.5
Counselling/Casework	21.0
Physiotherapy	12.1
Health promotion	11.1
Other	10.1
Podiatry	7.5
Speech pathology/Therapy	5.6
Dietetics	4.3
Occupational therapy	3.9
Audiology	0.9
TOTAL	100.0

A higher proportion of Community Health services were delivered in metropolitan regions than in rural regions. Figure 4 shows the relative distribution of service types by metropolitan and rural services. In most service types the number of occasions of service delivered by metropolitan agencies exceeds that provided in rural agencies, particularly for counselling/casework, audiology and occupational therapy.

The exception to this trend is nursing, where 139,238 occasions of service were delivered in rural agencies (66.3 per cent). This is in contrast to 70,696 occasions of service delivered in metropolitan agencies (33.7 per cent).

⁵ Data source: Primary Health Performance database. ‘Other’ includes client education and service coordination activity.

Figure 4 Total number of occasions of service by service type in rural and metropolitan agencies 2007–08⁶



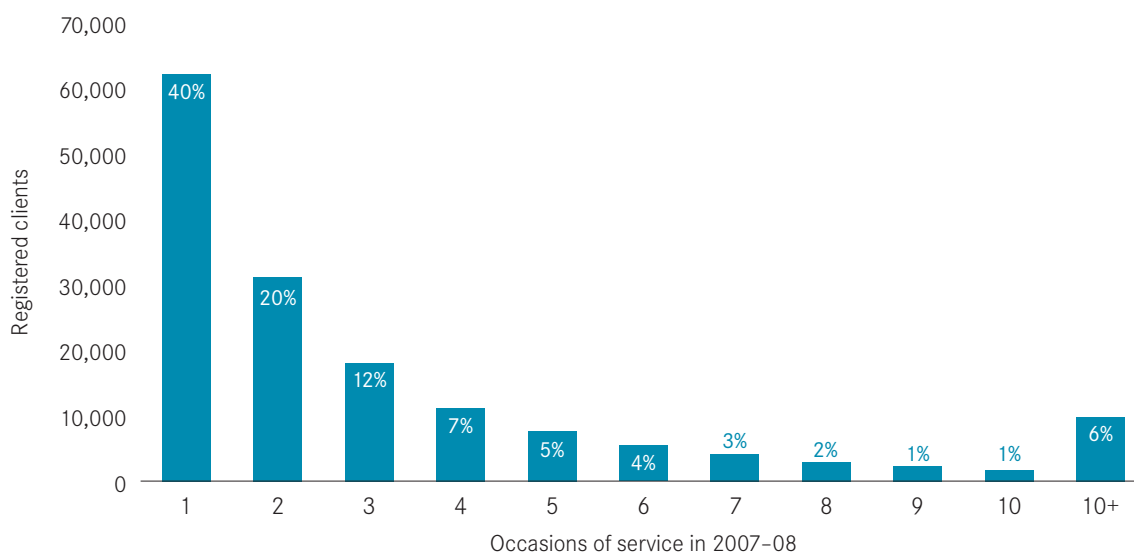
Frequency of service provision

The majority of registered clients (60.4 per cent) accessed more than one occasion of service in 2007–08.

Of the various service types:

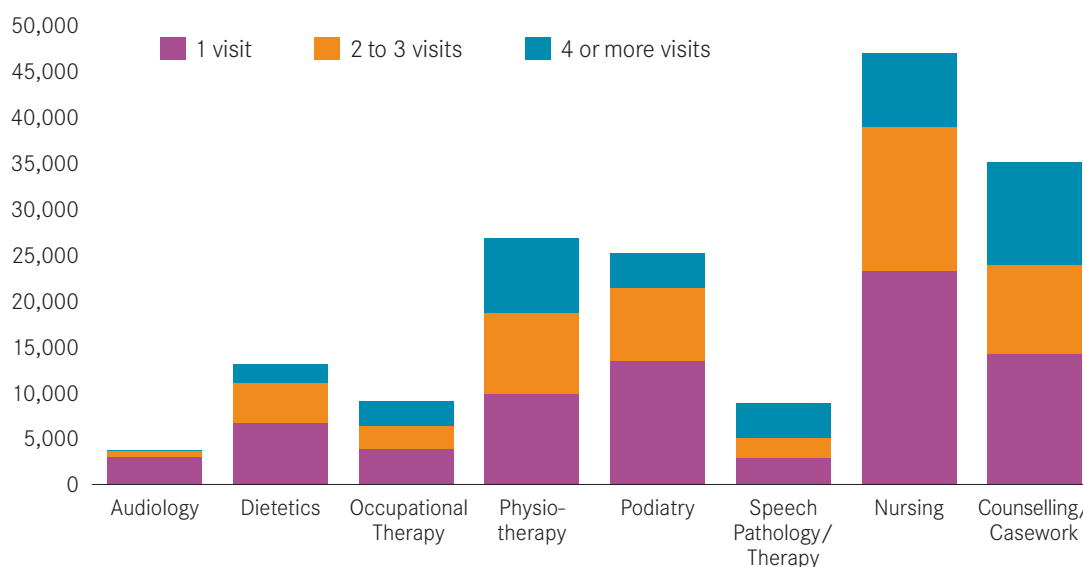
- speech therapy had the highest proportion of clients visiting more than four times within the year (35 per cent) followed by counselling (25.8 per cent)
- audiology had the highest proportion of single visit clients (77.4 per cent) within the year.

Figure 5 Frequency of occasions of service for registered clients 2007–08⁷



⁶ Source: Primary Health Performance database.

⁷ Source: Primary Health Registered Clients database.

Figure 6 Frequency of visits by service type 2007–08⁸

Group sessions by service type

Group sessions are services delivered to groups of clients. More than half (52.2 per cent) of the 55,490 group sessions delivered by Community Health programs in 2007–08 were health promotion activity. Physiotherapy (16.5 per cent) and nursing (10.4 per cent) and counselling/casework (7.7 per cent) collectively delivered a further third of total group sessions that year.

Table 6 Group sessions by service type 2007–08⁹

Service description	%
Health promotion	52.2
Physiotherapy	16.5
Nursing	10.4
Counselling/Casework	7.7
Speech pathology/Therapy	5.1
Dietetics	4.0
Occupational therapy	3.3
Podiatry	0.5
Other	0.2
Total	100

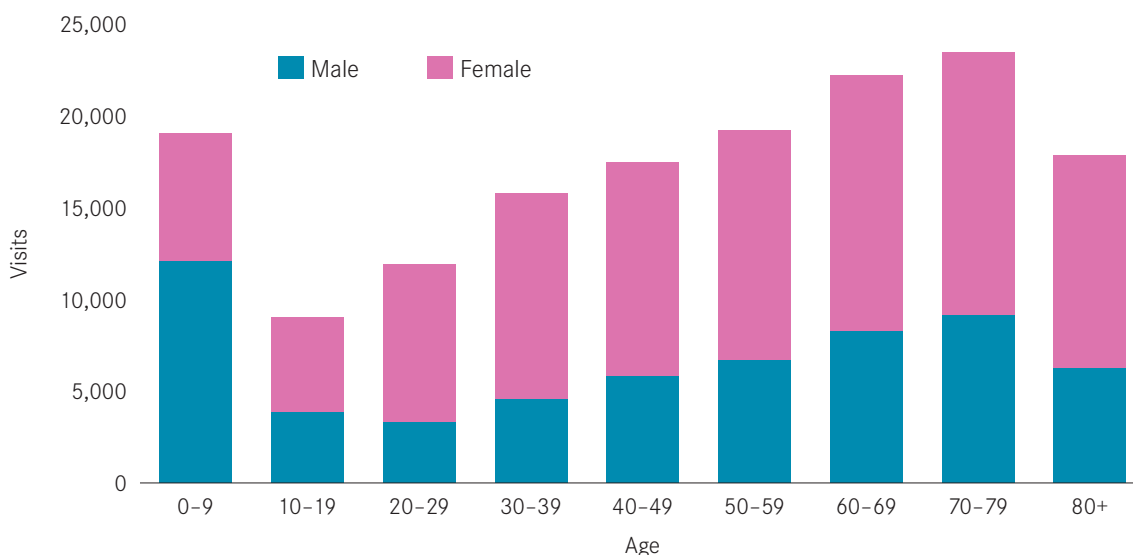
⁸ Source: Primary Health Registered Clients database.

⁹ Source: Primary Health Performance database.

Service use, age and gender

In 2007–08, the majority of Community Health registered clients were female (61.7 per cent). This occurs across all age groups excluding the youngest (0 to 9 years), where the majority of registered clients were male (63.2 per cent).

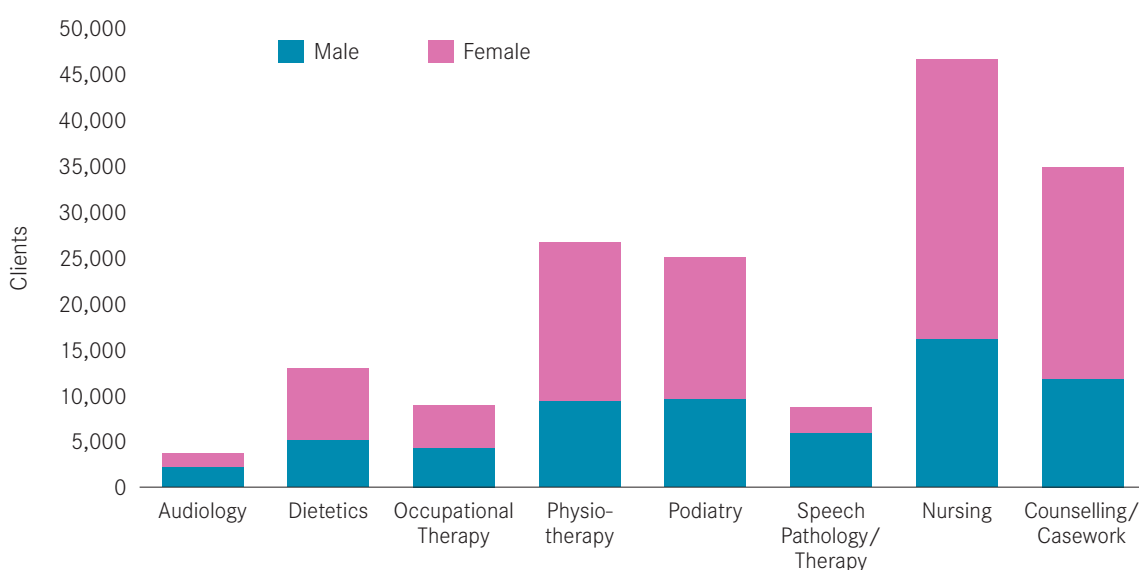
Figure 7 Service use by age and gender for registered clients 2007–08¹⁰



Female registered clients were more likely to access most service types, including counselling/casework and registered nursing (representing 66 per cent of registered clients for each service).

However, more males than females accessed audiology and speech therapy services (representing 66.6 per cent and 57.7 per cent of registered clients respectively).

Figure 8 Service use by gender and service type for registered clients 2007–08¹¹



10 Source: Primary Health Registered Clients database.

11 Source: Primary Health Registered Clients database.

In 2007–08, older registered clients were more likely to access podiatry and occupational therapy services (with a median age of 69 years and 63 years respectively).

In contrast, younger registered clients were more likely to access audiology and speech therapy (both with a median age of 4 years).

Table 7 Service use by median age and service type for registered clients 2007–08¹²

Service type	Median age
Audiology	4
Speech therapy	4
Counselling/Casework	43
Nursing	52
Dietetics	54
Physiotherapy	59
Care coordination	61
Occupational therapy	63
Podiatry	69

Source of referral

Where the referral source was provided, the majority of Community Health clients were either self-referred (31.7 per cent) or referred by a community-based GP (22.8 per cent).

Table 8 Sources of referral for individual client contacts 2007–08¹³

Referral source	%
Self	31.7
GP/Medical practitioner community-based	22.8
Hospital	13.9
Other	7.2
Community nursing or health service	6.9
Family, significant other, friend	4.6
Other community-based service	4.0
Disability support service	2.2
Other medical/health service	3.3
Law enforcement agency	0.9
Psychiatric/mental health service or facility	0.8
Combined total for sources with <1% of referrals	1.8
Total	100

12 Source: Primary Health Registered Clients Database.

13 Source: Primary Health Registered Clients Database. Note that instances where the referral source was not stated or adequately defined were not included.

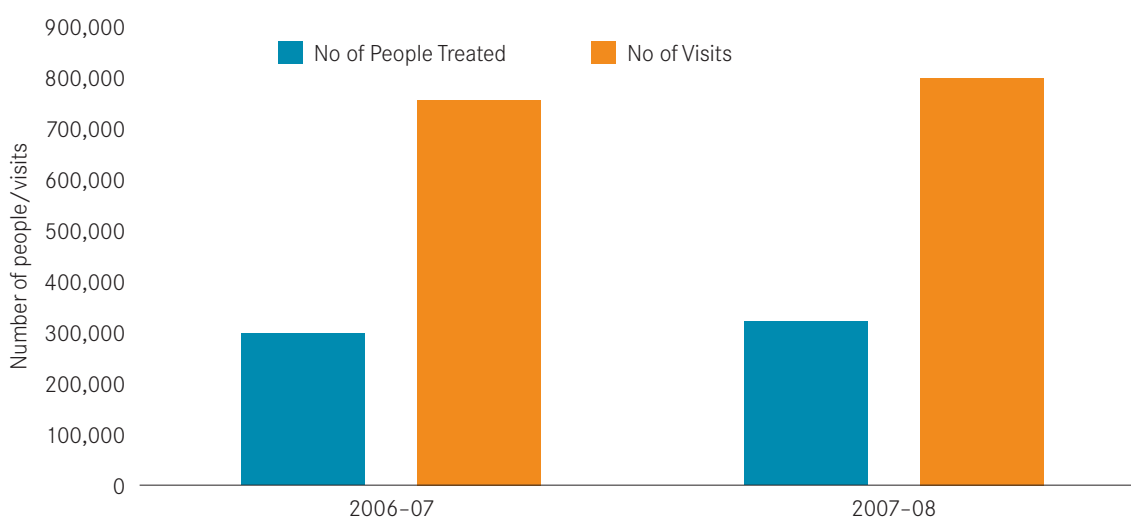
Dental Health

Frequency of visits

In 2007–08, there were 798,435 visits to dental public services. This is an increase of 5 per cent on 2006–07 (up from 758,152 visits).

Likewise, there was a 7 per cent increase in the total number of people treated, from 297,035 people in 2006–07 to 320,920 people in 2007–08.

Figure 9 Number of people treated and the number of visits 2007–08



Presenting issues

Of the 355,568 courses of care provided, 173,374 (48.8 per cent) were for emergency dental care in 2007–08.

Table 9 General dental and emergency dental courses of care 2007–08

	Total courses of care	%
General dental	182,194.0	51.2
Emergency dental	173,374.0	48.8

Dental chairs

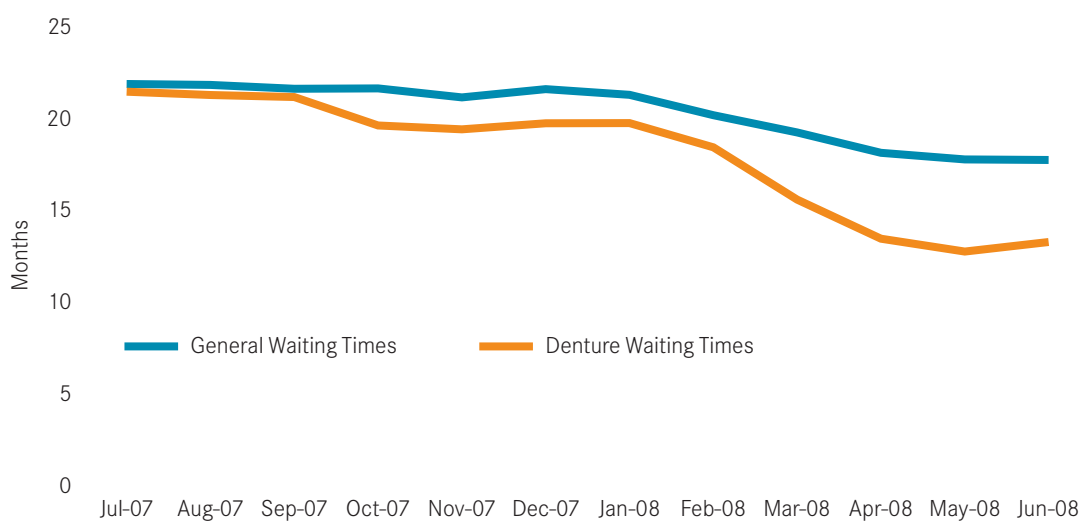
In 2007–08, 20 new dental chairs were built across Victoria (comprising additional and replacement chairs), increasing the number of public dental chairs to a total of 373 chairs.

Waiting times

From June 2007 to July 2008, the average waiting time for dentures decreased 38 per cent from 21 months to 13 months.

The average waiting time for non-urgent dental care decreased 18 per cent, from 22 months in June 2007 to 18 months in July 2008.

Figure 10 General and denture care wait times 2007–08



NURSE-ON-CALL

Call volume

In 2007–08, NURSE-ON-CALL answered 372,169 calls. On average each caller spoke to a registered nurse for 9.73 minutes.

Call outcomes

In 2007–08 triage accounted for 70 per cent of calls. The most common triage guidelines used were for:

- fever (paediatric)—19 per cent
- vomiting (paediatric)—18 per cent
- abdominal pain/discomfort—15 per cent
- cough (paediatric)—10 per cent
- nausea/vomiting—10 per cent.

Figure 11 Triage guidelines used 2007-08

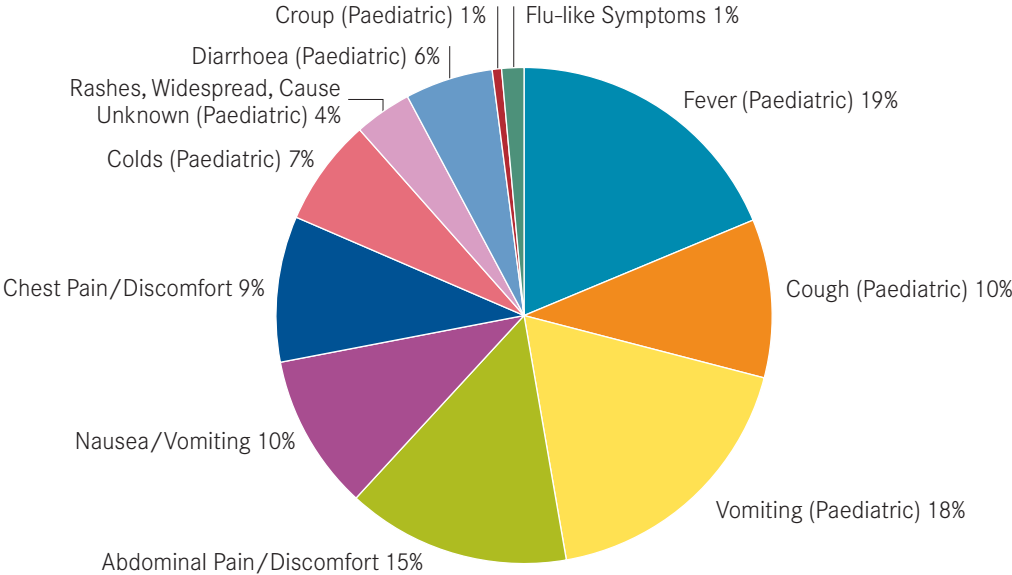


Figure 12 demonstrates a monthly fluctuation in the top five triage guidelines used. For example, the paediatric fever guidelines are more likely to be used in the warmer months.

Figure 12 Top five triage guidelines per month 2007-08

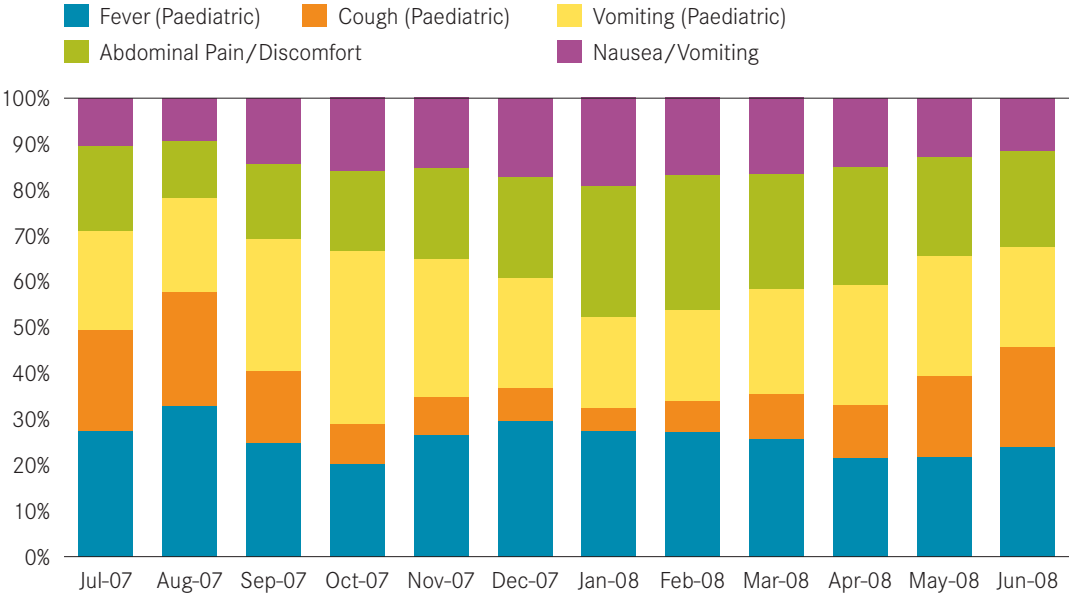
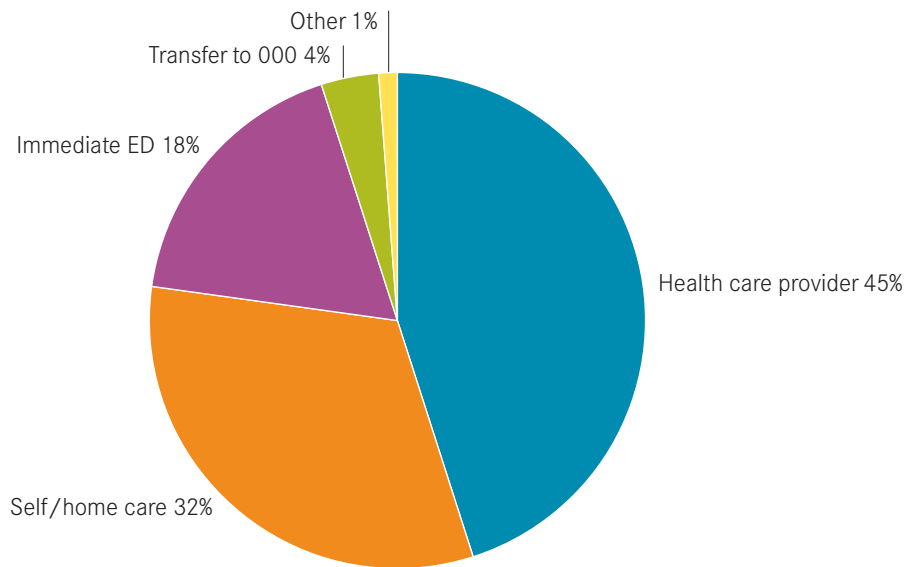


Figure 13 below shows the final disposition (outcome) of triage calls in 2007–08, with the majority of patients referred to a health care provider (45 per cent).

It is important to note that a single call made to NURSE-ON-CALL can result in two or more call outcomes. For example, a caller might be provided with general information and a referral to a service.

Figure 13 Final disposition of triage calls 2007–08



Client profile

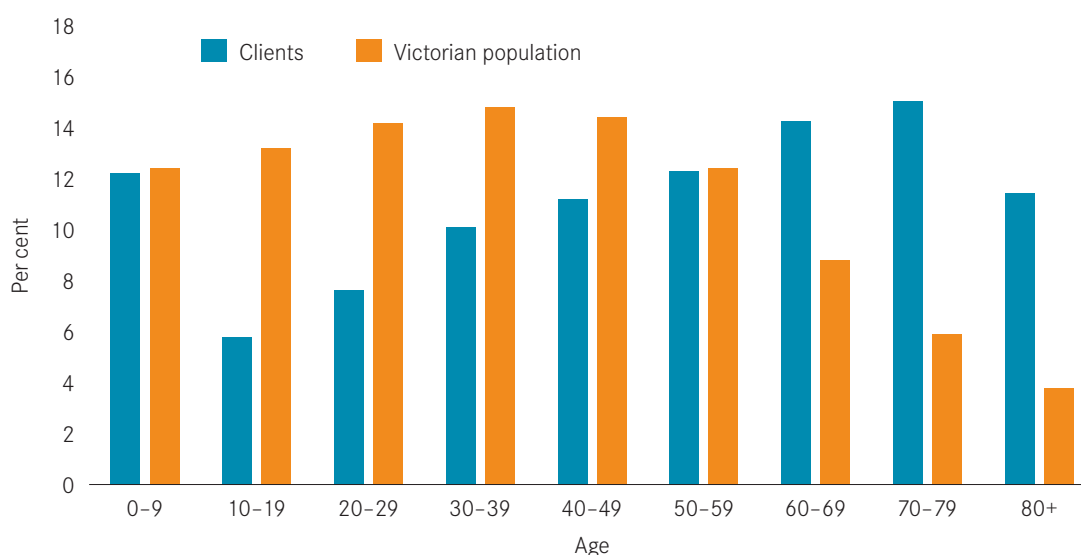
Primary health programs

Community Health

Age and gender

A comparison of the age distribution of community health services registered clients with that of the full Victorian population (Figure 14) shows that the relative proportions of 0–9 year olds and 50–59 year olds are representative of the broader population. This pattern is expected as it reflects the differing demands for primary health services for each age group (and given the increasing prevalence of health issues occurring in the over-50s population).

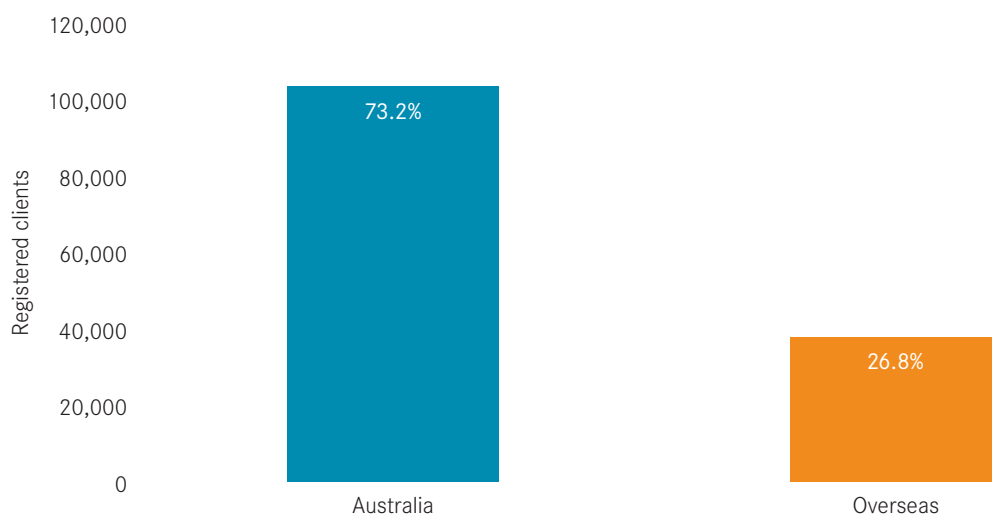
Figure 14 Age of community health services registered clients compared to Victorian population 2007–08¹⁴



Cultural and linguistic profile

In 2007–08, over a quarter of community health services registered clients were born overseas (26.8 per cent). This is slightly lower than the overall proportion of Victorians born overseas (approximately 28.9 per cent).

- The proportion of Australian-born community health services clients in metropolitan regions (59.6 per cent) is lower than the overall Victorian proportion (approximately 66.0 per cent).
- In contrast, the proportion of Australian-born clients in rural regions (89.8 per cent) is higher than the Victorian rural population (approximately 85.0 per cent).

Figure 15 Birthplace of Community Health registered clients, Australia versus overseas 2007–08¹⁵

For those born overseas, the five highest contributing countries for Community Health registered clients were:

- England (3.2 per cent of total clients)
- Italy (3.1 per cent)
- Greece (1.6 per cent)
- Vietnam (0.9 per cent)
- Malta (0.8 per cent).

This contrasts with the top five Victorian immigrant-origin countries of:

- England (3.6 per cent of total population)
- Italy (2.0 per cent)
- Greece (1.2 per cent)
- Vietnam (1.2 per cent)
- New Zealand (1.2 per cent)

(noting Malta is the 14th highest country-of-birth origin in Victoria).

The relative contribution of different immigrant populations to Community Health clients is further detailed in figure 16 below which shows the breakdown by region of origin.

After Europe, North Africa and the Middle East contribute the greatest proportion of overseas-born clients, followed closely by South East Asia. This demographic contribution is further supported by the top five of preferred languages shown in table 10, where Arabic and Vietnamese are the 3rd and 4th highest languages after the top two European-origin languages of Italian and Greek.

¹⁵ Source: Primary Health Registered Clients database. Note that the figure excludes registered clients whose country of birth is not stated or inadequately defined.

Figure 16 Region of origin for overseas-born Community Health registered clients 2007–08¹⁶**Table 10 Top 5 preferred languages of Community Health registered clients 2007–08¹⁷**

Top 5 preferred languages	Registered clients	Per cent of all registered clients
Italian	2,659	1.7
Greek	1,719	1.1
Arabic	1,545	1.0
Vietnamese	1,171	0.7
Other south east Asian languages	936	0.6
SUB TOTAL	8,030	5.1

Indigenous profile

While only 1.1 per cent of Community Health registered clients identified as Aboriginal or Torres Strait Islander, this is significant given approximately 0.6 per cent of the Victorian population identified as Aboriginal or Torres Strait Islander¹⁸.

In addition, a proportion of registered clients (17.2 per cent) did not state whether they were Aboriginal or Torres Strait Islander.

Dental Health

Age

Adults comprise the majority (69 per cent) of people treated under Dental Health.

Indigenous profile

Of people receiving treatment through Dental Health, only a small proportion identify as Aboriginal or Torres Strait Islander (less than 2 per cent).

16 Source: Primary Health Registered Clients database.

17 Source: Primary Health Registered Clients database.

18 The proportion of the Victorian population that identifies as Aboriginal or Torres Strait Islander is based on the 2006 Census (Australian Bureau of Statistics, last viewed April 2009, available at <<http://www.censusdata.abs.gov.au/ABSNavigation/prenav/ProductSelect?newproducttype=QuickStats&btnSelectProduct=View+QuickStats+%3E&collection=Census&period=2006&areacode=2&geography=&method=&productlabel=&producttype=&topic=&navmapdisplayed=true&javascript=true&breadcrumb=LP&topholder=0&leftholder=0¤taction=201&action=401&textversion=false>>).

NURSE-ON-CALL

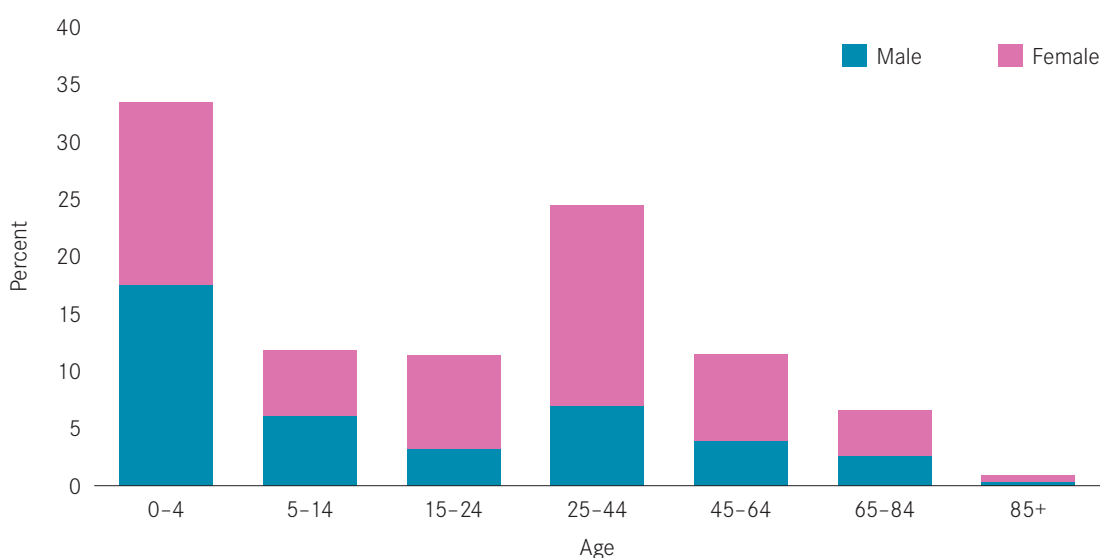
Age and gender

In 2007–08, there were 157,002 female patients (59.6 per cent) and 106,424 male patients (40.4 per cent).

- The majority of patients in all age groups were female—except for patients aged between 0 and 15 years.
- Overall, the majority of patients were 0 to 4 years of age (27.2 per cent).

The majority of callers were female (75.8 per cent) and were in the 30 to 34 year age group (19 per cent of callers).

Figure 17 Age of NURSE-ON-CALL patients 2007–08



Cultural and linguistic profile

The majority of callers were born overseas (54 per cent), with the United Kingdom the most common overseas country of birth.

Table 11 Top 10 overseas countries of birth for callers¹⁹

Country of birth	Percentage of total callers born overseas
United Kingdom	23.4
New Zealand	10.3
India	9.3
Italy	7.0
Greece	4.7
Sri Lanka	4.6
Vietnam	3.7
Lebanon	3.4
Germany	3.4
Philippines	3.3

¹⁹ Note: this does not include callers where the country of birth was not provided.

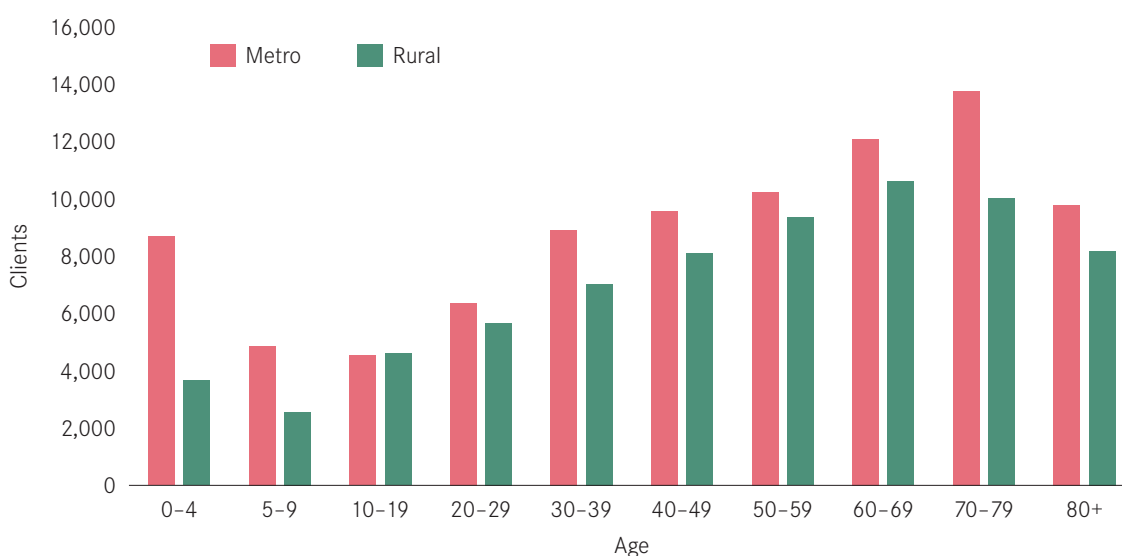
Regional profile

Primary health programs

Community Health

The age distribution of metropolitan and rural Community Health registered clients demonstrates that metropolitan agencies see a greater relative proportion of 0–4 year olds and a peak age group of 70–79 year olds. By contrast, rural agencies’ peak age group is 60–69.

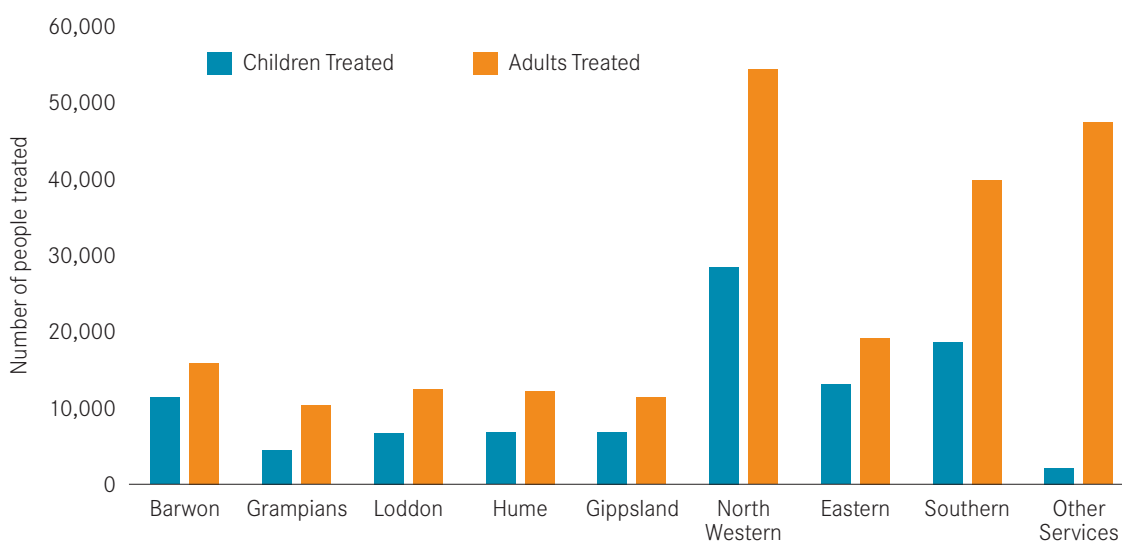
Figure 18 Age of Community Health registered clients by rural and metropolitan regions 2007–08²⁰



Dental Health

Consistent with the finding that adults comprise the majority of people treated by dental public services, the number of adults treated in each region is greater than the number of children treated.

Figure 19 Number of adults and children treated by region

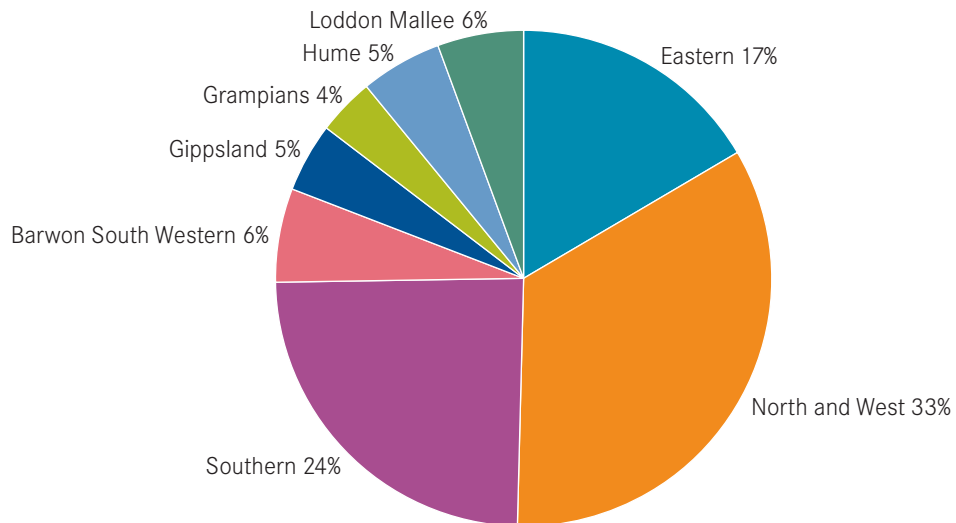


²⁰ Source: Primary Health Registered Clients database.

NURSE-ON-CALL

The majority of NURSE-ON-CALL callers were from North and West Region (33.8 per cent), Southern Region (24.3 per cent) and Eastern Region (16.5 per cent).

Figure 20 NURSE-ON-CALL callers by region



Appendix

Primary Health Branch service delivery partners

Primary health sector service delivery partners

The Primary Health Branch works with a range of service delivery partners within the sector, including:

Aboriginal health services

Twenty-one Aboriginal Community Controlled Health Services operate across Victoria. A range of programs can operate from each of the services including maternity programs, sexual health, chronic disease, mental health, nutrition and physical activity, family violence, aged care (home and community care), palliative care, spiritual and emotional wellbeing programs, community development and health education. Medical and oral health services are provided by some of the Aboriginal Community Controlled Health Services.

Children and youth health services

The growing evidence base for the importance of early intervention in early years has seen a stronger emphasis on related programs. Responsibility for early childhood programs rests with the Early Childhood Programs Branch within the Department of Education and Early Childhood Development. Key contributions are made by maternal and child health nursing, primary school nurses, secondary school nurses, the children's paediatric allied health program and local government youth programs.

Community drug and alcohol services

There are a variety of Victorian Government funded services available to help with drug problems. These include counselling and support, withdrawal, rehabilitation and post withdrawal, family, youth and Indigenous services.

Community health services

Community health services are the principal provider of state-funded primary medical, dental, allied health, counselling and nursing services and health promotion action.²¹ In addition, they often provide a range of other primary health care services, such as home and community care (HACC), drug and alcohol, mental health and in some cases ambulatory care services. Community health services are key community organisations and provide significant access to services for the most vulnerable groups in our community, intervening early to maximise health outcomes and preventing or slowing progression of ill health.

Community health services provide health services for population groups that may have trouble accessing appropriate health care, such as Aboriginal people, people with disabilities, refugees and people seeking asylum, the homeless and those at risk of homelessness, people from culturally and linguistically diverse backgrounds and, in some areas, people living in rural communities.

Community mental health services

A range of services to support people with more severe mental health conditions, such as crisis intervention to after-hours services and long-term care. A number of group support services are also available.

Dental Health Services Victoria

Dental Health Services Victoria has lead responsibility for purchasing integrated community dental services, planning the best distribution of purchased services and providing generalist and specialist services through the Royal Dental Hospital of Melbourne.

General practice

General practice can be defined as 'the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities' (Royal Australian College of General Practitioners, 2008). General practitioners (GPs) are commonly the first point of contact for health care and are responsible for referring on for specialist medical care or to other community based services.

²¹ Allied health refers to audiology, dietetics, occupational therapy, physiotherapy, podiatry and speech therapy.

Home and community care

A range of support services, including health care, provided for older persons and people with disabilities. The objective of the services is to support individuals and their carers to continue living in the community. The services are funded by all three levels of government, with local government playing a strong coordinating role. Services are delivered by community health centres, local government, home nursing services and a number of non-government organisations (involved in the aged and disability sectors).

Non-government organisations

Non-government organisations provide advocacy and community or sector support services. This can include integration or coordination with state-funded primary health care services.

Other private primary health care services

Private primary health care services provide a significant proportion of dental, allied health, sports medicine, mental health and alternative medicine services. These services charge a fee for the service, some of which can be rebated through the Medicare Benefits Schedule (for those with chronic illness) or private health insurance schemes.

Pharmacies

Pharmacists dispense medications, provide health education, sell over-the-counter medicines and health care products and undertake medication reviews for people on multiple medications.

Primary care partnerships

Primary care partnerships are a core component of the primary health sector in terms of creating partnerships, coordinated care arrangements and integrated health promotion between service providers and other sectors. They are required to deliver outcomes in the areas of partnership development, integrated health promotion, service coordination and integrated disease management.

Women's health services

Women's health services work to improve the health and wellbeing of all women, but prioritise those population groups for whom access to health services is difficult. These include Koori women, women from culturally and linguistically diverse backgrounds, women with disabilities, rural women and women identified by statewide, regional and community health planning processes. There are 12 services funded through the Women's Health program in Victoria. They include nine regional services and three statewide services.

Other partners

In addition, there are a range of partners outside the sector working with the primary health care sector to address the primary health needs of Victoria, including:

- ambulatory, acute and post acute health sectors
- aged care services
- mental health services
- local government
- victim support services
- place based initiatives such as Neighbourhood Renewal and Community Renewal
- academic sector
- professional colleges and peak bodies.

List of community health services

Of Victoria's approximately 100 community health services, 39 are independently managed community health centres as declared under the *Health Services Act 1988*. The others are larger health services that provide community health as one component called 'integrated community health services', and a small number of non-government organisations.

Table 12 Community health services

Region	Name of community health service
Barwon-South Western	Bellarine Community Health
Eastern Metropolitan	Eastern Access Community Health Inner East Community Health Service Knox Community Health Service Manningham Community Health Service MonashLink Community Health Service Ranges Community Health Service Whitehorse Community Health Service
Gippsland	Bass Coast Community Health Service Ensay Community Health Centre Lakes Entrance Community Health Centre Latrobe Community Health Service Nowa Nowa Community Health Centre
Grampians	Ballarat Community Health Centre Grampians Community Health Centre
Hume	Goulburn Valley Community Health Service Mitchell Community Health Services Ovens and King Community Health Service Upper Hume Community Health Service
Loddon Mallee	Bendigo Community Health Services Castlemaine & District Community Health Service (CHIRP) Cobaw Community Health Service Northern District Community Health Service Sunraysia Community Health Services
North and West Metropolitan	Banyule Community Health Service Darebin Community Health Service Dianella Community Health Doutta Galla Community Health Service ISIS Primary Care Moreland Community Health Service Nillumbik Community Health Service North Richmond Community Health Centre North Yarra Community Health Plenty Valley Community Health Services Western Region Health Centre Sunbury Community Health Centre
Southern Metropolitan	Bentleigh Bayside Community Health Service Central Bayside Community Health Services Inner South Community Health Service

Integrated community health services are community health services which are part of larger health services or hospitals.

Table 13 Integrated community health services

Region	Name of community health service
Barwon-South Western	Barwon Health Casterton Memorial Hospital Colac Area Health Hesse Rural Health Service Lorne Community Hospital Moyne Health Services Portland and District Community Health Centre South West Healthcare Terang and Mortlake Health Service Coleraine District Health Services Penshurst & District Health Service Western District Health Service
Eastern Metropolitan	Angliss Health Services Box Hill Hospital Maroondah Hospital Yarra Valley Community Health Service
Gippsland	Bairnsdale Regional Health Service Central Gippsland Health Service Gippsland Southern Health Service South Gippsland Hospital West Gippsland Healthcare Group Yarram & District Health Service
Grampians	Ballarat Health Services Beaufort and Skipton Health Service Dunmunkle Health Services East Grampians Health Service East Wimmera Health Service Edenhope & District Memorial Hospital Hepburn Health Service Rural Northwest Health Stawell Regional Health West Wimmera Health Service Wimmera Health Care Group
Hume	Alexandra District Hospital Beechworth Health Service Delatite Community Health Service Cobram District Hospital Glenview Community Care Inc. Goulburn Valley Health Mansfield District Hospital Northeast Health Wangaratta Numurkah District Health Service Seymour District Memorial Hospital Tallangatta Health Service Wodonga Regional Health Service Yarrawonga District Health Service Yea & District Memorial Hospital

Table 13 Integrated community health services (continued)

Loddon Mallee	Bendigo Health Care Group Echuca Regional Health Inglewood & Districts Health Service Kyabram & District Health Services Macedon Ranges Health Services Maryborough District Health Service McIvor Health and Community Services Swan Hill District Hospital
North and West Metropolitan	Djerriwarrh Health Services
Southern Metropolitan	Gaulfield Community Health Service Frankston Community Health Service Cardinia Casey Community Health Service Inc. Greater Dandenong Community Health Service Kingston Centre Peninsula Community Health Service

List of primary care partnerships

There are 31 primary care partnerships (PCPs), comprising 800 services, across Victoria. Details of these PCPs can be found at: <http://www.health.vic.gov.au/pcps/webpages/index.htm>.

Table 14 Primary care partnerships (PCPs) in Victoria

Region	Name of community health service
Barwon-South Western	Barwon PCP South West PCP Southern Grampians–Glenelg PCP
Eastern Metropolitan	Inner East PCP Outer East Health and Community Support Alliance
Gippsland	Central West Gippsland PCP East Gippsland PCP South Coast Health Services Consortium Wellington PCP
Grampians	Central Highlands PCP Grampians Pyrenees PCP Wimmera PCP
Hume	Central Hume PCP Goulburn Valley PCP Lower Hume PCP Upper Hume PCP
Loddon Mallee	Bendigo-Loddon PCP Campaspe PCP Central Victorian Health Alliance Northern Mallee PCP Southern Mallee PCP
North and West Metropolitan	Banyule-Nillumbik PCP Brimbank-Melton PCP Hume-Moreland PCP Moonee Valley–Melbourne PCP North Central Metropolitan PCP Westbay PCP
Southern Metropolitan	Frankston-Mornington Peninsula PCP Inner South East Partnership in Community Health Kingston–Bayside PCP South East PCP

Glossary

Term	Description
Ambulatory care	Care that takes place as a day attendance at a health care facility or at the consumer's home. This umbrella term incorporates primary, secondary and tertiary level services, services provided to individuals or populations, services provided on a same day basis and acute episodic or longitudinal care.
Audiology	Assessment, diagnosis, treatment and prevention of disorders of human hearing, including population/public health approach to targeted population groups—all performed by a suitably qualified person.
Casual client	Client who has brief interaction with service agencies.
Client	A client is an individual, organisation or group that receives a service from a provider. For the purposes of recording data, clients are considered to be either individuals (including individuals and family units) or organisations (business, social, community, government or education body).
Community health service	Agencies in receipt of Victorian Government funding through the Primary and Dental Health output group also deliver a wide range of other primary health and support services to meet local community needs. This definition includes community health centres and primary health units or divisions of rural and metropolitan health services.
Contact	One-to-one consultations with individual clients, includes case conferencing, secondary consultation and advocacy (excludes groups).
Counselling	Significant counselling and therapeutic activities, performed by suitably qualified persons, often includes practical assistance and advocacy. Also includes assessment, therapeutic interventions, practical assistance, crisis care, support, referral and advocacy with the goal of harm reduction and/or improved quality of life, social function and/or health.
Department	The Department of Human Services
Dietetics	To provide nutritional support for individuals and groups in health and illness, including population/public health nutrition approach to targeted population groups—all performed by a suitably qualified person.
Health promotion	Health promotion is the process of enabling people to increase control over, and improve, their health. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. The fundamental conditions and resources needed for good health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.
Health service	A publicly funded organisation providing health care. This includes hospitals, rehabilitation centres, aged care services, community health centres and primary care services.
Individual client	An individual client may be one person, a couple or family receiving a one-to-one service from a service provider or providers. A family should be treated as an individual client where a one-to-one service is provided to the family unit. If individual family members receive a separate invoice, this should be treated as separate direct services.

Term	Description
Integrated health	Agencies and organisations from a wide range of sectors and communities in a promotion catchment working in a collaborative manner, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.
Neighbourhood Renewal	A major State Government initiative aimed at tackling socioeconomic disadvantage in Victoria. Locations have been selected because of their relative disadvantage compared to other parts of Victoria and are generally where there are concentrations of public housing.
Nursing	Nursing services are provided by a suitably qualified person who is involved in the provision of clinical care, support and referrals to individuals and/or their carers and groups regarding a variety of medical, social and environmental issues.
Occasions of service	For the purpose of this document only, this refers to the total number of contacts and sessions.
Occupational therapy	The assessment and treatment of people with a temporary or permanent physical disability, including population/public health approaches to targeted population groups—all performed by a suitably qualified person.
Organisational client	A collection of people who, on behalf of an identifiable entity (such as a business, social community, government or education body), receive a service from a provider/s (includes secondary consultation).
Physiotherapy	The assessment, diagnosis, treatment and prevention of disorders of human movement, including population/public health approaches to targeted population groups, with a special emphasis on the neurological, musculo-skeletal and cardiovascular systems—all performed by a suitable qualified person.
Podiatry	The diagnosis and treatment of ailments of abnormal conditions of the human foot, including population/public approaches to targeted population groups—all performed by a suitably qualified person.
Referral	The transmission (physically or by other means) of personal and/or health information relating to an individual from one service provider to another service provider with the individual's consent and for the purpose of care or treatment.
Refugee	According to the United Nations Convention (1951) and Protocol (1967) relating to the Status of Refugees, a refugee is defined as any person who: ‘...owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it.’
Registered client	Clients for whom service providers keep detailed demographic and service use information.

Term	Description
Service coordination	Service coordination aims to place consumers at the centre of service delivery, ensuring that they have access to the services they need, opportunities for early intervention and health promotion and improved health outcomes.
Service planning	Planning that is undertaken periodically with the aim of providing an effective and efficient health service which meets the needs of the catchment population.
Speech therapy/ pathology	The assessment, diagnosis and treatment of individuals with speech disorders, eating and drinking difficulties and swallowing difficulties, including population/public health approaches to targeted population groups—all performed by a suitably qualified person.
Visit	For the purpose of this report, a visit is an attendance to a service for assessment and treatment.

